



The Development of the London Hospital System

1823-2020

Geoffrey Rivett

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'There is no remembrance of former things; neither shall there be any
remembrance of things that are to come with those who shall come
thereafter.'
Ecclesiastes 1, 11.

Second edition with minor revisions 2020

In the midst of all this turmoil the great hospitals go on quietly accomplishing their allotted work, doing on the whole an enormous amount of good, and necessarily doing also a certain amount of mischief.'

Lancet, 18 January 1873

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Foreword

This institutional history of hospitals and the hospital system in London begins with the foundation of *The Lancet* in 1823. The first edition ended in 1982 with the restructuring of the National Health Service. By then management of hospitals in isolation from community health services had ceased. In the last thirty years there have been great changes and this revised edition moves the story on to 2013 when the NHS faced three significant problems. As well as the perpetual need to reconfigure to meet new clinical demands, the capital's hospitals, as did the NHS as a whole, faced the implementation of the Health and Social Care Act 2012, an economic crisis, and the Francis Report into bad patient care in Stafford. Yet changing organisation structures, financial crises and scandals have recurred for two centuries.

Until the health service began in 1948 London's hospitals operated without much thought for national policy. Then increasingly they were affected by national developments such as the expansion of medical science and medical education outside the metropolis, the *Hospital Plan*, resource allocation decisions, changes in hierarchy, management doctrines, the accent on quality and the rights and expectations of patients. London's hospitals, for ever needing to change, had a tough time.

The geographical area with which this book is concerned corresponds roughly with that of the old London County Council. It was in the 19th Century, and often inside London, that many ideas developed which still condition our thinking about the hospital service.

The opening chapters consider the endowed and voluntary hospitals, the poor law infirmaries and the fever hospitals in turn. Thereafter the book is chronological and considers several themes in parallel, the development of concepts of charity, state aid, districts and regionalisation. The interaction of professional developments with medical education, nursing, finance and matters of administration makes it impossible to consider any issue independently. I have not sought to replicate the many excellent histories of individual hospitals or wider ranging accounts of developments in the public health. Neither could justice be done to the evolution of scientific medicine, the great sanitary revolution, or the changes in the social background against which the hospitals developed. Concerned as it is with the issues and debates which affected the London hospitals as a group,

and the acute hospitals rather than those dealing with long stay patients or the mentally ill, the book may seem to discount wider developments by concentrating on the capital. Regretfully I must ask those who wish to know more about individual hospitals or national events to look elsewhere.

The author has spent all his working life in the NHS. In retirement he has been a governor of a Foundation Trust and wrote a further book on the first 50 years of the NHS. This was published in 1998 by the King's Fund and is kept to date on internet at www.nhshistory.net. This second book goes far beyond institutional history into the story of the clinical advances and the politics and finance of the NHS. It contains more details of the wider background against which the London hospital service has operated in recent years.

As far as possible I rely on contemporary material, for latter-day mythology is as common in the hospital service as in other fields. Even so, papers often conceal as much as they reveal, assume a background knowledge few now possess, and frequently stress the achievements of a body beloved by the author and its claims on the private or public purse. This account leads to few organisational or political conclusions about the principles which have governed the development of London's hospital system save that short term and parochial interests have often created immense problems for later generations. Many of those concerned have been wrapped up in their own world. Whilst they were inevitably swayed by the concepts of their time, the interests of their hospital and patients usually came first. In spite of this, the organisation of services has slowly and haltingly improved, the most recent example being the trend to organise specialist services across the system as whole, and not solely within single institutions.

Much of the nineteenth century material has been derived from the medical press, the records of certain hospitals, and to a lesser extent the files of the Public Record Office. For the first half of the 20th century the archives of the King's Fund and the London County Council are prolific sources of material. For the period since the 1939-45 war good records have been kept in a number of hospitals and it has been possible to gain much from talking to those directly involved in the events of the time. My thanks are due in particular to Professor Brian Abel-Smith, Sir Desmond Bonham-Carter, Mr A H Burfoot, Sir Cyril Chantler, Dr Clark-Kennedy, Sir John Ellis, Dr James Fairley, Sir

George Godber, Dr Malcolm Godfrey, Dame Nancy Hallett, Professor Rudolf Klein, Sir Harry Moore, Sir Robert Naylor, Mr David Noble, Mr John Pater, Lady Evelyn Sharp, Dr Charles Webster and Dame Albertine Winner. Where opinion has been allowed to creep in it is my own.

My thanks are also due to the librarians and archivists who have helped me, with much patience, to locate old records, particularly those at the Department of Health, the Greater London Record Office, the Wellcome Institute, the Institute of Health Services Management, and hospitals such as Guy's, St Bartholomew's, the Middlesex and University College Hospital.

Those seeking information on individual London hospitals, specifically those now closed, may find information by searching for a website, *Lost Hospitals of London*. Sadly in this edition it has not been possible to include all the original illustrations nor to recompile more than a skeletal index.

About the author

Geoffrey Rivett was educated at Manchester Grammar School, Brasenose College Oxford and University College Hospital. After house jobs and national service in the RAMC he joined an innovative general practice and in 1972 he moved to the Department of Health and worked in fields such as the planning and management of health services in London and the south-east, which led to his interest in this subject. Later he was concerned with the refashioning of the framework of general practice and primary health care. As a civil servant he saw the NHS reorganisation (1974), restructuring on a district basis (1982), the implementation of the general management function (1984), and the Conservatives' NHS reforms (1989) and was later lead governor of a foundation trust in London.

His second book on the first 50 years of the NHS, *From Cradle to Grave*, was published by the King's Fund in 1998, revised in 2012 and is available on line and on print-to-order.

He is a Fellow of the Royal College of General Practitioners, of the RSM, and a liveryman of the Apothecaries and Barbers. His interests include photography and web-authoring. He lives in the Barbican in central London.

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Chapter 1 The shaping of London's hospital system

'The embarrassing position of London in matters of health administration has always been recognised by those who study local organisation, and the problems of developing, and where necessary remodelling, that administration, when the health of so vast and heterogeneous a population is concerned, is admittedly one of unending difficulty.'

The Lancet, 14 August 1920.

Few things in the hospital world are accidental, and virtually nothing in London is the result of chance. This book is the outcome of curiosity about why things are as they are. A capital city is often the centre of political, ethnic and sociological changes and the hospitals which are maintained by such a society must in some measure reflect the alterations taking place outside their walls. Hospitals are therefore never static, and neither is the system of which - sooner or later - they form part. London's hospitals have been affected by changes in the population structure, the city's politics, the development of medical science and the conquest of diseases. Professor Brian Abel-Smith has written about the development of British hospitals in a national and sociological context.¹ Here the aim is more limited, to consider how during the last two hundred years the hospitals of inner London developed and were shaped into a system. Many of the buildings and even more of the concepts of the two hundred years are still with us. Those who are interested in the hospitals of London and their future cannot ignore their past.

There is a fascination in the sheer complexity of London and the hospitals within its boundaries. 'It is notorious', said *The Lancet*, 'that the problems of London in all matters of social administration and development are different from those present in areas not so immense. Centres of population that are less widely separated into widely differing sections of wealth, status and occupation more readily conform to general schemes.'²

London was unique in its size and speed of growth, and its local government was made no simpler by the independence, power and privileges enjoyed by the vestries and the Corporation of the City of London. Faced with the near incomprehensible complexity of the metropolis, hospital reformers, campaigners and administrators might

adopt symbolic, even simplistic, concepts to guide them. Centralism, voluntarism, municipalisation, cooperation or sanitation might become battle-cries. But the problems of London defied solution by formula; the inbuilt checks and balances are too great.

The state of the metropolitan hospitals

London's hospitals were of interest to a variety of nineteenth century reform movements. All was not well. In 1873 *The Lancet* criticised hospital administration, remarking that none of the eleven largest hospitals was managed in the same way. There were three radical faults.³ First, medical staff were often excluded from the management committee, so that much was left in the dark which should have been told. Second, financial control and general administrative power might lie in the same hands, with the result that expenditure was screwed down in the wrong place and at the wrong time. Finally, the committee of management did not always have absolute control over the nursing staff.

Professional affairs also left much to be desired in the early part of the 19th century. Looking back fifty years to its foundation, *The Lancet* said

‘Speaking broadly, it may be said that professional knowledge was a private and individual rather than a public and widely diffused possession. The eminent men who, by dint of great gifts and unceasing labour, had come to be recognised as masters of their craft, were hindered in their desire freely to disseminate the treasures of their experience and erudition, and were so hindered partly by the absence of easy and recognised channels of publicity, and chiefly by the mistaken views of inferior men, colleagues who had been placed in hospital offices by nepotism or by payment, and who shrank, like the quacks our own day, from imparting to others the weapons by which they trusted to win a way to fortune for themselves. At that time medicine and surgery were still "mysteries", and the hospitals, their temples, were closed to all who had not paid the necessary fee, and at all periods that fee did not cover. The lectures of great men, comparatively seldom embodied in books, were indeed taken down more or less completely by some of the members of their classes, but even then they were guarded with jealous care against publication. A scientific discovery, a new medicine, a new method of treatment, or a new theory of disease, remained for months or years the property of a small number of persons, used or tested perhaps only within the walls

of a single hospital' 3

Such a state of affairs could not last. From the date of the first census in 1801 there was an increasing belief that the state had a duty to know in detail the number and economic conditions of its citizens. Social knowledge of this sort came to be seen as a kind of action in its own right, and the precursor of change. Factual information about the size of a population, its death rate, the migration to the cities, the sanitary conditions of towns, and the institutional treatment of the sick paved the way for reform. Changes in the hospitals took place alongside the campaigns for parliamentary reform, developments in local government and municipal facilities, the creation of a public educational system and the great sanitary movement. Controversy and debate were characteristic of Victorian England as 'good men' fought against 'vested interests'. In his book, *Portrait of an Age*, G M Young said: 'I was constantly being told that the Victorians did this, or the Victorians thought that, while my own difficulty was to find anything on which they agreed.'⁴ So it was in London's hospital world, as conflicts and disputes were waged in the press.

Hospital systems

Small towns only needed one hospital or a small number of institutions each serving a specific purpose. Capital cities such as London and Paris had many and it was in the nineteenth century that it came to be appreciated that the various institutions interacted with each other as components of a system. The approach to organisation was vastly different in the two cities. In Paris the property of the hospitals had been pooled and to their income was added a large contribution from the municipal authority. The hospitals were open to all the sick poor who had a right to claim admission. Each hospital was part of a larger whole and the staff, medical and non-medical, were employed by a single authority and could be moved between institutions. This extreme form of centralism had produced an effective hospital service in Paris, albeit one which was hardly acceptable to English taste.

In London the pattern of the hospital system had grown up in a more haphazard way, shaped in part by the growth in the size and wealth of the city populations, the illnesses from which people suffered, and the advance in the capacity of doctors to treat them. In 1844 an article in *The Lancet* said that the entire hospital system in England was essentially bad. The hospitals were charitable institutions which could

only relieve a certain amount of misery. The state contributed nothing and exercised little or no control over them. The workhouse infirmaries were the state hospitals, and such was their quality that it was distressing that the destitute, when sick, should have to take refuge in them. *The Lancet* preferred centralisation on the Parisian model, placing all hospitals under a central authority and the same regulations. There was little hope of this, for it would require major changes to the Poor Law and the shape of the poor law system of medical relief.

The press and the reformers

The influence of the press on hospital development was considerable. *The Lancet* was founded in 1823 by Thomas Wakely, a friend of the radical politician Cobbett. Wakely was brought up in the West Country and was apprenticed to a country general practitioner. Then, following custom, he came to London to attend the Webb Street School, run by the Graingers, and to walk the wards of the Borough hospitals. The heights of the profession were not open to him as he was unable to pay to be apprenticed to a leading surgeon, and so he entered general practice with the help of his father-in-law. During a melodramatic episode in his first year in practice he was assaulted and his new house was burned to the ground. He turned to journalism and his radical views found a target in the power possessed by the élite of the hospitals and the Royal Colleges.

His journal had several functions: to work for medical reform, the abolition of quackery, the rights of the rank and file, and the education of the profession. Few doctors, after qualification, could either afford or were able to attend the practice of the hospitals, so he fought for a free medical press and the right to publish medical and scientific lectures, previously regarded as the private property of their author. While editor of *The Lancet* he fought parliamentary elections and eventually entered the House as a radical member, where he pressed the case for medical reform. He also became one of the first medical coroners. Wakely's campaigns sought to force hospitals to improve their management, for he opposed nepotism in the selection of medical staff and the systems of closed government as adversely affecting the care of the poor and the education of students.⁶ He reported the decisions taken in the hospitals and the views he expressed were always forthright and sometimes libellous. His accounts of hospital affairs were widely read and at sixpence a copy *The Lancet* became a

prosperous venture. Not surprisingly Wakely encountered great opposition and was frequently in the courts, but when the Charity Commissioners enquired into the endowed hospitals of St Bartholomew's, St Thomas's and Guy's they said that the publicity the 'greater operations' were receiving was 'highly advantageous' for it made the surgeons exert themselves to the utmost.⁷

The emergence of *The Lancet* and other journals, some of which were founded to attempt to counter the effect Wakley was producing, was a reflection of the increasing freedom and growth of the popular press. Even the mighty *Times* would comment upon events in the hospitals. *The Medical Times*, founded in 1839 and sold at half *The Lancet's* price, also sided with the reformers until its ownership and policy changed. *The Medical Gazette*, edited by Roderick MacLeod of St George's, supported the establishment. The medical journals all adopted an abrasive style, and fought each other. *The Lancet* maintained that it alone was independent, whilst its contemporaries were confined 'to the narrow task of upholding particular men or parties, promulgating or supporting measures which advanced particular interests.'

Social reformers have always been part of the London medical scene, and have never had need to complain of a want of subject matter. Sometimes they mellowed with age, but they frequently disagreed with each other as much as with those who supported the status quo. Some might be involved in a number of campaigns. Edwin Chadwick, a disciple of Jeremy Bentham and a liberal by inclination, was an assistant commissioner for the enquiry into the poor law, and the Report of the Royal Commissioners (1834) was drafted mainly by him. Later he became Secretary to the Poor Law Commissioners, and was involved in central government's reorganisation of the older system of relief. It was largely his work which led to the first Sanitary Commission in 1838 and the great Inquiry into the *Sanitary Conditions of the Labouring Population of Great Britain* in 1842. A key figure in the sanitary movement, he laid down precise rules for the construction of dwellings and hospitals. In his later years he was a close associate of Dr Southwood Smith of the London Fever Hospital and an adviser to Florence Nightingale. The statistician William Farr (1807-1883) was another reformer who in his earlier years provided an intellectual leadership to disgruntled members of the medical profession. Even some of Thomas Wakley's early opponents, like Mr Guthrie, the President of the Royal College of Surgeons, were keen to raise

standards and brought about change in their own organisations.⁸

Political and religious differences might determine who supported whom, and the governors of the great London hospitals might be either Whigs or Tories; both parties introduced measures designed to improve the hospital services. Those supporting the hospitals might be high in the church, members of the nobility, utilitarians, humanitarians, dissenters or radicals. They acted with varying degrees of enlightenment or self-interest, often inheriting their beliefs from those who had gone before them. Most came to have the same general objectives, the relief of the sick poor, the strengthening of the hospitals and higher professional standards. The majority wished to raise the poor to honest independence, although some rejected the charitable principle believing that the working man could, if properly organised, provide for his own care through provident societies. All kept a wary eye on costs and came to regard inadequate care as a scandal, whether it was a pauper dying in a workhouse or a newly qualified doctor turning a patient away from a hospital. 'It is organisation, not destruction, at which we would aim,' said *The Lancet*.⁹ Nevertheless reformers spoke bluntly, and in the rough and tumble of the times referred to the Society of Apothecaries as Rhubarb Hall and the Royal College of Surgeons as the Bat's Cavern.

Health and social conditions

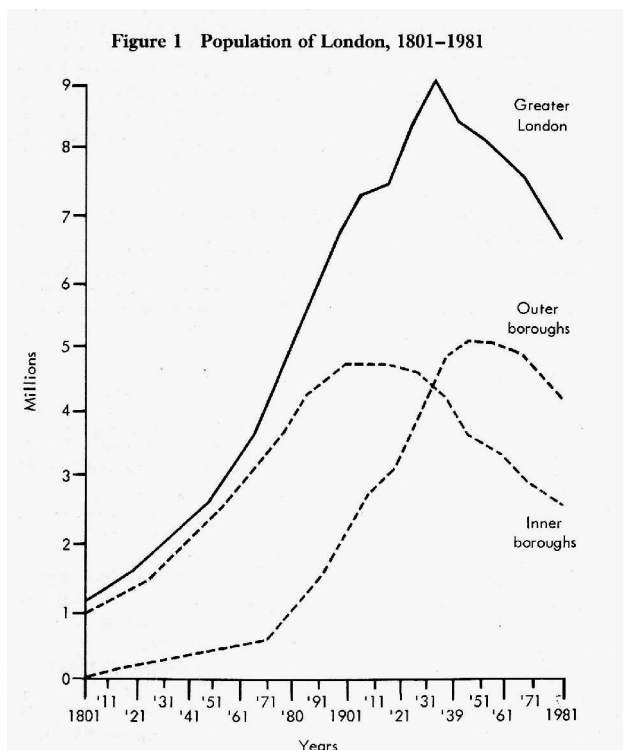
The centre of town, where the hospitals were clustered, had long been an unhealthy place as the bills of mortality showed. Crowded conditions, great poverty, old buildings in narrow courtyards, inadequate drainage and poor water supplies were ever present, and Chadwick pointed to the association of epidemic and endemic diseases with 'atmospheric impurities produced by decomposing animal and vegetable substances, damp and filth, and overcrowded conditions'.¹⁰ The Health of London Association believed that an immense amount of sickness was caused by defective drainage and sewerage, the shortage of pure water and inadequate cleansing of the streets.¹¹

A greater interest in statistics and improved registration of deaths increased the information available about the diseases affecting the population. The Statistical Society of London was founded in 1834, and Farr's work at the General Register Office with the Weekly Reports for the metropolis demonstrated differences in mortality. In

1847, the year before John Simon was appointed as Medical Officer to the Corporation of the City of London, Hector Gavin, a lecturer on forensic medicine at Charing Cross, wrote that there was an excessive mortality in town compared with the country, in some towns over others, and in some parts of the same town over other parts.¹² He pointed out that the excess mortality fell mainly on the lower classes and presented the average age of death by borough. In Southwark the average age of death was 20 years for artisans and 46 for the gentry, well below that of their country cousins. London was the supreme example of Disraeli's 'two nations'. Patterns of disease, of life and attitudes, separated East End and West End. What reason had the west-ender to visit the east, and what advantage befell the east-ender who went up west? The populations knew little of each other's worlds.

The pattern of disease in the capital was dominated by fevers and was associated with poverty, hunger, vice and dirt. The hospitals by themselves could do little about the underlying problems, which were attacked by the sanitary reformers. Hospitals and workhouses contented themselves with dealing with the consequences of the conditions around them; hospitals for those who were proper objects of charitable relief and the workhouses for the destitute. 'It is notorious', said *The Lancet*, 'that the great majority of acute illnesses of the poor are directly caused, and that the residual minority are greatly aggravated, by conditions arising out of the utter neglect of sanitary legislation.'¹³ The need for radical reform of local government in London, with its seven different commissioners of sewers, a hundred different paving authorities, and its competitive supplies of unfiltered river water was appreciated by reformers like Chadwick. There was no coordinated approach to the problems until the Metropolitan Board of Works was established in 1855, and not until 1889 was the London County Council formed, well after the corporations of the provincial cities had been established. The twenty eight London boroughs did not replace the vestries for a further decade.

The correlation between poverty, overcrowding, poor sanitation, disease and infant death was increasingly recognised. From 1857 Dr George Buchanan, Medical Officer of Health to St Giles' and St George's Bloomsbury, recorded in his Annual Reports the different incidence of disease in the slums and in the better parts of his district. Five times as many infants died in the slums.¹⁴ In 1928 two Ministry officers, reporting on the institutional treatment of London's sick, could still point to a relationship between overcrowding and the number of



The population of inner and outer London, 1801- 1981

people receiving institutional relief.¹⁵

Demand for care was greatest where housing was poorest, and discrepancies in the correlation were mainly due to local practices. Lewisham had a good reputation and many sought care, while the board of guardians of Islington were strict in applying the criteria for admission, so fewer received indoor relief. In 1945 the London Hospital Survey again pointed to the effect of environment on the demand for hospital services, stating that 'it seems broadly probable that the needs for an urban area like London are greater than a rural area like Dorset, and those of the east end of London greater than those of a sea-side resort like Eastbourne.'¹⁶ Census information repeatedly showed that there is a consistently high level of deprivation

in inner London, which is amongst the most deprived areas in the country, and the tendency of boroughs to maintain the same characteristics over a period of many years. Health inequalities are still with us.

Population changes

London began to grow quickly during the eighteenth century. successive maps demonstrate the speed of growth, for as late as the first half of the nineteenth century fields surrounded Islington, approached Westminster and were close to the south bank of the Thames. As the population grew new hospitals were founded in increasing numbers; St George's in the west (1733), the Middlesex in the north (1745) and The London in the east (1740) were built on the edge of town where land was most easily available. Workhouses and infirmaries were also built on the periphery, soon to be engulfed as London grew. The demographic changes were charted by the censuses and the pattern of development was soon recognisable. Population projections appeared in *The Lancet* as early as 1867.¹⁷ By 1889 the journal was commenting on the high rate of increase in the outer suburbs.¹⁸ From 1871 onwards the central districts lost population in every decade, the inner boroughs reaching their peak population before the outer ones, Westminster before Hackney. Greater London expanded at the expense of the inner city, for while many still came to live in the centre a greater number were leaving to live in the suburbs.

From the 1830s the development of railways and the construction of new roads led to the destruction of slum property and the eviction of the poor in their thousands. After the formation of the Metropolitan Board of Works in 1855 the process of 'metropolitan improvement' proceeded rapidly.¹⁹ New Oxford Street and Victoria Street had already cut through massive areas of slums. Holborn, Clerkenwell Road, Shaftesbury Avenue and Charing Cross Road led to the demolition of a bewildering maze of streets and narrow alleys between 1867 and 1887. Being dispossessed, the poor fled to live amongst those equally poor in neighbourhoods such as St Pancras. Efforts to rehouse those who were displaced were made by the Metropolitan Board of Works and charitable bodies such as the Peabody Trust, but went only a little way towards meeting the need. No money from the rates of the richer parishes helped the parishes to which they had exported their paupers.²⁰ Such matters were not settled on the merits

of the case, but by the effects on the rates of rich and poor parishes. Rates equalisation and the advantages of a 'common metropolitan fund' were frequently discussed, but how could rich and poor vestries agree on this?

The suburbs were hailed as a possible answer to the housing question. Speculative building and transport links led to rapid development, but this was not evenly spread around London. As early as 1873 tramlines spread out from Aldgate and Whitechapel to Stratford, Hackney and Stoke Newington. Other lines connected Finsbury Square to Highbury, Holloway and Archway. The introduction of cheap workmen's fares under the Cheap Trains Act (1883), particularly along the lines of the Great Eastern to Stamford Hill, Edmonton and Tottenham, led to further speculative development. Hospital provision was never adequate in the new areas, although in total the number of beds provided in hospitals and infirmaries rose rapidly.²¹ The disparity between the population and the services available to them long remained a characteristic of the suburbs.

Medical development

The shape of the London hospital system has also been affected by developments in medical science and medical education. In many ways it has been the activities of doctors which have determined the pattern of the hospitals. The increasing ability to treat disease and improved standards of care shortened the time patients spent in hospital, raised the demand for services and led to an escalation of cost. The development of specialisation led first to the development of the special hospitals and later to special departments within the general hospitals. Advances in bacteriology, biochemistry, physiology and radiology created the need for laboratory accommodation and service departments, so that hospitals no longer consisted merely of an operating theatre and a series of wards. Sub-specialisation ultimately meant that services had to be organised on a regional basis and the very reputation of the capital's doctors affected the number of patients to be seen. The hospitals of central London have long served a population much larger than their local residents.

It is against this complex background of population movement, poor social conditions, disease, wealth and poverty, professional expertise, critical comment and publicity that the London hospitals developed. A complex institutional pattern emerged. Voluntary hospitals grew up

beside the ancient royal and endowed hospitals. A local government service providing institutional care for sick paupers developed alongside the hospitals. A network of fever hospitals, scientifically planned from the outset, was established. Physically near to each other, staffed by doctors who had trained in the same hospitals, and often serving the same people, the different objectives and status of the institutions led them to work in virtual isolation from each other. Each hospital had its own traditions and nobody standing in the middle of a ward could have doubted for a moment the type of hospital he was in. Countless details gave each an atmosphere of its own, and the different methods of administration and levels of staffing set them apart.

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Chapter 2 The Voluntary Hospitals

'A hospital is, of all social institutions, the one in which perhaps the greatest mixture of motives, the most incompatible ambitions and the most vexatious vested interests are thrown together.'

Westminsster Hospital 1719-1948 Langdon-Davies 1952

The concept of a hospital is a simple one to patients seeking care. To those who work within them hospitals are worlds and empires of their own. The groups working within hospitals have, on the face of it, a common aim - but their interests are divergent. As a result the reaction of a hospital to change may baffle the outside observer, who knows little of the pressure groups within its walls. This chapter considers some of these groups, and issues of importance to them.

Like other social services, London's voluntary hospitals owed their foundation to charity. In the middle ages they were not solely devoted to the acutely ill; they also provided a haven for the lame, the blind, the chronic sick, the mad and the beggar. After the dissolution of the monasteries the citizens of London made a careful census of those for whom they wished to provide care. The royal hospitals included St Thomas's, St Bartholomew's, Bedlam, Christ's Hospital and Bridewell. St Thomas's and St Bartholomew's took care of the ill, curable and incurable alike, Christ's Hospital took foundling children, Bridewell the idle, and Bedlam the insane. Though closed at the time of the Reformation, St Bartholomew's was re-endowed by Henry VIII as a result of a petition by the Lord Mayor of London, and St Thomas's by Edward VI. A legacy of the Middle Ages, they were supported by estates confiscated from the Church but preserved for charity. Guy's, founded in 1721, was maintained by the riches of that prudent speculator Thomas Guy and represented the philanthropy of modern commerce. All three could subsist on the income from their large investments without recourse to appeals to the public. They were therefore known as the 'endowed' hospitals.

Otherwise there was little interest in the founding of hospitals until the early eighteenth century when it became increasingly common. A group of like-minded individuals might form a charitable association, with one or more medical men. The doctors might be professional leaders, such as Cheselden who was on the staff of several hospitals. On the other hand they might merely be seeking a reputation. Simultaneously there were developments in medical knowledge and

the role of the hospitals began to change. From being places of refuge they began to develop into institutions for curing, rather than care and comfort. Sometimes a single individual would follow Guy's example and make a magnificent donation. In 1832 Captain John Lydekker left four of his ships to be sold for the benefit of the Seamen's Hospital. But such men were uncommon, and the single pious benefactor gave way to groups of the wealthy and charitably inclined. The new hospitals were founded on a wave of philanthropy by those who wished not merely to alleviate distress but to restore the afflicted to respectable and independent citizenhood.

The great general hospitals came to cluster, like the Pleiades, within the boundaries of eighteenth century London. St Bartholomew's and St Thomas's, north and south of London Bridge, were well sited for Elizabethan London. Guy's was built directly opposite St Thomas's by the wish of the founder. The Westminster, the first of the new wave of voluntary hospitals, was founded in 1720 to meet the needs of the poor living nearby. With St George's, formed in 1733 by a group of doctors who seceded from the Westminster and established themselves at Lanesburgh House in the healthy air of Hyde Park, it provided services to the West End for the first time. The London Hospital (1740) was built in the east on the quiet road leading from the City to the pleasant village of Mile End for the poor of Aldgate and the adjoining riverside.

Shortly after, in 1745, the Middlesex was established to serve the sick and lame of Soho. By 1809 London could boast seven general hospitals, four lying-in hospitals, two for infectious diseases, the Lock Hospital for venereal disease and an eye hospital.

By the early years of the nineteenth century the hospitals were developing yet another function. Not only were they treating patients but they were developing an educational and scientific role. A witness to the Select Committee on Medical Education (1834) said that the hospitals were amongst the chief sources of the advancement of medical science. They provided the best basis for the study of pathology and therapeutics, as long as the staff were up to standard. Three hospitals founded around this time reflected the new role. Charing Cross Hospital was developed in 1821 on the basis of a plan proposed by its founder, Benjamin Golding. From its outset Charing Cross was to combine a medical school and a charity for the welfare of the poor. University College Hospital and King's College Hospital were

also academic foundations, established close to the colleges it was their function to serve and to which they owed their creation.

University College was founded in 1828 in the Benthamite and utilitarian tradition to provide a university education for the youth of the metropolis, without reference to religious creeds or distinctions. Wishing to establish a medical faculty, it presented land to a committee established to create a hospital by expanding an existing dispensary. *The Lancet*, which was critical of the standard of medical education in the existing hospitals, welcomed the establishment of the new North London Hospital which opened in 1834.² It provided 130 beds to 'improve the efficiency of the medical school, and serve the 250,000 residents around Islington and St Pancras.'

The Royal Free Hospital was founded in 1828 by Dr William Marsden on a principle then new for London's hospitals. It provided treatment without asking prospective patients for a governor's letter of recommendation, or expecting any form of payment from them. The need for treatment was the sole passport to admission. St Mary's (1845) was a response to the needs of a local neighbourhood which 'had grown immensely in population and wealth while remaining destitute of any adequate means of relief of the poorer inhabitants when suffering from accident or disease'. Its size was determined by examining the ratio of beds to population, members of the board studying the experience of the Assistance Publique on a visit to Paris. With a population of 150,000, it was calculated that Paddington stood in need of 376 beds.

King's College, an Anglican reaction against University College, had greater difficulty in finding a site for its students, and after seeking to utilise the clinical facilities of the new Charing Cross Hospital, it took over the old Strand Union workhouse. The medical press was less enthusiastic about this decision. 'If a person well acquainted with London was desired to name its most unhealthy spot he would inevitably fix on that of Clare Market. Flanked by two grave yards, offal shops and human piggeries an old building has been selected by the wise and disinterested managers of King's College for their hospital.'³ It was located 'in an atmosphere impregnated with the effluvia of the dead, by shambles, brothels, disease and death'.⁴ King's College bought a larger site nearby in 1846, but could not afford to rebuild until 1860.

The great hospitals therefore had a variety of origins; some were ecclesiastical or charitable in origin, and a few were educational. Other smaller hospitals were also founded, often on the basis of an existing dispensary to which beds were added.

The smaller hospitals might not be so wealthy, but they were proud of their reputation and often enjoyed Royal patronage; the Metropolitan Free Hospital, established in 1837, was supported by Prince Albert. Its object was 'to grant immediate relief to the sick poor of every nation and class whatever may be their diseases, on presenting themselves to the charity without letter of recommendation; such letters being always procured with difficulty and often after dangerous delay'.⁵

A German doctor who visited London in 1840 remarked on the admirable cleanliness of the hospitals, the excellence of the provisions, the attention of the nurses, and last but not least the number and purity of the water closets. The criticisms he made were of the want of any central board of organisation, the difficulty patients had in obtaining admission if they did not have a governor's recommendation, the restriction of admissions to one or two days a week, the insufficient frequency of the visits of the physicians and surgeons, and the small number of beds compared with the population in London when contrasted with the continental cities.⁶

The dispensaries

Alongside the voluntary hospitals, which initially provided little in the way of outpatient care, lay dispensaries supported by charity to serve those of the sick poor whose condition did not require admission. Two were established around the beginning of the eighteenth century, but did not survive. The first to become firmly established was the Royal General Dispensary in Bartholomew Close, which was founded in 1770, amalgamated with St Bartholomew's Hospital in 1932, and ultimately succumbed to bombing. In early days treatment was free, but the patient had to produce a letter of recommendation from a subscriber to the charity. Later dispensaries might ask patients for payment, perhaps for the medicine supplied, and others were established as part of a drive to form a chain of provident dispensaries to which potential patients subscribed on a weekly basis. Dispensaries, like hospital outpatient departments, might therefore compete with general practitioners and if they did not charge an

economic rate they were looked on with disfavour. If they did levy a comparable charge, the dispensaries found it difficult to survive in the face of the competition of the free outpatient departments of the hospitals. Free, provident or private dispensaries sometimes came to specialise in particular conditions, and they might develop into a small hospital by the addition of beds. The teaching staff of the private medical schools often held an appointment at a dispensary, which was therefore used for teaching; and dispensaries might be stepping stones to a post at a major hospital.⁷ Dispensaries would issue certificates to students to say they had attended for the clinical experience, and these enabled the student to take the Licence of Apothecaries Hall.

The sick poor

Hospitals existed to help the 'sick poor'. But what type of sickness should receive treatment and who, precisely, were the poor? *The Lancet* described a hospital's functions as to assist 'suitable cases for charity, supply the wants of the afflicted, and obtain the assistance of eminent advisers with the comfort of adequate provision, whilst they are unable because of sickness or accident to follow their normal pursuits.'⁸ Some concepts, generally accepted in the eighteenth and nineteenth centuries, are hardly understood today. Society distinguished those who were *poor* from those who were *destitute*, and likely to remain so. Self-reliance and thrift led some who were poor to make provision for the cost of illness, but the hospitals usually interpreted their role generously so that labourers, small tradesmen and mechanics needing their facilities would be admitted. To extend charity further, to assist those who sought free care but were well able to pay, was considered an 'abuse' of the funds contributed by the charitable.

Neither was it the province of charity to assist those who should turn to the Poor Law. Charity should *prevent* destitution. It was the role of the Poor Law to relieve it. Charity was a free gift designed to raise people so that they could support themselves independently once again. Funds were limited and they had to be applied selectively where they would do the most good. Those unlikely to recover rapidly as a result of hospital treatment would inevitably be a burden on the charity, and they were often refused admission. Selection of patients might also be affected by religious or social attitudes. Fallen women, those with venereal disease, or who were suffering as a result of their own

dissipation, might be regarded as unfitted for charitable care. If future independence was impossible, and the claimant was likely to remain destitute, charity had little part to play and might indeed be injurious.⁹ Hospitals were there to admit deserving cases, capable of rapid improvement. Sir Henry Burdett, a well-known hospital administrator, said:

"The object of the hospitals is to cure with the smallest number of beds the greatest number of cases in the quickest possible time. The people who are entitled to free relief are those who are able to maintain themselves independently of all extraneous assistance until the hour of sickness when the breadwinner, for instance, is struck down, or the added expense of sickness in the home renders it necessary that the hospital or dispensary should step in."¹⁰

The organisation of clinical work

Until the end of the nineteenth century there was little treatment a hospital could offer which could not be provided just as effectively in a well-appointed domestic dwelling. The better-off, who were ineligible for hospital care, were therefore treated in their own homes. Nevertheless, by the standards of the time the great voluntary hospitals of London provided a high quality of care and according to a French enquiry in the 1860's it was safer to be in a London hospital than one in Paris.¹¹

In 1822 Sir Gilbert Blane listed the commonest conditions in hospital, as opposed to private practice, as intermittent fevers, rheumatism, dropsy and continued fever.¹² Chronic tuberculosis, affecting bones and joints, tumours at an advanced stage, bladder calculi and the late results of syphilis were also frequent. Graphic accounts of individual cases can be found in the hospital reports and 'mirror of hospital practice' in *The Lancet*. From the first issue in 1823, Wakley published detailed accounts of patients under the care of the physicians and surgeons of the metropolitan hospitals. Not only had he personal access to the wards and theatres, but he employed senior students as his reporters.

The way clinical work was organised in the three endowed hospitals was described in some detail by the Charity Commissioners in 1840.¹³ It was customary to admit patients on one day of the week; Tuesday at St Thomas's, Wednesday at Guy's and Thursday at St

Bartholomew's. Usually there would be between 50 and 100 applicants each admitting day, but emergencies and accidents would be received at any time. During the first 33 weeks of 1836, 1,725 cases were admitted to St Bartholomew's on Thursdays, and 1,797 cases as emergencies on other days. Medical staff made a rapid assessment of the clinical priority of those attending, who were well aware that a judgment was also being made on whether they were fit objects of charitable relief. In the endowed hospitals the urgency of the case and its medical interest were the main criteria for admission, but elsewhere a recommendation from a subscriber or a governor's letter might prove the decisive factor. Once admitted a patient would be bathed and put to bed. A card bearing the patient's name and that of the medical officer responsible might be fixed to the bed. The doctor would visit the patient and write his prescriptions in the ward book, which would be taken by the sister to the hospital apothecary's shop for the medicines to be dispensed. When the hospital was full patients would regretfully be turned away to try their luck elsewhere.

Until anaesthesia was introduced in 1847 comparatively few operations were performed. Each hospital had a traditional operating day, published in the journals. All the hospital's surgeons would receive notice of the cases and might attend, crowding the theatre with their dressers and pupils. When ready for discharge, a patient might be asked to visit the Steward's office and give humble thanks to the charity for his cure. Both the endowed and the voluntary hospitals concentrated on the curable to prevent abuse of their facilities and avoid the risk of their becoming mere almshouses. Some charities framed their rules to exclude specific diseases. Nevertheless, Bristowe and Holmes showed in 1863 that all the great hospitals were admitting typhoid and typhus fever, that smallpox sometimes found its way into the wards, and that syphilis was regularly admitted to the Middlesex, the Royal Free, Guy's and Bart's.¹⁴ Cancer cases would be taken by the Middlesex. Hospital committees might stipulate how a charity was to be run, but the principles and practice of a hospital did not always coincide. As the capacity to treat disease grew, hospitals became increasingly selective, choosing those who would benefit rapidly, particularly from surgical treatment. Selection was necessary because the number of beds available was restricted by the money which could be raised. The population of London was growing, and the accommodation was unable to meet the needs. Those who required long periods of treatment could not be admitted even if improvement was ultimately probable. The hospital was not a refuge from the

buffeting of the outer world, but a great and complicated piece of machinery, every detail of which had as its object the care of the patient.¹⁵

Reliable information about the clinical activities of the hospitals was difficult to obtain. The witnesses giving evidence to the Select Committee on Medical Education in 1834 regretted that analyses were not available in the London hospitals as they were in France and Germany.¹⁶ Wakley estimated that about 25,000 inpatients were treated each year in the London hospitals, of whom about 2,200 died. How many were investigated and recorded in the hospital records? Wakley quoted a book written in 1732 by Francis Clifton, physician to the Prince of Wales, which suggested that details of cases be kept and published annually. *The Lancet* believed that numerical methods were necessary for the advancement of medical science. The Statistical Society of London had circulated forms for the hospitals to use, for the accumulation of facts was an obvious duty, and medicine was a science of facts and experience.¹⁷ Florence Nightingale supported the cause of better hospital information, read a paper on the method of reporting hospital statistics to the International Statistical Congress in 1860¹⁸, and designed returns which hospitals might

However only a few hospitals, such as Guy's and University College Hospital, kept good records. Even fewer published systematic analyses of their work, with the mortality of each type of case. With increased interest in medical science some began to do so around the middle of the nineteenth century. St George's started to publish its figures in *The Lancet* 20, and roughly at the same time a uniform nomenclature of disease was prepared by William Farr and adopted by the Registrar General. The foundation of a hospital statistical system was laid.

As selection of cases for admission became increasingly refined, some needs had to be disregarded. *The Lancet* said that every hospital physician and surgeon must have suffered many a pang while laying down the rule that hospitals were for the really sick, and not merely wretched; and that curable cases had priority over those which could not expect relief.²¹ Those working in the hospitals saw the need for additional accommodation for cases which required prolonged care and skilled nursing. Some hospitals therefore developed convalescent homes or country branches, like St George's which was enabled to do so by a legacy from Mr Atkinson Morley. He had been a student at St

George's and was later the proprietor of the Burlington Hotel in Cork Street.

Medical interest rather than social need is too glib a way of expressing the policy of selection. Any other approach would have created its own problems. There were plenty of examples showing that a hospital attempting to meet all needs from foundling children to the infirm elderly soon ceased to provide a service for the acutely ill. The growing importance of the medical schools attached to the great hospitals could only accelerate the trend to selectivity, and the large number of patients who applied for charitable relief inevitably meant that some were more fortunate than others. The voluntary hospitals could not meet all needs.

The governors

With the exception of the endowed hospitals, where other rules applied, the governing body usually consisted of everyone who had made a significant contribution to the funds of the hospital, either on an annual basis or by life subscription. The details varied from hospital to hospital, but usually stemmed from the way in which the institution had been established. Most had been founded by individuals or small groups, and were constituted by Royal Charter, Act of Parliament or by a constitution agreed at a public meeting of subscribers. The governors were not publicly accountable, yet increasingly these privately run institutions came to bear public responsibilities. At St Thomas's and St Bartholomew's the treasurer was a senior governor; at Guy's he was the chief officer.

The Lancet said that 'a passion deeply rooted in the human race is the love of governing'.²² There were extensive opportunities for the energetic subscriber to govern for it was from amongst the governors that the weekly management committee was elected. These committees undertook the regular business of the hospital and met more frequently than the full governing body. Most governors, however, were not energetic and were indifferent to all their privileges, save the right to recommend patients for admission by 'governors' letters'. In the competition for subscribers this privilege was widely offered; the initial appeal on behalf of the North London Hospital (University College Hospital) offered three-guinea subscribers the right to recommend three inpatients and six outpatients yearly, four of whom might be pregnant women.²³

Thus hospital management tended to pass into the hands of a few people, usually prominent subscribers, sufficiently skilled and with enough time to devote to the charity. Wakley and *The Lancet* did not approve of inner circles, particularly as medical staff were often excluded from governorship and management. At St Thomas's and the other endowed hospitals the concentration of power in the hands of the treasurer was great indeed. When management committees met, the individuals present tended to vary. The policy of a hospital might therefore change without warning. Few would entrust their personal affairs to a body never likely to be the same twice in a year, but this was the position in many hospitals. It was hardly surprising that management was sometimes lax.²⁴ The role of the governors inevitably altered as the functions of the hospitals themselves changed. Founded as philanthropic institutions for the sick poor, they rapidly became training schools for doctors and centres of scientific research. The power structure within a hospital which was developing an educational role as well as a ministering mission could be controversial since contributions were usually forthcoming for the care of the sick, not because of the scientific reputation of the institution. Professional eminence alone did not guarantee a hospital financial prosperity - indeed it could be a drawback. Doctors were seldom major subscribers to the charities, although they might give their time free of charge. He who pays the piper calls the tune - and the hospitals depended upon lay support.

Finance and philanthropy

The wealth and financial security of the voluntary hospitals varied widely. In any year there might be a small surplus or a worrying deficit. The London Hospital had to close wards and streamline administration to meet straitened circumstances at the end of the eighteenth century. The Middlesex Hospital narrowly avoided a strike in 1800 when the staff objected to the shortage of potatoes and the poor quality of the beer following an economy campaign. In 1821 the weekly board was told that more expensive drugs were being dispensed than was proper for a charitable institution, the surgeons were increasingly prescribing and that the use of leeches had risen to almost a hundred a day. As they cost sixteen shillings a hundred it was suggested that each was used twice. A leader in *The Lancet* pointed to the need for hospitals to combine efficiency with economy and for medical men to assist in keeping hospital expenditure within due bounds. Junior doctors

seemed to believe that drugs were cheap and were extravagant in the use of lint and bandages. Their seniors might cut costs by substituting beer for wine and normal diet for eggs and fish when the nature of cases permitted.²⁵

Only the three endowed hospitals had significant reserves. The others were dependent upon the money received year by year, and ran continuous appeals and publicity campaigns. Some financial crises lasted many years; an agricultural depression would affect investments and the ground rents received. Those subscribing might be actuated by pure philanthropy, or a desire for social advancement, but hospital secretaries were concerned with money rather than motivation. Reports and appeals would be written to create in the minds of those who were charitable only in the slightest degree, a flattering illusion of their virtue. Hospitals stressed their individual attributes, the Westminster its position as the 'oldest hospital in London supported by voluntary contributions'; Charing Cross the services it rendered to victims of accidents in the Strand and Covent Garden; and the Seamen's Hospital its work for merchant seamen of all nations and in the field of tropical medicine. Regular subscribers were courted and subscription lists were invariably published.

Desperate advertisements for donations and festival dinners at which the nobility presided and the wealthy attended, provided at best precarious support for hospitals without large endowments. It was easy to ridicule these dinners, for the costs sometimes exceeded the sums apparently raised, but the managers of a charity might use a dinner to focus and impress the features of an appeal, and obtain publicity. As long as hospitals of renown were compelled to beg, anything which brought publicity had to be welcomed or condoned. All were enrolled in the cause of sweet charity. At a charity performance at the Hospital for Sick Children, Great Ormond Street, a well known actress, referring to a notorious highwayman, delivered lines typifying the tone of appeals 26

*I crave for them your sympathy untold,
Your love, your help, your pity — and your gold!
The last I'm bound to have, for, you must know
I played Jack Sheppard many years ago!
I've not forgot his impudence, his dash
-His rare persuasive power when seeking cash!
Stand and deliver - sovereigns, fifties, fives -*

We want your money, for we want their lives.

Sometimes those who made only a small contribution at a dinner, later became major benefactors and hospitals had to be persistent to remain in the public eye.²⁷ The London hospitals were in the centre of the wealthiest city in the world, but unlike the hospitals in provincial towns they were not a focal point of municipal pride. They were in financial competition with each other, a competition which might become bitter when major appeals were launched simultaneously. The numbers of charitable people were as few then as they are today, yet the Corporation of the City of London helped when it could. The Mansion House was often the meeting place for those discussing the problems of the hospitals and raising funds, and the Lord Mayor himself frequently launched appeals.

The doctors

The medical staffing arrangements differed according to the size, the wealth and the prestige of the hospital concerned. At the three endowed hospitals the arrangements were broadly similar.¹³ There were three principal physicians and three principal surgeons who attended their cases several times a week. The senior medical staff of the great hospitals were generally Fellows of the Royal Colleges of Physicians or Surgeons. If they were not, with few exceptions they soon obtained this distinction. The smaller voluntary hospitals, and the dispensaries, could not be so selective. A salary might be paid to the senior medical staff but it would be small and largely symbolic. A greater reward was to be expected from the fees paid by pupils and dressers. Each surgeon at Guy's had the right to appoint four dressers from among the pupils. Dressers were not chosen for their talents or proficiency, 'but in consideration of an additional fee of £50 for twelve months'.¹³ At hospitals of less renown than the endowed hospitals the medical staff might be smaller, doctors would not be remunerated for their services and, if there were no medical school pupils, dressers and house surgeons might not be found.

In the absence of the senior staff patients would be looked after by assistant physicians or surgeons, who generally had duties in the outpatient department. The assistants could look forward to promotion with some confidence, for in the words of the Charity Commissioners in 1840: 'there seems no doubt that the fact of being connected with

the establishment forms a very important element in the probability of success of a candidate for one of the three surgical or medical offices of the hospital.' Open competition as a way of advancement in a profession was rare in the early nineteenth century; competitive examinations were not instituted in the Civil Service until 1870.

The Times said that connection with a great hospital was the main ambition of London physicians and surgeons.²⁸ 'It gives professional status; it brings fees for tuition which are serviceable during the time of waiting for fame; it often leads to a large and lucrative practice; and, indeed, without it there is scarcely a possibility of a very high position being attained.' *The Times* considered that men possessing such advantages wished to share them with the smallest possible number of people, and to pass them on to their own kinfolk and friends. The position of apothecary had passed from father to son at both St Thomas's and Guy's. Indeed though many brilliant men served the hospitals, the methods of selection were easy to criticise. Generally senior medical and surgical staff were elected by ballot of the governors, a practice which had seemed harmless enough to begin with, for who were better placed to guide a charity than its subscribers? But, as the Charity Commissioners pointed out, few governors had the knowledge to decide upon the relative competency of rival candidates, and it was inevitable that they would look to the existing staff for advice.¹³ Personal influence rather than achievement was therefore the key to advancement. One treasurer said that the reputation which a post on his staff conferred was worth £5,000. Posts being the doorway to fortune, the profession 'keenly and not seldom meanly contested the opportunity to give away their skill, time and experience.'²⁹ Whilst doctors were so willing to serve a hospital without apparent reward, it was hardly surprising that governors saw no reason to pay them. Posts would be contested as fiercely and as expensively as those in a parliamentary election. Candidates circulated handbills to the governors and might pay for their friends to become governors to add to the votes they would receive. Pupils who had paid the substantial sum to be dresser to a surgeon might in later life look to him to support their candidacy. Under such a system outsiders stood little chance, and inbreeding was the rule in most of the great London hospitals. ³⁰

The relationship between the medical staff and the administration was usually smooth but could be, in the words of *The Lancet*, 'fruitful in annoyance and far from conducive to efficiency'. As a rule, the

honorary staff were excluded from the governing body. Only at University College Hospital and the Westminster was this not the case - and at St George's and St Mary's where doctors were eligible to subscribe and become governors like anyone else. At no London teaching hospital was any of the consultants a member of the weekly management committee. In the three endowed hospitals exclusion was based on the principle that the management of the hospitals' princely revenues required specialised knowledge and ample time, qualities not often found amongst eminent medical men.²² The claim for greater medical influence was frequently pressed in medical journals such as *The Lancet* and it became a matter of open controversy from time to time, as it did at St Thomas's in the 1860s, Guy's in the 1880s and the National Hospital for the Paralysed and Epileptic at the turn of the century.

In the earlier part of his career one of the great figures in the Victorian hospital world, Henry Burdett, supported the demand of medical staff for board membership. Later he came to prefer the approach adopted at St Thomas's, The London, the Middlesex and other great hospitals, which operated 'peacefully and satisfactorily'. At these hospitals it was recognised that the medical staff had a purely professional role and there was a medical committee to which the board referred matters of hospital management with professional implications. The alternatives were for two of the medical staff, elected by their colleagues, to serve on the board or, rarely, for the whole of the medical staff to be ex-officio members. 10, 31

The medical press objected to suggestions that doctors who gave their time to a charity free of charge should be regarded as no more than employees of the governors. Doctors would certainly have preferred a medical presence on their board, but usually they only became outspoken when they found themselves unable to influence the governors. This was the position at the National Hospital for the Paralysed and Epileptic, where the staff felt that although it was their skill which had established the hospital's reputation, their views would only reach the board if Mr Burford Rawlings, the secretary-director, was prepared to pass them on. After thirty two years of service the board seldom overruled 'so splendid a specimen of hospital officialdom', as he was described by Burdett. In Burford Rawlings' view, doctors found it difficult to balance the needs of their patients against purely scientific and professional considerations. He therefore felt that doctors should be excluded from governing bodies, that the lay

administrators should have wide powers, and be accountable to the board for their use. After a battle lasting many months the doctors gained representation on the board and Burford Rawlings resigned to make way for a hospital secretary prepared to accept a professional presence on the Board. 27, 31

The nurses

It is traditional to be critical of the standard of nursing care in the earlier part of the nineteenth century, but whilst the medical journals seldom commented upon it, the London voluntary hospitals enjoyed the reputation of providing 'the best that the knowledge and the practice of the times permitted.'³¹ The report of the Charity Commissioners on nursing at St Thomas's in 1836 makes it clear that in some hospitals at least it was disciplined and responsible and that Sairey Gamp would not have lasted for long. The ward sisters, as the principal nurses in immediate personal attendance on patients, played the key role. As they were responsible to the matron and the steward for everything within the ward which was not a matter for the medical staff, the selection of a new sister received great attention. Usually women were recruited who had received some education and had lived in a respectable rank in life: perhaps widows in reduced circumstances, head servants, housekeepers or head nurses in gentlemen's families. The sisters required 'much good sense, zeal and bodily activity' and the necessary practical skill and experience were only fully attained after long service.¹³ St Thomas's preferred to have a relief sister in training so that an unexpected vacancy could be filled by a woman already tested for a position on which 'so much happiness and misery depended'. Once appointed, sisters usually retained their post for life. Nurses were seldom promoted, as they generally came from a lower social class.

Nurses were appointed by matrons who tried to find women of good character. In 1845 the matron of the Middlesex told the weekly board how she chose nurses. They should be between 30 and 45 years of age, strong, healthy, unmarried and unencumbered with children. They should be accustomed to nursing, able to read and write, humane, honest, sober and clean in their work and person. They should be neither stupid nor conceited, good tempered and able to bear with those who were not, but who nevertheless needed to be nursed. The nurse had to be firm in seeing that the rules in the ward were complied with, yet gentle in her manner of enforcing them.¹³ Pay being low,

recruitment might be difficult and from time to time it was necessary to discharge nurses for taking bribes, drunkenness or rollicking with the patients. By day the nurses performed domestic duties and administered to the wants of the patients. At night 'watchers' of a yet lower class supervised the wards, calling the sister who slept nearby if there was an important change in the condition of a patient. If watchers lay down or slept they were instantly discharged.

The theoretical basis of nursing practice being slender, nurses inevitably learned their craft in a practical way. Catholic nursing orders had long selected their probationers on a vocational basis, and the protestant deaconesses at Kaiserswerth, near Dusseldorf, were also chosen in this way. Kaiserswerth, where Florence Nightingale spent a short time, was something of a model for the Protestant Sisters of Charity organised by Elizabeth Fry. This order trained nurses for private work, but they and succeeding orders gained experience in hospital wards at Guy's, St Thomas's, the Middlesex and other London hospitals. St John's House and Sisterhood, founded in 1848 as the first purely nursing order of the Church of England, was more significant for London's hospitals. Louisa Twining credited the order with beginning the reform of nursing.³³ The order introduced a system of promotion for nurses of proven competence, instruction being provided on the wards of the Westminster and the Middlesex hospitals. Its training school was a comparatively small affair and in 1856 it numbered 19 sisters, 27 nurses and 10 probationers.³⁴ St John's House provided the model for a number of other sisterhoods, many High Church in outlook, and offered a new way of staffing hospitals and improving the standard of nursing care. In spite of the opposition of some members of the medical staff and the hospital management committee, St. John's House was asked in 1856 to provide the nursing service at King's College Hospital for a fixed sum per year. The Order's first reform was the introduction of 'scrubbers' to relieve the nurses of household drudgery. Next came the abolition of the notion that night nurses were an inferior order by rotating day and night staff. Then followed the proper care of the nurses' health by the provision of well cooked meals in a common dining hall.³⁵ A simple but sensible pamphlet was given to the nurses on the need for careful observation of the patient, obedience to medical instructions and the desirability of keeping good records. The nurses of the Sisterhood, clad in their dark woollen robes, were under the instructions of the medical officers, but remained members of the religious body. They reported to their own female head, a system of which Miss Nightingale

approved and were not servants of the hospital committee or under the orders of the hospital secretary.^{19, 36}

From 1866 St John's House also provided the nursing for Charing Cross Hospital. The Order of All Saints, which had extreme High Church tendencies, took charge of the nursing at University College Hospital in 1862 after a trial period. The lady superintendent at University College Hospital had previously been a sister at King's, and when she took over the standards of cleanliness and order improved, just as had been the case in the Strand. Voices were frequently raised against the nursing being 'farmed out' in this way, sometimes because of the division of authority within the hospital, sometimes because it was alleged that sisterhoods were less concerned with nursing standards than with the Christian frame of mind in which patients died. Sectarianism might also cause dissension because it could affect the selection of probationers. A High Church woman would probably apply to King's College Hospital, or to University College Hospital where the All Saints' Sisterhood would only accept members of the Church of England. A Catholic or Dissenter might choose to go to The London, the most unsectarian of the hospitals, which had declared itself firmly against nursing by sisterhood.³⁷

When a physician or surgeon needed a nurse to look after a private patient at home he would turn to his own hospital or to a nursing sisterhood. In 1872 *Kelly's Medical Guide* listed eight nursing institutions 'from which skilled and properly trained nurses and attendants could be obtained', including St. John's House and Sisterhood.³⁸ The provision of nurses for private patients produced a steady income for the sisterhoods and enabled nurses to obtain employment at a rate higher than the hospitals themselves would pay. The sisterhoods would also supply staff for dangerous and unpleasant duties. During epidemics they would assist the hospitals, supplying nurses to help as the wards became filled with cases of smallpox and cholera.

Hospital 'healthiness' and hospital design

The cause of fevers and septic diseases in hospitals was debated for much of the nineteenth century. Where they the result of foul air, stagnant putrefaction, bad drainage and overcrowding? How important was it to separate the sick from the healthy? Was it dangerous to aggregate epidemic cases in large hospitals? And later, after the work

of Louis Pasteur and Lister, how far was the germ theory of disease valid? These disputes divided those interested in hospitals into warring factions, for the rival theories affected the way in which hospitals were designed, located and organised. A belief in miasmata, unhealthy influences saturating the atmosphere and penetrating the structure of buildings, underlay many of the principles of hospital construction.

In the early years of the century London hospitals performed their duties fairly well as long as they were occupied mainly by chronic medical cases and were not overcrowded. Under conditions of stress their performance deteriorated. The building of railways in the vicinity led to the admission of many accident cases and often to a rise in the sepsis rate. 'Hospitalism', as it was called, became an inevitable if spasmodic feature of the wards, with pyaemia, erysipelas and gangrene complicating otherwise successful surgery. The mortality rate of different hospitals was compared, although Sir Gilbert Blane had pointed out as early as 1822 that such tests were unreliable unless the severity of the cases admitted was taken into consideration. A high death rate might merely mean that the selection of cases had been judicious.¹² 'Hospitalism' might also have been exacerbated by the rapid increase in the number of operations carried out after the introduction of anaesthesia in 1846, which increased the pressure on the wards, straining buildings designed for a less active style of medicine. *15, 39*

The inevitability of hospital sepsis came to be questioned, and the principles of hospital siting and design were examined. Better architects had considered such matters for many years; when the Westminster Hospital was rebuilt in Broad Sanctuary in 1832 the architect, Mr Inwood, who had designed the Coliseum and St Pancras Church, 'contrived to afford unstinted supplies of natural light and ventilation'. Each patient was allowed 1,900 cubic feet. More often, however, architects called upon to design a hospital or infirmary would apply their experience of domestic architecture uncritically. Buildings would be erected with handsome frontages, often in the form of Grecian temples with elaborate porticos, behind which the wards would be crowded together.

Continental practice was studied assiduously. The new hospitals in France at Lariboisière and Vincennes, which were built on the pavilion principle, were considered greatly superior to the new military hospital at Netley, on Southampton Water.^{40, 41} In 1856 Florence Nightingale

met William Farr; both were close associates of Edwin Chadwick. Farr and Nightingale collaborated in campaigns for sanitary reform and in 1858 Miss Nightingale presented papers on the principles of hospital construction to the Social Science Association. The papers brought together the features of the hospital design which the sanitarians considered to be of importance and they were reprinted as *Notes on Hospitals*.⁴² 'The first requirement in a hospital', she wrote, 'is that it should do the sick no harm.'

Miss Nightingale, Dr Southwood Smith and many of the sanitarians underestimated or discounted the possibility of contagion and believed that the cause of slow recovery of patients, the high mortality rates of the hospitals, and hospital fever, were the results of air-born miasma caused by overcrowding. Florence Nightingale therefore stressed the need for natural ventilation, and objected to, 'agglomerating a large number of sick under one roof.' She also disapproved of town-centre locations, saying that in a hundred years' time it would be considered impossible to put the sick down in the middle of a crowded city.⁴³

'If the recovery of the sick is to be the object of hospitals they will not be built in towns. If medical schools are the object, surely it is more instructive for students to watch the recovery from, rather than the lingering in sickness. Land in towns is too expensive to secure the conditions of ventilation and light, and of spreading the inmates over a large surface area instead of piling them up three or four stories high.'
42

Dr Stone, medical registrar to St Thomas's, was one of a number of doctors who rebutted the criticisms levelled at the existing hospitals located in the centre of town.⁴³ He pointed out that the hospitals with comparatively few beds selected the acute, the critical and the moribund. The hospital in the greatest demand had the highest death rate; the more foul its contents the more efficiently it was doing its duty.⁴⁴

John Simon (1816—1904) who was a lecturer in pathology and surgeon to St Thomas's, first Medical Officer to the Corporation of the City of London and to the Privy Council, was keenly interested in the variations in death rates. Comparatively few of the studies which he commissioned bore directly on hospital care, but in 1863 he asked the Lords of the Privy Council to commission an investigation into the sanitary conditions of hospitals. He appointed Dr Bristowe, physician

to St Thomas's, and Mr Holmes, assistant surgeon to St George's, to undertake the study. They spent a year visiting 103 hospitals in the United Kingdom and 15 in Paris. Their report included the ground plans of the hospitals they visited, details of the admission policies, the diagnoses of the patients on the day of the visit, the problems of sepsis and, where possible, the clinical activities of the hospital. They discussed the influence of construction upon mortality, the causes of 'unhealthiness', the advantages of town and country locations, how fever cases should be distributed within a hospital and the importance of accurate records. The report was 281 pages long, and *The Lancet* considered it so important that it serialised a précis.¹⁴

Bristowe and Holmes considered that case selection was the dominant factor affecting the death rate of a hospital. The mortality of surgical cases was lower than medical ones, so that the proportion within each hospital was important. The demand for treatment also influenced the mortality rate because a hospital under stress admitted those who were most seriously ill. Large city hospitals admitted graver conditions than small country ones, which had fewer demands upon them and were more like almshouses. The system of governors' letters and the restriction of admissions to certain days of the week also tended to exclude emergencies and those who were gravely ill, to such an extent that some hospitals were largely filled with the protégés of the subscribers.

Bristowe and Holmes classified the basic designs of hospitals and tried to relate 'healthiness' to the pattern of construction. The pavilion plan with its entirely separate blocks was costly to construct, required much space, and the distances between departments were considerable. Nevertheless the blocks were well ventilated from all sides and the plan was probably ideal from the sanitary point of view. Corridor-hospitals, in which the wards were connected by corridors off which they opened, resembled the pavilion hospitals, the pavilions being regularly arranged along a spine corridor. They might be several stories high, but if the wards were large, the corridors well ventilated and the spacing between the blocks wide, they were satisfactory. H-shaped hospitals, with the wards in the side limbs, built around a pattern of corridors, had much to commend them, but were difficult to extend.

Because Bristowe and Holmes did not accept that the location and sanitary state of a hospital were the main factors determining its

	<i>Number of special inmates on 8 April 1861</i>	<i>Average number of inmates in each hospital</i>	<i>Number of deaths in the year 1861</i>	<i>Mortality %</i>
In 106 principal hospitals in England	12,709	120	7,227	56.87
24 London hospitals	4,214	176	3,828	90.84
12 hospitals in large towns	1,870	156	1,555	83.16
25 county and important provincial } hospitals	2,248	90	886	39.41
30 other hospitals	1,136	38	457	40.23
13 naval and military hospitals	3,000	231	470	15.67
1 Royal Sea Bathing Infirmary (Margate)	133	133	17	12.78
1 Dane Hill Metropolitan Infirmary (Margate)	108	108	14	12.96

mortality rate, they were attacked by Farr and Nightingale who produced statistical evidence in favour of the sanitary case.⁴⁵ Tables Farr produced for the report of the Registrar General in 1864 presented the death rates in hospitals differing in size and location. Farr expressed mortality as the number of deaths in a year compared with the average bed occupancy, so that in effect he did not distinguish between 12 patients each occupying a bed for a month, and one patient in hospital for a year. A hospital with an average bed occupancy of a hundred in which, during a year, there were two hundred deaths therefore had a mortality rate of 200 per cent. It appeared from Farr's figures that the mortality of the sick who were treated in large hospitals in large towns was double the figure for small hospitals in country towns. Farr's figures were used by Florence Nightingale who said that while there was difficulty in comparing hospitals because of the different proportions of serious cases, the aggregated mortality rates were reliable evidence that the most unhealthy hospitals were those of the metropolis.

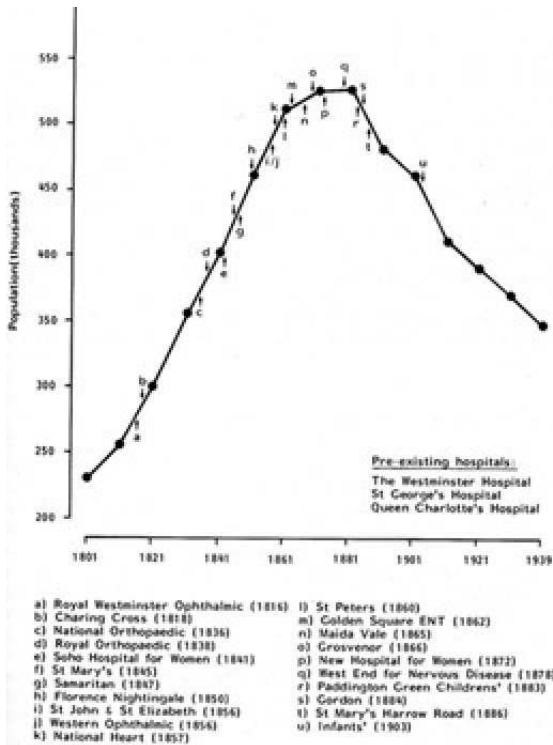
The Lancet, reviewing the 1863 edition of *Notes on Hospitals*, said that inadequate attention was paid to the different types of cases admitted, and a comparison of the outcome of similar clinical conditions treated in different types of hospitals was needed. Holmes accused Farr in *The Lancet* of devising an erroneous method which led to absurd conclusions and said that 'in so far as the method was original, for medical purposes it was untrustworthy'.⁴⁶ Maintaining that the sanitary state of a hospital was one of the lesser factors affecting a

hospital's death rate, he drew attention to the effect of the presence of a medical school, as it led the hospital to collect a disproportionate number of grave cases, often referred from a distance. The debate on the healthiness of town and country sites, and of patients treated in private and hospital practice, rumbled on for many years. Sir James Simpson and Timothy Holmes spoke about it at the British Medical Association meeting in 1869 and wrote at length in *The Lancet*. *The Times* also commented on the differences between hospitals. Some might be 'half-full of superannuated coachmen or hysterical housemaids, whilst the poor languished in mortal sickness in adjacent streets.' 28

The controversy had little effect on the distribution of hospitals in London. Those which were later relocated did not move to the country, but to busy parts of town. Doctors became more interested in the mortality of particular diseases, treated by different methods in different hospitals. Though antiseptic procedures were slow to be adopted in London hospitals, they seemed to offer a more direct way of reducing mortality. Holmes always lamented the 'exaggerated importance' attributed in the writings of Miss Nightingale and the sanitarians to the details of hospital construction and ventilation, when in his view little improvement was needed to most of the London hospitals. 47

Specialisation

The subdivision of medicine into specialties, taken for granted today, was a mid-nineteenth century development. Concentration on fields narrower than general medicine or general surgery met with resistance within the great general hospitals. Specialisation 'narrowed the mind' and led doctors to diagnose their favourite condition in every patient they saw. Even worse, some members of the medical profession viewed specialisation as an attempt on the part of a young doctor to advertise his talents. The ideal doctor was the man like Jonathan Hutchinson who was at the same time a superb general physician and master of specialties. The failure of the general hospitals to find room for doctors who were sometimes the best in their line was partly the reason for the emergence of special hospitals. The medical schools, said *The Times*, 'are constantly sending forth men who are conscious of powers above the average, and who are ambitious of a fitting arena for their display. To some fertile brain the idea of the first "small" hospital must have occurred ... and the hospital is usually not only



Changes in the population and the foundation of hospitals in Westminster

small but “special”. An ambitious man who does not see his way to any existing hospital will found one of his own.’

The first special hospitals to be established were lying-in hospitals, hospitals for fevers, for venereal disease and for the eyes.⁴⁸ Sometimes special hospitals developed from a dispensary to which inpatient accommodation was added. A few provided services to particular groups of patients - Italians, French, seamen, or women and children. Others only dealt with particular illnesses or organs, like the Lock Hospital, founded in 1746 to provide the West End with facilities for the treatment of venereal disease. Some were founded for purely charitable reasons, as was the National Hospital for the Paralysed and Epileptic. Certain groups of patients, such as consumptives and

children, were seldom received by the general hospitals, and the dispensaries, special hospitals and workhouses filled the gap. With the exception of a single ward at Guy's, one might walk the wards of every hospital in London in 1850 without seeing a single case of disease in childhood.⁴⁹ But most special hospitals owed their origin to the quest for professional advancement of a new breed of doctor - the specialist. The usual procedure to found a special hospital was to form a committee, obtain an eminent patron, take a house, appoint medical staff and launch an appeal. Advertisements for funds would appear in the press pointing out how appallingly deficient was the care for certain diseases, but that now as a result of the benevolence of disinterested and far-seeing men the lack might be remedied.⁵⁰ As the population rose, a large number of the special hospitals were established, as private hospitals are today, in the area which is now the City of Westminster. Counting their number was difficult, for many were ephemeral. Kershaw made the attempt, and his figures demonstrate heyday of special hospital development.⁴

1810-1819	4	1850-1859	10
1820-1829	0	1860-1869	13
1830-1839	3	1870-1879	5
1840-1849	6	1880-1889	3

The size and wealth of London provided an opportunity for the development of specialism and specialist hospitals, which did not exist to the same extent in the provinces. The professional rewards could be considerable but jealousy was ever present. Only occasionally was support from colleagues forthcoming, as it was when the medical staff at St Thomas's and Guy's supported the establishment of the London Dispensary for the Eye - now Moorfields - by an ex-colleague.

The management committees of general hospitals tended to be suspicious of specialist care and it was often the staff of the special hospitals who were responsible for advances in diagnosis and treatment. General hospitals would wait a few decades until a new field of work was well established before providing beds and opening their own department. When a general hospital did so, the doctor appointed might merely be the newest member of the staff, whether or not he had previous experience in the field. Such men might be given little authority and might even be denied the right to operate on their own patients.^{51,52} Service and teaching inevitably suffered and research into new methods of therapy was handicapped. Scientific

advance might be easier in the special hospitals, where conditions might be admitted which were rejected by the general hospitals. Consumptives, for example, had a poor prognosis and a long length-of-stay and were seldom admitted to general hospitals. The Hospital for Consumption was established to meet their needs, and the first report from the Brompton was of such excellence that *The Lancet* said that it placed the hospital in the first rank amongst the useful medical charities of England.⁵³

The medical press and the special hospitals

The medical press had little time for the special hospitals. *The Lancet* wrote: 'if a stranger were to peruse the list of our London medical charities, commencing with the magnificent endowed hospitals, and going through the tedious list of dispensaries and special institutions, his first impression might possibly be one of admiration at the apparently boundless philanthropy of the British public. He could not account for their multitude and variety otherwise than by concluding that charitable beneficence is actually a passion so absorbing and insatiable, that it is ever keenly on the alert to discover new objects on which it can be exercised. The eye, the ear, the bones and tendons, the heart and lungs, the rectum, the uterus, the skin, women and children, are all specially provided for. Many individual diseases besides, as cancer, consumption, fistula, syphilis, sore legs, supposed to be of too recondite pathology for the general hospital physician, form special objects of treatment in distinct institutions. Division and subdivision in medicine having been carried so far that there is nothing left to divide, the rage for curing everybody for nothing is necessarily expended in multiplying institutions of the same kind.' ⁵⁴

There was no doubt that some special hospitals were mainly concerned with marketing the skills of their staff. Bristowe and Holmes wrote that 'it is not want of charity to say of most special hospitals that they are founded to serve private ends and neither have nor were intended to have any beneficial effect on the public health'. There were also medical problems. The mortality rate of maternity and children's hospitals could be horrific.⁵⁵ Only by closing the hospital down for some months could some epidemics of sepsis be controlled, and it might be asked if such hospitals did not do more harm than good. Nevertheless special hospitals would not have multiplied as they did if they had not met a genuine need. They probably provided a milieu in which a new activity could flourish. For example, Spencer Wells, at the

Samaritan Hospital, demonstrated that with careful technique, ovariectomy could be performed with an acceptable mortality at a time when the general hospitals discouraged such operations.

The Lancet was not mealy mouthed in its condemnation. 'There are public injuries which cannot be justified by private necessities; and among these must be classed the multiplication of special institutions in this metropolis ... These excrescencies are being reproduced with all the prolific exuberance characteristic of malignancy and soon the metropolis threatens to swarm with nuisances of this kind.' *The Lancet* said that amongst the worst was a hospital founded to provide a special form of treatment already available in the general hospitals. 'This institution is denominated the Galvanic Hospital ... next may come a Quinine Hospital, a Hospital for Treatment by Cod-liver Oil, by the Hypophosphites or by the Excrement of Boa-Constrictors.' The Hospital for Stone, the Dispensary for Ulcerated Legs and the Dispensary for Diseases of the Throat and Loss of Voice had been founded, in the opinion of *The Lancet*, by doctors unmindful of the good opinion of their colleagues, who had deviated into 'ultra-special paths over which blows the blast of professional reprobation.' Their medical staff should refuse to be associated with such hospitals and resign.⁵⁶ The Galvanic Hospital and the Dispensary for Leg Ulcers replied to the attack that if the teaching hospitals would establish effective galvanic wards or agree to admit chronic leg ulcers there would be no need for their establishments.

The best argument for special hospitals was that some diseases were inadequately catered for and the special hospital could bring similar cases together for study. The special hospital then formed a centre from which knowledge could spread. 'Classification we must have', said Jonathan Hutchinson of The London Hospital, 'for the good of the patient, the better advance of science, and the convenience of both teacher and learner.'⁵⁷ However, it was argued that administrative costs were increased and charitable money was wasted by multiplying hospitals, and that by collecting together all the cases of a single disease they deprived the medical schools of the material they needed for teaching. Students therefore might be poorly trained.⁵⁸ *The Medical Times and Gazette*, *The Times* and *The Lancet* said that the solution was in the hands of the general hospitals. They must develop good special departments themselves, group patients with particular diseases together, and keep young men of talent and energy within the general hospitals to develop these specialties. Then special

hospitals would disappear. *The Lancet* examined how far this had happened in a survey in 1869. Most of the general hospitals had established outpatient clinics for skins, eyes, and ear, nose and throat diseases, but only for diseases of women and ophthalmology had inpatient departments been created and these were rather small.^{59, 60, 61}

The rapid development of special hospitals owed much to the energy and inventiveness of their secretaries, who were often highly effective fund-raisers, even if it sometimes seemed that the money raised merely paid for more fund-raising activities.⁶² In 1875 the 36 special hospitals in London raised between them almost as much as the eight voluntary hospitals with medical schools which were largely dependent on public subscription.⁶³ The special hospitals also received substantial sums from the Hospital Sunday Fund when that was established, although *The Lancet* felt that they had no claim on the public purse and that the money should go to special departments of general hospitals instead. Unlike the general hospitals, the special hospitals frequently charged their patients, receiving more from this source than from regular subscriptions. They were therefore in competition with both the general hospitals and with general practitioners. Patients who clearly could not pay might be exempted, but most special hospitals expected a contribution towards the cost of care unless the patient had a governor's letter of recommendation. As the special hospitals were small, their management costs were high; and because they equipped their staff with the latest in technology, such as instruments illuminated by electricity, they had high case costs.

Some special hospitals were transient, like the London Galvanic Hospital and the 'massage hospitals' which were little more than brothels. The *British Medical Journal* wrote in 1894 that the treatment was almost always left in the hands of young ladies whose attractive qualities were deftly indicated in various ways and were described by their pet names as 'nurse Dolly' or 'nurse Kitty.' Advertising in the *Morning Post*, the premises were probably in a flat in a West End locality. No enquiry would be made of the patient's name or complaint.⁶⁵

A few bona fide special hospitals amalgamated with each other, but many thrived, moving to larger premises and developing medical schools open to undergraduate and postgraduate students.⁵⁸

Specialists might have a foot in both camps, the special department of a general hospital and an appropriate special hospital. Yet rivalry between special and general hospitals was a feature of the London medical scene. Sometimes a distinction was drawn between the larger special hospitals, with an international reputation, and the smaller ones, but as a group the special hospitals were never free of a feeling of being under siege. The Select Committee of the House of Lords in 1892 deprecated 'the establishment of small special hospitals where they were not wanted, the waste of money in badly managed small institutions, and work carried out in incommodious buildings under unsanitary conditions.'⁶⁶ Their Lordships thought that there should be more cooperation between special and general hospitals and subsequent reports frequently contained statements about the desirability of amalgamating special and general hospitals. Inevitably such statements placed the special hospitals on the defensive.

The achievement of the voluntary hospitals

The voluntary hospital system, which encompassed the great endowed hospitals, the general and the special hospitals, was a massive monument to the concern of the wealthier members of society for the poor in time of sickness. There was pride in the London hospitals for nowhere else did there exist a service so extensive or of such quality. The hospitals had the support of the churches, the patronage of the nobility, and their activities were a central part of the London social scene. Looking at what had been accomplished the philanthropist could be excused a certain degree of self-satisfaction. From the point of view of the patient matters were not so satisfactory. When one considered what was required and examined what was being supplied, the record ceased to be as imposing as the charitable liked to believe. Comparatively few of those needing hospital attention could find a place in the voluntary hospitals, for money was short and beds were in demand. Many who might have been eligible for admission were incapable of doing the rounds of the subscribers in the hope of obtaining a letter of recommendation. To present oneself at a hospital without a letter meant running the gauntlet of the beadles and the porters who had a reputation for brusqueness, but who were not always above taking bribes. Admission was far from assured. Charitable care was better than the poor law, if one could get it, but it was no bed of roses. Charity was incapable of meeting the demands.

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Chapter 3 Hospitals and Medical Schools

"Good education is amongst the rarest things going; difficult to buy at any price"

The Lancet, 1886

The medical schools which developed in London did so in close alliance with the great voluntary hospitals. Private schools attached to the larger hospitals also existed in the provinces, but outside London medical education tended to become an integral part of multi-faculty universities as soon as these developed, in close association with their science departments. In Europe the medical schools also developed within a university milieu. In London, however, the schools were firmly established before the creation of the University of London in 1836. In most cases the school was established after the hospital, and it always had a closer relationship with its allied hospital than with the University.

The pattern of medical education

Medical training in London evolved from informal arrangements between the physicians and surgeons of the hospitals and potential students, occasional courses which had been held for many years in the endowed hospitals, and private anatomy schools which grew up near the hospitals towards the end of the eighteenth century. *The Medical Calendar or Students' Guide to the Medical Schools*, published in 1828, said that the 'medical schools of London are collected around the Public Hospitals. The lecturers are the Physicians and Surgeons of those Hospitals, and the Private Lecturers who have established theatres in the vicinity.¹ Since William Hunter's day it had been accepted that the education of a well-trained doctor should include a course of lectures on anatomy and dissection.² More extensive instruction was required following the passage of the Apothecaries Act (1815) and those who did not hold a university degree were bound by law to take the licence of Apothecaries Hall if they wished to practice as a general practitioner or apothecary. The Society of Apothecaries laid down conditions of entry to its examinations and as well as having undergone an apprenticeship to an apothecary the student had to produce certificates of attendance at courses on anatomy, physiology, medicine, chemistry and materia medica. Surgery was not part of the examination. Private schools, established outside the walls of the hospitals, benefited from the

subsequent demand for instruction and eminent men, or those rising in the profession, frequently held positions in them. Private schools were sited near one or other of the great hospitals. Thus the Graingers ran the Webb Street School near St Thomas's and Guy's, the Aldersgate School was near St Bartholomew's, and the Windmill Street School was near the Middlesex. The schools' reputations rose or fell as men like the Bells, the Hunters, the Graingers, Baillie or Marshall Hall joined or left the staff. The demand for bodies for dissection was considerable and until the Anatomy Act (1832) created a better and more equitable supply, the resurrection men plied a busy trade in central London cemeteries.

Increasingly, hospital governors allowed their own staff to take pupils and later assisted them by building dissecting rooms so that anatomy could be taught. The Charity Commissioners noted the use of the endowments for educational purposes, but thought on balance that the sick benefited from the presence of the school. The hospitals' own schools were also private concerns. Students' fees were often pooled and after expenses had been deducted the residue would be divided into shares of varying size and divided amongst the staff. The profit made up in some measure for the time the staff gave to their clinical duties, and in the case of the more renowned teachers the rewards could be considerable. The money also helped more junior staff to subsist until they had established their reputation.

By 1830 students were obtaining clinical experience in one or other of seven large hospitals which were open to students on payment of fees. From east to west they were The London, St Thomas's, Guy's, St Bartholomew's, the Middlesex, the Westminster and St George's. Lectures had been given at St Bartholomew's and St Thomas's for many years and their schools date from the middle of the seventeenth and eighteenth centuries. Gradually clinicians like William Blizard of The London came to recognise that a hospital with a medical school attached not only provided a better education but also increased in fame. The schools of The London and St George's came into existence at the end of the eighteenth century. The Borough hospitals of St Thomas's and Guy's cooperated for many years as the 'United Hospitals' until an academic dispute in 1826 led them to go their separate ways. The Westminster established its school in 1834. The Middlesex, which had drawn its pupils mainly from the celebrated Windmill Street School, accepted students from University College when it was established in 1832 and the Windmill Street School

closed. Finding itself unable to secure a permanent link with the Middlesex Hospital, University College set to work to build its own hospital, donating the ground required. Staff were recruited to the new hospital on the principle that the best man should win, and there was a considerable infusion of talent from other hospitals and other cities.

The supply of pupils at the Middlesex Hospital diminished and Sir Charles Bell, who was on the staff of both hospitals, petitioned the governors to allow the establishment of a medical school at the Middlesex, which opened in 1836. Charing Cross Medical School opened in 1834, when the hospital of which it was an integral part was rebuilt. King's College, a religious antidote to University College training youth to revere 'all that was great and good and solid in Church and State', created its own medical faculty in 1832. Lacking a hospital at a time when Charing Cross was being rebuilt, King's proposed an association in 1832, 1836 and again in 1837. Each time King's was rebuffed because of the difficulties in reaching agreement between the various interested parties. Charing Cross would have benefited financially, for it would have gained the pupils' fee and avoided a competitive institution in the Strand. However Charing Cross maintained that to unite two such youthful institutions would be a hazard to both, and that it would be a premature and dangerous experiment. The governors could see no benefit from an amalgamation which might have rendered it subservient to the objectives of another institution.³ An opportunity was therefore lost, at its very outset, to identify Charing Cross with university-based medical education, not from any lack of goodwill but from practical considerations. An alternative scheme, to transport students from King's by steamer from Waterloo stairs to St Thomas's also failed.⁴ King's College, like University College, established its own hospital and chose staff from all quarters, although with some sectarian bias. Relationships with Charing Cross remained surprisingly good and several members of staff moved between the two institutions.

The older hospitals like Guy's, St Bartholomew's and St George's were less inclined to appoint men who had trained elsewhere, and a family feeling was cultivated. Promotion was made easier for their own students, while at the new schools men could expect nothing more than a first-rate education and a fight to maintain their position against all-comers.⁵ Competition led to a rise in standards and the old order began to change. The hospital schools, 'where science and practice are imparted under the same roof,'⁶ improved in efficiency. In spite of

their lower fees the private schools were slowly eclipsed, partly as a result of discriminatory regulations. The Royal College of Surgeons prohibited dissection in the summer term, a traditional time for attendance at private schools. R D Grainger, who ran Webb Street School, closed his establishment and moved to St Thomas's as Dean. The changes in the medical schools were often announced in the introductory addresses at the beginning of the academic year.⁷ St Thomas's, having experienced a catastrophic decline in the number of students registering in 1842, which led to a mass resignation of the staff, established paid lectureships and a hall of residence, 'so that the hospital might not be behind any of the metropolitan schools.'⁸ The introductory lecturer at St Bartholomew's in 1847 pointed out that because of the improved state of medical education more labour was required of students than had previously been the case. Nevertheless, although the private schools were giving place to schools within the hospitals themselves, these were just as 'private' in finance and management as the institutions they were supplanting. The profit motive was equally evident amongst their staff.

The medical course

Until the establishment of the General Medical Council in 1858 the pattern of medical education was largely determined by the Society of Apothecaries and the Royal College of Surgeons - 'College and Hall'. Students usually began their studies as apprentices to local practitioners, and most then came to London to attach themselves at moderate cost as pupils, or for a higher fee as dressers or 'cubs' to leading surgeons. On the wards, students picked up what they could in a practical way. Those who could afford the larger fee to be apprenticed to a hospital surgeon might assist the chief when he operated, see new patients first when he was out of the hospital and be on call for patients under the supervision of the resident medical officer or apothecary. *The Lancet* published an annual students' guide each September and advised students not to select a school on the basis of its low fees or its imposing appearance. The earlier editions did not shrink from naming hospitals students would do well to avoid and made candid comments on the ability and the time-keeping of the lecturers. In 1834 *The Lancet* recommended St Thomas's as a good choice, for 'students were treated with the utmost liberality and clinical observations constantly heard in the wards were numerous and valuable'.⁹ Such information must have been most useful to students new to London, for their attention was drawn to new developments

such as the opening of University College's North London Hospital, where for a time comparatively low fees were charged. To reduce the problem of travelling *The Lancet* advised students first to select a hospital and then attend lectures and a dissection room nearby, either one within the walls of the hospital chosen, or an adjacent private school where the fees would invariably be lower. It was a constant complaint that the medical staff of the London hospitals were not prompt for their rounds and extorted immense sums of money from students in the form of fees. Lecturers appointed by the Royal College of Surgeons benefited financially from the requirement for certificates of attendance at their lectures before examinations might be taken. Finals could consist of four viva voce examinations each lasting a quarter of an hour, a somewhat crude test of academic achievement. ¹⁰ The College's examiners were usually the ten oldest members of the Council, who received a major part of the fee of £22 paid by each candidate.¹¹

The reform movement

There was a growing disenchantment during the 1820s about the powers enjoyed by the Royal Colleges and the Society of Apothecaries, which culminated in 1833 in a petition to the House of Commons. 'Forty nine physicians of known reputation practicing in London including the heads of most of the medical schools of the metropolis' asked for an enquiry into the state of the profession throughout the country with a view 'to framing laws to remove existing evils and place the medical institutions of the country on a more liberal and equitable basis.' The issue being raised concerned standards of medical education, by whom they should be laid down, what subjects students should be taught, who should teach them and how they should be examined. The absence of a degree-giving body for London, and dissatisfaction with the Royal Colleges and the older universities, led to a demand for reform. The reform movement affected the colleges, the medical schools, and after 30 years, led to the establishment of the General Medical Council in 1858.

The inquiry was established in 1833 as a Select Committee under the chairmanship of Mr Warburton (1787-1858, a philosophical radical, and an MP selected by the reformers as their advocate) to inquire into the regulations and usages governing medical education and the practice of the various branches of the profession. Wakley saw the committee as an opportunity to put on public record the restrictive

practices which placed control of teaching in a few hands, raised the cost of obtaining a medical education and militated against the interest of students, patients and the wider community. The medical establishment probably did not relish the publicity which resulted from the detailed and careful questioning of the committee. Still less could they be enthusiastic about the possibility of new legislation. However Wakley had been campaigning for ten years for reform and he relished the possibility that Parliament would abolish the privileges of 'the monopolists' of College and Hall.

The evidence revealed the influence of the three great 'orders' of the medical profession - the surgeons, the apothecaries, who combined the dispensing of medicine with the diagnosis of disease, and the physicians who, having been educated at Oxford or Cambridge, belonged to the learned world of the day.¹² Senior members of each order were united in their resolve to maintain London's pre-eminent place in medical education, but sometimes their power was used to exclude doctors of talent from positions of influence. Much of the evidence to Warburton's committee was concerned with the detrimental effect of the division of the profession and the exclusive claims and rights of each group, but some witnesses were more worried about educational standards. They wished to see careful checks on the attendance of students at lectures and more adequate facilities like museums in the schools of anatomy. The witnesses were concerned about the clinical material available for teaching and while a few believed that with careful selection of patients only a few beds were required, most agreed with the President of the Royal College of Surgeons, Mr Guthrie, that schools needed at least a hundred beds. The recognition of the Westminster Hospital by the College had been questioned at one time as it was below this size but its excellent reputation in surgery and its status as the oldest subscription hospital in the country led to an exception being made. Nevertheless on its reconstruction in 1834 in Broad Sanctuary the hospital was enlarged. Charing Cross also had difficulty in obtaining recognition and was accused of filling its wards with invalids from the local workhouses on the day of inspection, it being too expensive to admit true patients.⁴ Dr James Clark, a Licentiate of the College of Physicians, felt that student education would be improved if there were more teaching rounds and more medical staff; he also wished to see better patient records and statistical analyses of the hospitals' work. Other witnesses suggested improvements in the preliminary scientific education of students, less emphasis on pharmacy and longer clinical

attachments¹³.

The reform party had high hopes that Parliament would move to end abuses in the hospitals, the schools and the examination system, perhaps by establishing a central body to conduct a national examination. Their hopes were dashed. The government fell and the evidence, though it was published, did not lead to legislation. The exposure of the weaknesses of the system nevertheless provided fuel for the campaign and Warburton was himself the author of another medical reform bill in 1840.

There was great pride in the London medical schools. When Syme, after a brief and unhappy period as Professor of Surgery at University College Hospital, attacked the standards of the London teaching hospitals, a leading article in the *Medical Times and Gazette* pointed out that they brought to focus the great variety of cases which had baffled provincial doctors, and provided all the advantages which come from the association of clever men with each other. Students were attracted to London not by ancient universities 'but by the practical opportunities which her charitable institutions afforded, and the experience which her esteemed practitioners had accumulated'. It was this experience which invested the private lecturer with the dignity of public professor.¹⁴ A German visitor, comparing London medical education with the schools in his own country, said it was 'much more incomplete, far less intellectual, but nevertheless much more true and practical.'¹⁵

The Lancet continued to campaign for improvements in the educational system, for better clinical teaching, examinations at intervals throughout the course and for free admission to the practice of the hospitals.¹⁶ Matters began to improve and the University of London demanded proof of basic education before a student could begin to read for its degrees. The requirements for matriculation included chemistry, mathematics, a foreign language and English. The Society of Apothecaries also instituted a preliminary examination and 'even' the College of Surgeons introduced a test of classics and mathematics.¹⁷ The establishment of the General Medical Council in 1858, on which the major professional organisations were represented, made it easier to modify the curriculum, but the new trends were already well established. The time spent on basic studies of doubtful relevance was cut and *The Lancet* rejoiced that students no longer had to study the dentition of the mastodon. More time was left

for clinical work but *The Lancet* frequently criticised aspects of the syllabus. It disliked the emphasis on botany, a result of the influence of the Apothecaries, and rebuked the General Medical Council in 1863 when it was suggested that students should no longer be apprenticed to a general practitioner before starting their hospital work. *The Lancet* supported the claims of science and specialisation. 'No case of illness is now admitted to a medical ward which does not demand the careful use of the stethoscope, microscope and test tube in its investigation.'¹⁸ Later, in discussing the special hospitals, *The Lancet* proposed the establishment in the teaching hospitals of special departments in orthopaedics, ophthalmology and ear, nose and throat disease to ensure that the students' education was complete.¹⁹

Scientific education and medical school amalgamation

In an article of 1867, revealing new attitudes to scientific education, *The Lancet* contrasted methods of instruction based upon 'questions arising out of the cause of disease' with those relating to methods of cure. The English system placed the emphasis on the second approach. Students were called upon to 'act' before they 'had been taught to know'. More attention was required to the laws of physical science, anatomy and chemistry, structure and function. Students should understand scientific principles; unfortunately 'young men often aimed at being practical and were contemptuous of a more basic approach', adopting the attitudes of some of their seniors. *The Lancet* epitomised the aim of continental education as the production of a 'capable inquirer', while the English system produced 'a capable practitioner'. Neither alone was sufficient.²⁰ It was a criticism to be repeated later by Flexner and the Haldane Commission.^{21,22,23} As chemistry and biology developed it became increasingly difficult for doctors waiting for a position on the staff to teach scientific subjects effectively. Schools began to employ permanent staff to undertake this duty, which increased their costs.

Although the hospital schools had emerged as the unchallenged centres of medical education they were not beyond criticism. In 1867 the Medical Teachers Association was formed by representatives of all but two of the London schools and John Simon became its first president and chairman. On taking office he delivered a stinging attack on the examination boards as then composed and the quality of the scientific work undertaken by the schools. The report he subsequently wrote on the present state and future needs of medical education in

London showed him to be an educationalist of considerable stature. He urged the licensing bodies to bring their regulations into line with each other and to make them less minutely detailed and stringent. He did not believe it necessary to insist on attendance at systematic courses of lectures, ignoring other methods of study by which information might be gained. He believed that students' progress should be assessed at regular intervals, subject by subject, to prevent last minute cramming. The schools themselves should be free to design the course best suited to their resources. Subjects 'taught separately' should be examined separately; examiners should not attempt to cover the whole range of medicine, but restrict themselves to subjects of which they had special knowledge. Finally John Simon drew attention to the incalculable importance of continuing education 'far beyond the comparatively low point at which a standard of minimum qualification must be placed.'¹¹

The formation of the Association stimulated debate about the improvement of the education system. John Simon's advocacy of a better examination system was countered by Professor Richard Quain, Emeritus Professor of Anatomy at University College, who believed that improvements had to come from the colleges instead, because it was from leading teachers that improvements had always come and would always proceed. Dr Parkes, a member of the General Medical Council, published a detailed syllabus which he believed would improve the state of affairs.²⁴ Introductory addresses at the beginning of the academic year also contained references to educational policy. Speaking at St Mary's in 1870 the Dean commented on the waste of time, money and energy, which resulted from the attempt to teach pre-clinical sciences at so many medical schools. He advocated their amalgamation into two medical colleges with well-paid professors. Clinical instruction would continue at the great hospitals as customary. ²⁵ *The Lancet* believed that the Medical Teachers Association should consider such amalgamations because of 'the absurdity and practical impossibility of carrying out scientific education in eleven establishments.' Amalgamation would make it possible to teach the pre-clinical subjects better, providing chairs worthy of competition. Leaving aside Guy's and St Bartholomew's large schools which had refused to join the Medical Teachers Association and 'had prejudices of long standing which would probably interfere with any scheme which might be proposed,' and The London which was too far to the east to fall into an easy relationship with any other hospital, *The Lancet* said there were eight schools to consider. They fell into

northern and southern groupings. The northern group might include University College and the Middlesex which were half a mile apart and had already made coy overtures, St Mary's which might be ready for change, augmented by the Royal Free Hospital (Gray's Inn Road) and the Great Northern (Euston Road). The southern grouping would be more difficult because of the rival claims to pre-eminence of King's College and St Thomas's. St Thomas's would be more convenient for the students of St George's as it would be easier to get to the embankment than to the Strand.²⁵

The inter-relationship of schools and hospitals

Increasingly the medical schools were having an effect on the clinical work of the hospitals to which they were attached. An anonymous correspondent in the 1840s protested that cases were abruptly rejected and dismissed by the great hospitals if they were not suited to the instruction of pupils.²⁶ Bristowe and Holmes drew attention to the effects on the case-mix of 'the desire of medical men educated at the school to place cases of interest, doubt or danger under the care of their former teachers; the desire of patients to come into a hospital served by men of celebrity; and the desire of able men to obtain cases which will afford an opportunity for the exercise of their skill, and will be a source of instruction for their pupils.' When a hospital had a large school the wards were more likely to be full and the cases more acute. Indeed wards in some hospitals might actually be shut during vacations for reasons of economy. Even the design of the hospital might reflect teaching needs. 'So long as instruction is supposed to be afforded to students, and diagnosis and treatment not hindered by the medical officer making his visit to the patient at the head of a struggling crowd of from 50-100 students, it is necessary on this account alone that wards should be larger and beds widely removed. Fortunately so far the requirements of the school coincide with the requisites for healthiness' ²⁷

The quality of the clinical experience London medical students enjoyed was a traditional source of pride. In his farewell address at St George's Timothy Holmes said that hospital practice should be the basis of all studies. To provide living illustrations was one of the chief functions of the great hospitals, and one of their most important benefits to the public 'I had almost said their greatest', he added as an afterthought. ²⁸

The complex relationship of the hospital and its medical school was summarised by Burdett who said:

‘Not only are the hospitals placed at the disposal of the authorities of the medical school for the clinical instruction of their pupils, but the two institutions are very largely manned by the same individuals, an appointment on the staff of the hospital very often carrying with it, by custom if not by by-law, some definite status in the medical school, and similarly the junior appointments in the medical school being very sure stepping stones to the medical and surgical staff of the hospital. The control and management of the medical school is often vested in the governing body of the hospital, and in nearly all cases in this country the financial relations between the hospital and the school are very close. The hospital is called upon to provide the proper facilities for the carrying on of the clinical teaching within its walls, involving the provision of larger out-patient rooms, operating theatre, lecture rooms and laboratory; and the other school buildings - theatre, classrooms, library, museum, laboratories etc., are either provided by the hospital authorities or built with money advanced to the school by the hospital.’ 29

This interaction was mutually beneficial. Although the prime object of the governors might be the care of the sick poor and of the medical school the instruction of pupils, the blending of interests was of great advantage to both. A teaching appointment attracted able men to the hospital and kept them there in spite of the increasing demands of private practice. Students acted as unpaid assistants and they would remain as junior staff, without pay, after qualification. Honorary staff might be more punctual for their rounds if students were waiting, and the time spent by students taking histories led to thorough care of patients and kept the senior staff on their toes.

It was customary to divide the voluntary hospitals into those with schools and those without. There was no doubt which was the first division. Hospital and school looked to each other. The University of London, examining only a few of the students and teaching none, had little place in the close association of the hospital and its school.

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Chapter 4 The Development of the Poor Law Infirmaries

The framework of the voluntary hospital system in London had been established by the middle of the nineteenth century. The hospitals aimed to care for those of the poor who could be restored to honest independence, but for many this was not likely to be possible. The poor but destitute had a second and traditional claim to relief under the poor law, dating back to the 43rd Act of the reign of Elizabeth. Many of the destitute were also sick or infirm. Whilst the hospitals might use moral judgments in determining who were 'proper objects for charity', merit had nothing to do with assistance under the poor law. The provident and improvident, the virtuous and the vicious were equally entitled to it. The principles of this relief had evolved over many centuries, and their application varied from area to area. The system was reviewed by the Royal Commission into the Operation of the Poor Laws (1832-4)¹ whose recommendations were given substance by the Poor Law Amendment Act of 1834. This was a compromise between central control and local administration by boards of guardians formed by uniting parishes too small to run an independent workhouse efficiently. The formation of the unions was often a matter of contention. Parishes objected to the loss of long standing powers and the existence of private acts in a number of London parishes reduced the authority of central government.

The new principles, established by the 1834 Act, were logical if severe. In theory every detail of the help to be given was laid down by central regulation. The pauper was not to be allowed to enjoy the standard of living attainable by the independent labourer, otherwise he would rely on the guardians for support. The pauper's lot had to be made 'less eligible', both in appearance and reality, than that of the worst paid employee outside the workhouse. The assistant commissioners who monitored the implementation of the Act discouraged the giving of 'outdoor relief', the workhouse test was applied more rigorously, and the life of the pauper became tougher. The Royal Commission had suggested some degree of classification within workhouses and the separation of the sick and old from the able-bodied. The Poor Law Commissioners published architectural plans providing for this to help local boards of guardians,¹ but classification was seldom effective. Neither was any real consideration given to the position of orphans, deserted children, the ill or the elderly, probably because nobody had previously objected to their being given outdoor relief in the form of

rent, food or money. Was the principle of less eligibility also to be applied to them? For some thirty years after the poor laws were tightened the answer was 'Yes'. The hardship endured by the destitute sick was criticised by the *Medical Times* which asked 'where is the mischief which can spring from generous medical relief to the sick? Men will feel no anxiety to be ill because illness entitles them to careful medical attention. Our Commissioners act as if they have an insupportable horror of a poor patient getting too good attendance.'²

The great social evil of pauperism was considered to lie neither in the poverty nor the social conditions but in the need to give relief to the pauper and the moral consequences for the individual and society which flowed from this. Honest independence would be undermined and the birth rate might increase amongst those unable to support themselves. The Act was also designed to reduce abuses amongst those administering relief, for many had shown 'both a desire and an ability to extract from it a profit to themselves'.¹ As a result of the laxity and inconsistency with which relief was given the cost had risen alarmingly. Giving outdoor relief made it easier for tenants to pay their rent - and the landlords might be guardians. The Act was designed to reduce costs, and almost certainly did so, even though it did not achieve the national uniformity of practice for which many had hoped. The local boards of guardians retained considerable freedom of action and in London the members were usually small tradesmen or shopkeepers. The system of election was archaic and plural voting of owners and occupiers was in proportion to the rateable value of their premises. Representation therefore related to the burden borne by the taxpayer. Few exercised the right to vote and rigged elections were not uncommon. Local politics might intrude into the affairs of the guardians, for the press reported the meetings and to be a guardian might be a springboard to greater things. At the very least it could sometimes be turned to financial advantage.

The crisis of the sick in the workhouses

In earlier days most of the inmates of the workhouses had been able-bodied and under the age of sixty. Between 1845 and 1862, a period of comparative prosperity, the proportions changed. The able-bodied found employment more easily and were in any case loath to seek relief on the new, harder terms. The aged and infirm entered the workhouses in greater numbers and in 1857 the medical officer of

health for St Giles in the Fields and St George's Bloomsbury said that most of those in the infirmary were exhausted by the burden of their years, by chronic bronchitis or by incurable diseases such as paralysis or consumption. One out of every four or five admissions died - twice the rate of the hospitals.³

Then a rise in the level of destitution occurred, increasing the pressure on the workhouses. More of the inmates were clearly sick and in need of medical and nursing care. A new trend, encouraged by the Poor Law Board, became apparent. Increasingly paupers were classified into groups and accommodated separately. Children were removed from the workhouses and placed in district schools. Dangerous lunatics were not retained unless all the asylums in and around London were full.⁴ 'Quiet lunatics and imbeciles', when present in considerable numbers, were placed in separate wards or buildings. By common consent, cases of infectious or dangerous character were grouped in separate wards if practicable, or transferred to voluntary hospitals set apart for such diseases, such as the London Fever Hospital or the Highgate Smallpox Hospital. For one shilling a day guardians could dispose of a difficult problem. Sometimes indeed the guardians would subscribe to a voluntary hospital to facilitate the transfer of a sick pauper needing attention more readily available in a hospital than a workhouse infirmary. As the patients requiring separate accommodation increased in number, the infirmary or sick wards no longer formed the smaller part of the institution, nor did the older workhouses provide the type of accommodation the new conditions required.

The conditions in the workhouses

The quality of the care and the accommodation provided by the workhouses came to interest the reformers and following the Crimean war there was an upsurge of interest in sanitary problems. William Farr had shown that the death rate of the pauper inmates of the workhouses was higher than that of the districts from which they came, figures which Wakley had used with some effect in *The Lancet*. One of the first actions of the newly established General Board of Health in January 1849 was to ask Dr Arthur Farre and Mr R D Grainger, of the Webb Street School, to report upon the general state of the inmates of workhouses, particularly in respect of cholera and bowel complaints. They visited 38 of the metropolitan workhouses, reporting on the

sanitary conditions. With a few exceptions a good average state of health was observable. However the descriptions of the buildings revealed grave deficiencies and the surveyors recommended improved sanitary facilities, better ventilation (a minimum of 500 cubic feet of space per inmate) and the use of paid nurses.⁵ In 1856 Dr Robert Bence Jones submitted a report on the St Pancras Workhouse at the request of the Poor Law Board. It revealed a level of overcrowding which he believed could not be tolerated by the government. One of the worst areas was a bedroom used by lying-in women at night and night nurses by day. On analysis, the air contained 2.5 per cent carbon dioxide and the superintendent of nurses said that the smell was 'enough to knock you down.'⁶

The following year the Poor Law Board asked its Metropolitan Inspector, Mr H B Farnall, for a report. Farnall was a sound civil servant whose opinion was sought on the policy issues of the day by his superiors. He might be asked to comment on proposed legislation and was sent on two occasions to report on conditions of 'exceptional distress', as at the time of the cotton famine in Lancashire. Farnall was asked to obtain information about the sanitary conditions, ventilation, occupancy and death rate of a number of London workhouses and infirmaries. He selected those of Bethnal Green, Hampstead and Bermondsey. In general his report was reassuring. Tuberculosis was the chief cause of death, followed by cholera and the fevers. In a fuller report on all of the London workhouses prepared in 1858 he maintained that most of them were well managed and in a satisfactory state. There were a few exceptions, however, like the St Marylebone and the St Martin's-in-the-Fields institutions which were 'indifferent and inadequate.'

Louisa Twining, who was active in a number of charitable movements, sought formal permission from 1853 onwards to visit patients in the workhouses and eventually this was granted by the Poor Law Board. In 1857 she addressed the newly established Social Science Association on workhouses and was subsequently responsible for the formation of the Workhouse Visiting Society, an offshoot of the Association. The overt aim of the Workhouse Visiting Society was to provide comfort to individual residents. However, the basic motive was to influence public opinion. Many of the visitors were wives or daughters of members of parliament and men of high position.⁷ The society submitted unsolicited reports to the boards of guardians, who

sometimes acted upon them, and to the Metropolitan Inspector, Mr Farnall, who was known to be sympathetic to the society's aims. In 1859 Louisa Twining wrote to *The Times* about the poor quality of workhouse nursing. What else could be expected, she wrote, for to be the lowest scrubber in a hospital was considered a higher post than to be in sole charge of a workhouse ward.^{8,9} The evidence she gave to the Select Committee on Poor Law Relief told the same story of crowded wards, inadequate supervision of pauper nurses and a failure to classify patients adequately. Quite apart from humanity, she said that the sick would recover more rapidly if properly nursed and treatment would therefore be more economical. Reformers frequently maintained that money spent on better health care would save on the rates in the end. Miss Twining considered that it was important for there to be at least one trained and efficient person to superintend the nursing. If, in addition, medical men would visit workhouses with their pupils as they did hospital wards, many mischiefs would cease and medical training improve. However, when medical periodicals referred to the workhouses and their infirmaries the problems with which they were concerned were generally those of the poor law medical officers, rather than their patients.¹¹

Between 1862 and 1865 widespread unemployment in London increased the pressure on the workhouses and led to crowding.¹² The workhouses were coming to provide more beds for the sick than the hospitals, although there was little public recognition of the change. Hospital statistics were poor - Simon, Bristowe and Holmes lamented the inadequacy of the records when examining the question of the healthiness of hospitals.¹³ But when the London workhouse scandal broke, Dr Sibson of St Mary's was able to compare the case-mix of the St Marylebone and Kensington Infirmaries with St Bartholomew's and Guy's.

'A large proportion of Chronic cases are received into the Infirmary, where they amount to one-third of the inmates. These form only one-tenth of the medical cases in the Hospital. Aged persons are three times more numerous in the Infirmary than in the Hospital. More than two-fifths of the Medical cases in the Hospital are of an active and acute character, requiring ample air-space, close medical supervision, and careful nursing, whilst in the Infirmary such diseases form only 1 in 15 of the same cases in the Infirmary and one in twenty of the total number of inmates.'

'Finally, and this is the most important point of difference, the open sores, many of them of great gravity, including 175 amputations, besides 399 other cutting operations in a total of 6,227 surgical patients, amount to two-fifths of the surgical cases in Hospitals whilst in the Infirmary they form a fifth part of the same class of patient and a twentieth of the whole number of inmates.'

'The proportion of Medical to Surgical cases is three to one in the Infirmary, and two to five in the Hospital. Cases of fever, including typhus, enteric fever and scarlet fever, which are usually admissible in limited numbers into the General Hospital, are excluded from the Infirmary, being sent to the Fever Hospital.' Sibson found that the length of stay and the outcome of comparable cases was much the same in the hospitals and the workhouse infirmaries, with similar numbers of 'cured', 'relieved' and 'unrelieved'. The infirmaries were assuming the functions of true hospitals, rather than workhouse institutions.¹⁴

This progressive change in function was reflected in the design of the more recently constructed infirmaries, like the Mile End workhouse which 'consisted of a whole village behind boundary walls.' The architects retained the main design features of earlier buildings, but enlarged the accommodation for the aged and infirm. Detached infirmaries were built, with larger rooms and additional facilities. These separate infirmaries were still dependent upon the central facilities of the workhouse, such as kitchens, and were under the general control of the workhouse master. The pursuit of the policy of removing all the sick and infirm from the main building had a major effect on the design, since the accommodation for the sick became the dominant part of the complex.

Pressures for reform

These improvements were slow and patchy. Conscientious inspectors such as Mr Farnall might attend the meetings of the boards of guardians, keep closely in touch with their officials and recommend improvements. But the Poor Law Board did not have the power to insist that the improvements should be carried out. Many workhouses were administered under private Acts of Parliament, and an excuse for inaction could always be found. When times were bad guardians

would say that the ratepayers could not find the money necessary for improvements; when times were good it would be said that pauperism was so reduced that there was no need for new building. Better conditions for paupers were not amongst the most appealing of causes.¹⁵

Matters came to a head with the death of an Irish labourer, Timothy Daly, in St Bartholomew's Hospital in December 1864. Daly had developed bed sores whilst in the Holborn Workhouse Infirmary. His friends removed him to private lodgings and eight days later he was admitted to St Bartholomew's where he died the following day. The jury brought in a verdict of death from exhaustion from bed sores and rheumatic fever, adding that Daly had received inadequate care from the poor law medical officer. Critical articles appeared in *The Times* and *Spectator*, and Florence Nightingale wrote at once to Mr Villiers, the President of the Poor Law Board, to ask for an enquiry into the whole question of hospital nursing in workhouses. She maintained that when a pauper became sick he ceased to be a pauper and 'became a brother, and as a brother he should be cared for.' 'If you could only get to know', she wrote, 'how many poor have died because they were not nursed you would be shocked. Could you help by having a searching enquiry made into the nursing system of all workhouses?'¹⁶ Mr Villiers wrote back pointing out that there was a shortage of trained nurses and that the guardians could not compete successfully for staff with the rival attractions of the public hospitals and private sickness.

The Poor Law Board's enquiry into Daly's death exonerated the medical officer, Mr Norton, and suggested that two paid nurses should be employed and the medical officer's salary increased. Shortly after a second death from neglect occurred in another infirmary, that of Richard Gibson. This time the enquiry led to the resignation of the assistant medical officer and the paid nurse.¹⁷ Miss Nightingale saw Mr Villiers in February 1865 about nurses for the workhouses. The *British Medical Journal* and *The Lancet*, had supported the campaign of the poor law medical officers for higher pay, more authority within the infirmaries, and more medical assistants. Now a new campaign began on behalf of the patients. The *Medical Times and Gazette* suggested the separation of the sick wards from the rest of the infirmary, so that they could be conducted on different principles, and commended to 'the various Sisterhoods which are springing up around us the union hospitals of London as a most fitting field for their

exertions'.¹⁸ In May 1865 the Workhouse Visiting Society organised a large and influential delegation to Mr Villiers at the Poor Law Board, seeking increased medical and nursing staff and better facilities for the infirmaries. In July 1865 Miss Nightingale drafted her 'ABC of Workhouse reform': separation of the sick, insane and incurable from the usual pauper population, a general metropolitan rate for this purpose with central administration, and the continued care of the paupers and casual poor by the guardians.¹⁹ Her ideas were hardly original.

The Lancet Commission

The Lancet took up the new cause, supporting a campaign which was a classic example of the use of publicity to work for reform. Not only did the journal's activities culminate in a major legislative measure, but its reports as published led boards of guardians to make rapid improvements in their services. The campaign followed the usual formula of the day for unofficial action - information, agitation, the parent society, the local branch and the handbill, a method which had been used with great effect by the evangelicals in their campaign against slavery.²⁰ At James Wakley's request, Mr Ernest Hart (Dean of St Mary's Medical School and later editor of the *British Medical Journal*) approached Dr Anstie of the Westminster Hospital, and Dr Carr, a member of the panel which had enquired into Daly's death, for their help. In April 1865 *The Lancet* announced the establishment of a commission to enquire into all the metropolitan workhouses to which it could obtain admission.²¹

'The workhouse hospital system is a disgrace to our civilisation. Compare it with our public hospitals ... workhouse hospitals sin by their construction, by their want of nursing, by their comfortless fittings, by the supremacy which is accorded to questions of expense, by the imperfect provision made for skilled medical attendance on the sick, by the immense labour imposed on the medical attendants, and the wretched pittance to which they are ground down.'²² The article went on to summarise the results of the vast and meticulous enquiry, detailed reports of which appeared fortnightly in *The Lancet* for the next year. The medical press was not united about the need for reform. The *Medical Times and Gazette* said that the ratepayers should not be ignored. Long suffering and themselves impoverished, were yet heavier burdens to be placed upon them?²³ In areas of

destitution the increased poor rates during years of 'distress', enforced by law, could be the final burden which bankrupted a family. Thirty six of the 39 metropolitan workhouses readily agreed to inspection by *The Lancet*, two more agreed later and only St Margaret and St John, Westminster refused admission. Guardians were sometimes oblivious of the state of affairs in their workhouses and would find to their surprise that the visiting committee they had appointed had never in fact visited and that reports from their medical officer had been ignored. Commissioners might be given information by people who were interested in reform but were hesitant about making a public complaint. *The Lancet's* reports were written in astringent terms, supporting the medical officers where possible but castigating without mercy boards which were not providing a tolerable level of care. In a few places, it was noted, attempts had been made to provide simple and cheap comforts, but taken as a whole the commission was a massive indictment of the system. Infirmaries were classified in three groups: the very worst which were 'entirely improper as residences for the sick or even the able-bodied'; those which with certain necessary improvements might be satisfactory for chronic disease and infirmity; and those built on sound principles 'which might be developed into first-rate hospitals capable of serving the needs of large districts for the treatment of the more important and acute diseases, both surgical and medical'.²⁴ The infirmaries were treating more cases than the voluntary hospitals and had become, in truth, 'the great state hospitals of the metropolis'. Their management and staffing should be arranged on a 'modified hospital system'. The commissioners criticised the frequent failure to separate the sick wards from the rest of the workhouse. They commented on the widely varying standard of nursing, from a small but efficient staff with paid help to the employment of 'ignorant, drunken or decrepit paupers with few if any hospital trained nurses to supervise them'. The medical officers were few in number, overworked, on a low salary, and often had to supply drugs from their stipend. They were seldom able to challenge the decisions of the workhouse master or the guardians. The small size of some of the wards and their ventilation and sanitary condition, begged description. Patients with undressed sores were lying in filth. Guardians might protest that the reports were unfair, but they could seldom refute the statements which had been made and sometimes a second visit revealed worse scandals. Individual guardians joined the campaign, some feeling that the system of which they were part forced them to act as the persecutors rather than the guardians of the poor. *The Lancet's* commissioners were treated with goodwill by the Poor

Law Board and its officials, particularly by Mr Farnall who began to behave somewhat indiscreetly for a civil servant, engaging in an informal correspondence with Miss Nightingale.²⁵ In June 1866 he took Ernest Hart with him to see the male sick wards at the Whitechapel Infirmary. Hart's subsequent account of the visit, published in the *Daily News* and *The Times*, led the guardians to protest to the Poor Law Board that Mr Farnall had behaved improperly towards them and to their medical officer.²⁶

In May 1865 the Poor Law Board sent the guardians a circular letter discouraging the use of paupers as assistant-nurses, and pointing out the desirability of employing a sufficient number of paid nurses. The Strand board appointed 'a young and respectable-looking woman as a superintendent-nurse.'¹² Replying to a parliamentary question, Mr Villiers said that on the basis of information supplied by Miss Nightingale there was no difficulty in finding the staff which were needed. There were no fewer than 93 paid nurses in the metropolitan workhouses, and only eight infirmaries had none at all. The following December Ernest Hart published an article in the *Fortnightly Review* on 'The Condition of our State Hospitals'.²⁷ His article, which was later reprinted as a pamphlet, was addressed to a wider public and accused guardians of failing to understand their duties as the governors of state hospitals. He felt that there were not enough men of ability to perform such an exacting task and that parishes should combine to make better use of the most suitable buildings. In these amalgamated hospitals something like a true hospital system should be introduced.

A second article published in the *Fortnightly Review* of April 1866 suggested more detailed remedies. Each infirmary might be reconstructed or remodeled, but this policy would throw an impossible burden on the poorer parishes where the demand was greatest and where it was most difficult to raise the poor rate. Alternatively the existing workhouses might be taken over by a central authority, though this was probably too large a reform to succeed. The voluntary hospitals could themselves be expanded, but the extent of development necessary to produce an additional 6,000 beds would imply a complete revolution in their character. The solution Hart favoured was to build six new hospitals, each of a thousand beds, and support them from a common rate fund. He was aware of fears which the voluntary hospitals were expressing that large new infirmaries might drain them of their patients and decrease their income, but he

felt that the dangers were exaggerated. His proposal did not involve the admission of more patients, or patients of a different class - just better and more economical care.²⁸

Hart's main proposals were adopted by the Workhouse Infirmaries Association which had been founded early in 1866 and numbered among its members Louisa Twining, the Archbishop of York and two earls. It organised a large and influential delegation to Mr Villiers which was followed on 2 April 1866 by the setting up of a special enquiry by the Poor Law Board. 'Having had their attention drawn to the alleged inadequacies of provision made for the sick poor in the metropolitan workhouses' Mr Farnall and Dr Edward Smith were asked to inspect them carefully, paying particular attention to the size and ventilation of the wards, the medical staffing and the provision of nursing. Farnall discussed with Miss Nightingale the questions to be asked about the nurses.²⁹ The inspectors were to suggest alterations in the existing system, and in each infirmary, to secure the satisfactory treatment of the sick poor.^{30,31,32} Dr Edward Smith had joined the Board in June 1865 as an inspector and had been appointed, in addition, medical officer to the Board in February 1866. Two months later the inspectors submitted separate and detailed reports to the Board. Both admitted that deficiencies existed, but excused many of them. Dr Smith pointed out that the poor, having been accustomed to old and low buildings and deficient light and air, did not like the large and lofty rooms, the bright light and ventilation, the rigid cleanliness and order of the newer workhouses.³³

A new administration

The efforts for workhouse reform were interrupted when the Whig government resigned in June 1866 as a result of political upheavals preceding the passage of the Second Reform Act of 1867. Florence Nightingale's 'side' was replaced by a minority Tory administration. In place of Mr Villiers, Mr Gathorne Hardy became President of the Poor Law Board. A deputation of reformers immediately went to see the new Minister, who responded more rapidly than Mr Villiers who had taken little action for a year. In late July 1866 the Poor Law Board sent the reports of Mr Farnall and Dr Smith to all the metropolitan boards of guardians, asking them to remedy the defects which had been revealed. The guardians were to consider improvement in ventilation, the need for more space for each inmate, the separation of the aged

and infirm from the sick and the provision of a higher standard of medical attention and nursing. Mr Gathorne Hardy rapidly discovered that the London workhouses would be a troublesome problem. After a rather difficult interview with Mr Farnall he announced to the House on 6 August 1866 that he had begun new enquiries which would be conducted by inspectors unconnected with the London district.³⁴ The problems of London, he said, were too much for one inspector and Mr Farnall was transferred unceremoniously to Grantham, far away from his family's home in Kent, where he remained until 1870. He continued a regular correspondence with Miss Nightingale, attempted to obtain drafts of the reports of the inspectors who had replaced him, made caustic comments about both of them and the President of the Poor Law Board, and bemoaned his misfortune after all the diligent work he had performed for the Board.²⁵ He was kept in the north for three years and then entrusted with the south eastern district. Dr Smith was also moved. On his own admission he had discussed matters with Ernest Hart, and the President of the Poor Law Board was reluctant 'under the peculiar circumstances' to place in charge of a district an inspector who was thought to be publicly committed to any particular scheme for the future management of the infirmaries. Smith protested, but in vain. His duties were changed and he was asked to undertake an inspection of the provincial infirmaries. He was also relieved of duties to a specific district and made full time medical officer to the Board.³² In the place of Farnall and Smith the Board appointed two new inspectors, Mr U Corbett and Dr W O Markham. Corbett was an experienced man, summoned from Derby at less than a day's notice. His relocation was costly and the Poor Law Board had to seek special Treasury sanction for the reimbursement of the cost of moving him, his family, his furniture and his five servants to his new house in Onslow Square.³⁵ Markham had been the editor of the *British Medical Journal*.

The inspectors were men of seniority. With salaries of around £600 per annum they earned many times the pay of workhouse masters, medical officers or matrons. On 11 August 1866 a letter speedily drafted for the President of the Poor Law Board instructed Corbett and Markham to proceed at once to a further inspection of the workhouses. They were to suggest the immediate improvements required in the workhouses and in their medical and nursing attendance, and also the longer term and more extensive alterations required to ensure, permanently, the proper care and treatment of the sick poor. They were to begin with the infirmaries that Dr Smith had considered the

worst, and with the assistance of Mr Savage, the Architect to the Board, to provide an estimate of the cost of the alterations they recommended. In selecting Mr Corbett, the Poor Law Board had made a good choice. Ten years later, when he came to retire, the Secretary to the Board said that the zeal, ability and energy with which Corbett discharged his functions 'during the difficult years of 1867-8' were highly appreciated by his seniors. Within a week of his appointment, Mr Gathorne Hardy wrote to ask him about the method he habitually adopted in examining a workhouse. Corbett replied that he would go immediately to the sick wards of the infirmary without forewarning, to ensure that no preparations were made for his arrival. Inspection of the sick wards was the heaviest part of his work and a part he did not wish to hurry. He would question some of the inmates quietly, to gain their confidence, for as a rule paupers were not disposed to make complaints. He would try to find out if they were treated kindly by the officers, whether any little amusement or occupation was afforded them, whether the doctor was patient with them, the chaplain came to read to them, and whether they were well nursed and attended in the night.³⁵ 'Cheerful looks and clean bed linen and nightdresses are things which cannot be put on at a moment's notice, nor can rooms, closets and cupboards be readily furnished to order in the course of half an hour.' By using his eyes and following these principles, Corbett thought that whilst an inspector might on occasions be deceived, he could not always be misled about the real state of affairs.

Mr Gathorne Hardy also asked a group of eminent doctors including the President of the Royal College of Physicians and Captain Douglas Galton to visit the London infirmaries and advise on the cubic space to be allowed to each inmate. Galton, like Miss Nightingale, laid great stress on the need for good ventilation and the two were in constant touch with each other. Florence Nightingale felt that it would do 'their side' no good if the Cubic Space Working Party reached a unanimous conclusion, for that would assist Mr Gathorne Hardy of whom she disapproved.³⁶ Several scientific papers were submitted to the group and Miss Nightingale herself was invited to submit a memorandum. Characteristically it went far beyond nursing matters into those of hospital design and management.³⁷

Corbett and Markham assisted the Cubic Space Working Party, but were also hard at work on their own inspection. Writing from Yorkshire Mr Farnall asked for the draft, which was refused. The report of the new inspection made recommendations which could

only be implemented if the Poor Law Board took powers of direction and maintained control over detailed matters.³⁸ It recommended that:

1 The workhouse infirmary should always be as near as possible to the district to which it belonged.

2 The infirmary should be separated from the rest of the workhouse and under independent management, and that the treatment of sick paupers should be carried out under different principles from those to which the able-bodied were subject.

3 Attention should be paid to ventilation and space standards should be:

chronic and infirm	500 cubic feet
sick	800 cubic feet
lying-in women	1,200 cubic feet
'offensive' cases	1,200 cubic feet

4 Imbeciles, children, those suffering from smallpox and fevers, and possibly venereal disease should be excluded from the infirmaries and treated elsewhere.

5 The medical officer should have entire control of the infirmary, be independent of the workhouse master and report annually to the Poor Law Board. He should visit every patient regularly and should make notes on the patients' prescription boards, rather than relying on the nurses.

6 The nursing and the general management of the infirmary should be under the charge of a matron with some previous hospital training. Qualified nurses should take charge of the sick, the more menial duties being carried out by pauper nurses under their supervision. There should be one qualified nurse for every fifty patients by day and for every hundred at night. Drug administration should not be left to pauper nurses.

7 A system of uniformity in internal administration of infirmaries was desirable, especially in medical administration, ventilation, diet and nursing, for 'the practice of uniformity in minor things naturally tended to bring about agreement in matters of more importance.'

The Metropolitan Poor Act (1867)

Once in possession of the evidence he needed, Mr Gathorne Hardy prepared a bill to meet the essential requirements, and which stood a fair chance of passage through the House. It involved the intervention of the state in matters which had previously been left to the guardians

and the charitable, who had worked largely undisturbed. Opposition was therefore likely. The bill, which owed much to the ideas of Louisa Twining, Ernest Hart and Joseph Rogers, was mentioned in the Queen's speech at the opening of the parliamentary session and was introduced at an early stage.

The bill had been carefully framed to attract support without appearing to involve revolutionary changes, for it was necessary to avoid alarming the richer parishes like St George's, Hanover Square, 'where Charity began and ended at home'. The maintenance of the destitute was traditionally a parish responsibility, and many parishes worked under private Acts of Parliament, the repeal of which would be necessary. However difficult it might be for the poor and overburdened rate-payers of the East End to find money for improved services, the West End was not going to rush to their aid.³⁹ Introducing the second reading of the bill, Viscount Enfield referred to the reports in *The Lancet* and 'the very strong impression on the public mind that some sweeping reform was required'. He was however aware 'of the sensitivity of the parochial mind on the subject of local self-government'. A new system must be just to those who find the funds and merciful to those who receive relief. There should be no unnecessary expenditure and existing buildings should be used where possible, but every justice should be done to the poor. The bill was restricted to London and a common metropolitan fund would only reimburse the cost of treating easily recognisable illnesses such as smallpox, fever and lunacy.

Powers of direction would have to be obtained, for the guardians had taken little notice of the Poor Law Board's circulars. Mr Gathorne Hardy told Parliament that 'it is not of the slightest use to make orders or lay down rules unless you are in a position to carry them out, and enforce them if they are not complied with.' Under the bill, the Poor Law Board would nominate up to a third of the guardians and they would select men of 'influence, mind and heart' to ensure that those entrusted with the supervision of the workhouses would undertake the necessary reforms. Boards of guardians would henceforth contain both members selected locally and nominees of central government.

Florence Nightingale did not approve of Mr Gathorne Hardy's bill, describing it as 'an abortion of Mr Villiers' scheme'. She wrote to Sir Harry Verney on 1 March 1867 saying that in Mr Farnall's view the bill would open the way to more medical and guardians' jobbery. What

was needed was a 'central uniform management for the whole of the metropolis' with all infirmaries managed by paid, responsible officers. These officers would be interposed between the hospitals themselves and the Poor Law Board.⁴¹

A few small amendments were made to the bill at the committee stage, but it was essentially untouched and the bill was welcomed both on the floor of the House and in the medical press. On 14 March the bill was read for a third time and passed 'amid the cheers of the House'. 'We have little to complain of in all this', said *The Lancet*. Mr Gathorne Hardy had had his own way in almost everything and *The Lancet* suspected that, whilst he and not presented the measure as a radical reform, the extent of the changes would become rapidly apparent when the new system was working.³⁹

Armed with its new powers the Poor Law Board began to reorganise the pattern of the workhouses. In principle, each parish or union, when sufficiently large and when it had the means to provide for its own wants, was allowed to remain distinct. Throughout 1867 Corbett and Markham produced a variety of proposals to unite the smaller parishes into unions with populations of 70 - 100,000, each providing for roughly 1,000 inmates. They were not in entire agreement. Markham favoured large all-purpose unions, whilst Mr Corbett preferred to deal with the problem, on occasion, by creating united sick asylum districts for the care of the sick poor, leaving the smaller parishes and unions to continue to provide for the able-bodied destitute on a separate basis. It was clear that the guardians were not going to take kindly to any change in their responsibilities, but on balance they preferred Corbett's solution. This left boards with a continuing role, whilst placing the care of the sick and destitute in the hands of a separate body (the Sick Asylum District) which was responsible directly to the Poor Law Board and not to a board of guardians. Mr Corbett said that he regarded it as important to work with, and not in the teeth of, the existing boards of guardians, and the Poor Law Board agreed, believing it was 'wise and right to adopt a course which involves the least disturbance to present arrangements and is least unpopular with guardians'. A favourable opportunity had presented itself for reconstructing the union map of London but this had not been a prime object of Mr Gathorne Hardy, neither had the possibility been brought prominently before Parliament during the discussions on the bill.⁴² The aim was to achieve adequate classification of the sick and infirm - taking into account geography, the existing buildings and the land available for development - not to

disturb all the existing institutions.

In December 1867 the Poor Law Board asked Dr Markham and Mr Corbett if there were any wards in the metropolitan workhouses of such a character as to require immediate and direct interference by the Board to support or supplement the recommendations that the inspectors had already made. Dr Markham said that the defects had already been reported to the Board and to the guardians, who were prepared to remedy them at the earliest opportunity. Mr Corbett was more cautious and admitted that there was great overcrowding in some places, but he said that the guardians were often providing temporary accommodation and that the problems could not be wholly overcome until new building on an extensive scale had been completed. Only in the case of the Strand union had the inspectors' proposals met with refusal, and this union proposed to give outdoor relief more freely. Direct and immediate interference was not necessary.³⁵

In the same month Mr Corbett reported to the Poor Law Board that the level of distress was considerably higher than the previous year. In the East End it had reached the provident classes. To avoid 'coming on the rates', many people were pawning clothing and bedding and the Poplar union decided to lend bedding to the poor, taking the precaution of marking it with the union's name.

By the end of 1867, the estimated cost of the building work required had reached nearly £1 million. Included in the estimates were⁴²:

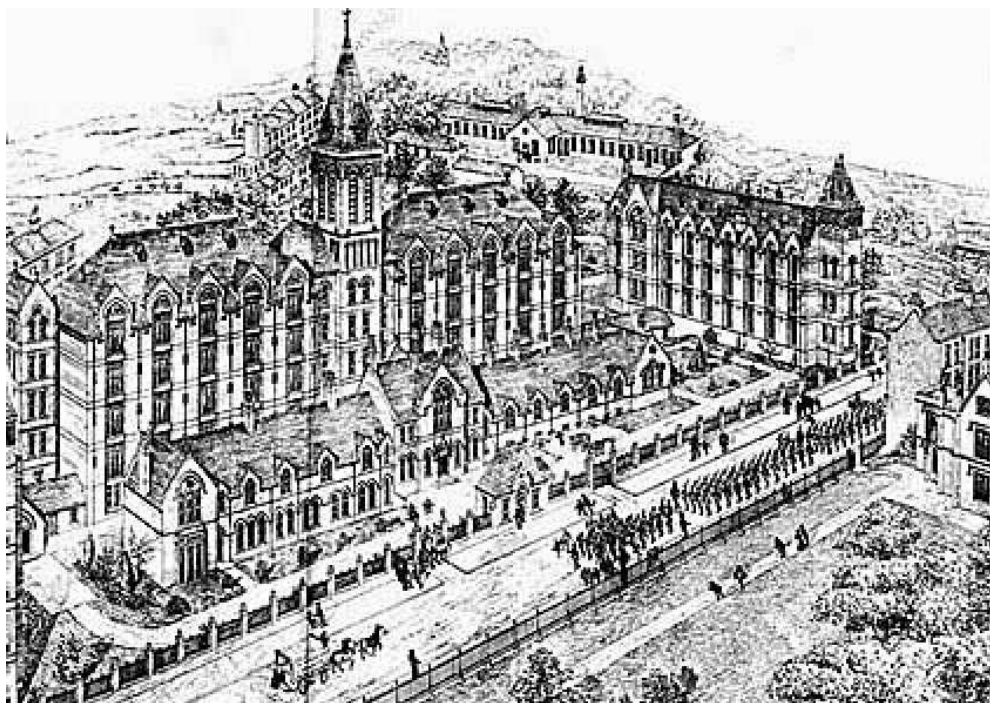
Two imbecile asylums @ £60 per head	£200,000
Three fever hospitals with sites	
@ £80 per patient	£70,000
Two small pox hospitals	£50,000
Bethnal Green Infirmary (for 500	
@ £50 per head)	£25,000
Clerkenwell Workhouse and Infirmary	£40,000

Including sites and fittings the cost of each of the new institutions was at least £40-50,000, and there were moments 'in which even the calmest & most humane seemed to feel the problem to be insoluble and to wish that it were possible to sink the entire pauper population to the bottom of the sea and have done with them.'⁴³ Classification there

had to be, but with small unions that meant a number of small and separate establishments. The Sick Asylum District, bringing together the more acutely ill paupers from a number of unions, was more economic. It placed the sick under different management and avoided the need to erect many new and costly buildings. Mr Corbett considered that the Strand Union, St James' Westminster, St Martin-in-the-Fields, St Giles' and St George's Bloomsbury might have a joint hospital for the acutely sick and the worst of the chronic sick, whilst the remaining chronic sick could go to the existing Strand workhouse. He discussed the proposition with Miss Twining, 'the most practical woman I have ever known amongst the many who have taken an interest in the subject'. Miss Twining said she could provide two lady nurses who would be delighted to undertake the duties of nursing superintendent or infirmary matron, should his plan be adopted.⁴²

Elections were held for new guardians, and the new brooms assisted by the centrally nominated members swept cleaner. Insubordinate staff were dismissed, paupers were classified more effectively and lunatics removed to county asylums. The St Pancras guardians, whose workhouse was severely criticised by Dr Markham in February 1867, and in a number of respects by *The Lancet* on a repeat visit the following year,⁴⁴ purchased land at Highgate and called for designs for a new infirmary.⁴⁵ *The Lancet* claimed credit for many of the changes which were taking place in the infirmaries, but it defended Mr Farnell whose move to Yorkshire had been interpreted as a censure allegedly for failing to expose and remedy the abuses which had come to light. He was, said *The Lancet*, the only official who over many years broke the monotony of corrupt stupidity and inaction in the management of the London parishes by the Poor Law Board. The journal continued to publish reports by its staff on the improvements which were being made⁴⁶, and commented helpfully on the architects' plans for the new infirmaries which the unions were being directed to build.

The campaign died away almost as rapidly as it had started. Ernest Hart moved to the *British Medical Journal* as its editor. Although at an earlier stage Hart's views had been sought by the authorities, now, wrote Miss Nightingale, they refused to admit him to their councils. Miss Nightingale believed that there was a conspiracy to keep things quiet. 'The world is to be put to sleep, as Mr Hart has been stopped' she wrote.²⁴ Hart did not use the *British Medical Journal*, as *The Lancet* had been used, to run a campaign. Early in 1868 it was agreed



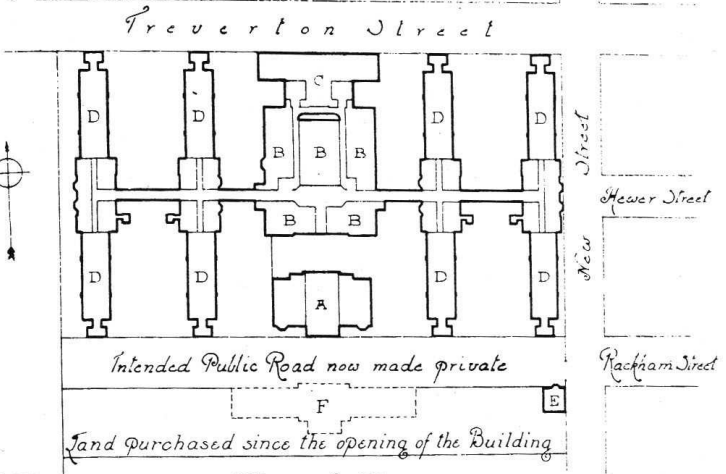
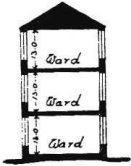
that Corbett's proposals for central London should be accepted and he was invited to name the new joint board for the parishes and unions which were to be united for the purpose of providing accommodation for the sick. He suggested that it should be called the Central London Sick Asylum District, and the board of management was established in May 1868 to serve the Strand and Westminster unions, and the parishes of St Giles'-in-the-Fields and St George's Bloomsbury. The board consisted of nominees of the parishes and unions concerned, together with four members selected by the Central department. Its first task was to determine the extent of the provision required, which in itself proved a difficult task, and the nature of the institutions available. After careful consideration, and in consultation with Corbett and Markham, it was concluded that none of the existing workhouses was suitable for conversion into a hospital. Nor could a suitable site be obtained by advertisement. A solution was found the following year. The parish of St Pancras was added to the Sick Asylum District so the new infirmary under construction at Highgate could be used for the sick of the entire district. It opened at the end of 1870 with accommodation for 523 paupers and a matron recommended by the Nightingale Fund.

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Architect's plan of St Marylebone Infirmary

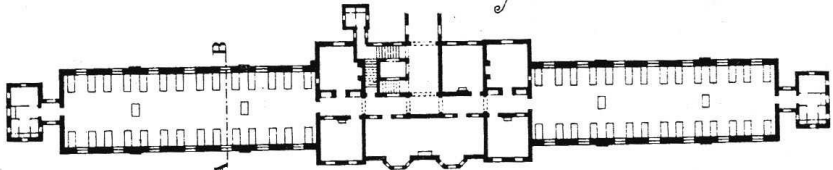
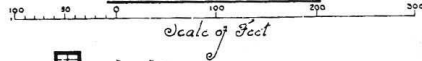
· St · Marylebone · Infirmary ·

- A. Officers' quarters and Chapel
- B. Administrative offices
- C. Laundry
- D. Sick Wards
- E. Porters' Lodges
- F. Proposed Nursing Institute.

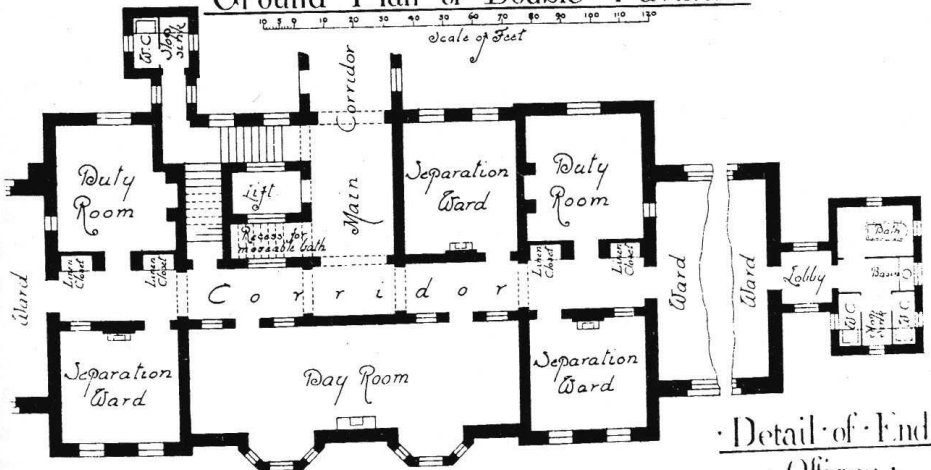
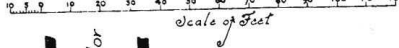


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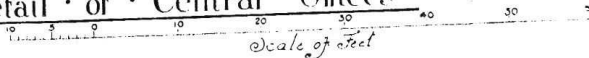


· Ground · Plan · of · Double · Pavilion ·



· Detail · of · Central · Offices ·

· Detail · of · End · Offices ·



In 1870 the Poor Law Board issued a circular to the metropolitan guardians specifying the cubic space allowance for the various classes of paupers, giving financial encouragement to guardians who were prepared to deal with overcrowding by erecting new buildings. It was the beginning of a major construction programme which gave London a system of separate infirmaries far in advance of other parts of the country. One after another was built from 1867 onwards and recorded in the annual reports of the Poor Law Board and the Local Government Board. Hospitals built on the pavilion plan were not cheap to construct, but the design was almost invariably chosen for the new infirmaries. The work of Douglas Galton on the cubic space working party was incorporated in the design guidance issued by the Poor Law Board, for while it was important to minimise public expenditure, the buildings had to be satisfactory for their purpose. In 1868 the board issued instructions for the guidance of architects in the construction of workhouses and workhouse infirmaries. The board said that it did not wish 'unduly to fetter their discretion', but in considering plans the guardians submitted for approval the Board would have regard to the guidelines. Some architects came to specialise in poor law buildings. Henry Saxon-Snell was one of these. A Fellow of the Royal Institute of British Architects, he was a pioneer member of the Sanitary Institute, now the Royal Society of Health. In his early days he was an assistant to Sir Joseph Paxton, who designed the Crystal Palace. He wrote extensively on hospital design, debunking an emerging fashion for circular wards. His book, *Charitable and Parochial Establishments*, was presented to the Prince of Wales when he opened the St Marylebone Infirmary. He wrote a second book, *Hospital Construction and Management*, in association with a doctor, Frederick Mouat.⁴⁸ His obituary in *The Builder* makes clear the extent of his contribution to London hospital architecture.⁴⁹ Long surviving examples included the Archway wing of the Whittington (illustrated), St Charles' Paddington, St Olave's and St Stephen's, Fulham. His infirmaries were designed in a style which has been dubbed 'Guardians' Gothic'. With disarming modesty he commented upon the St Marylebone Infirmary, later St Charles': 'It must not however be supposed that I consider it to represent the model of a perfect hospital building; the limited extent of the site alone would render this impossible; nevertheless, it is allowed to be the most perfect building of its kind yet executed.' It provided a cubic footage of 936 per patient, at a cost of £161 per bed. The Poor Law Board's circular 'Points to be attended to in the construction of workhouses' was modified by the architects to the Local Government B

board over the next 30 years and determined the form and content of infirmaries in one of the most active periods of hospital building London has seen.⁵⁰

Improvements in the infirmaries

Improvements were not restricted to the buildings. Florence Nightingale had expressed a desire to assist where possible with poor law nursing. After the St Pancras guardians had been criticised by the coroner for the poor standard of nursing in their infirmary⁵¹, the first poor law school of nursing in London was established at the new Highgate Infirmary in association with the Nightingale Fund. The school only lasted until 1878 but another, also associated with the Nightingale Fund, was subsequently established at Snell's St Marylebone Infirmary. There the guardians took a novel step and erected a building for forty probationers, including lecture rooms, at a cost of £12,000. In 1870 Dr Dudfield reported on the reduction of mortality which had accompanied the introduction of trained day and night nurses into the St Margaret's Workhouse, Kensington. Expenditure on wines and spirits had also fallen, the savings being more than the cost of employing the eight nurses. 'Much has been done by your Board,' reported Dr Dudfield, 'to ameliorate the condition of the sick, infirm and the aged, without in any way making the establishment attractive to that class of poor for whom the workhouses were originally intended.'⁵²

The London guardians were increasingly men of vision, but the supervision of the Poor Law Board remained essential.⁵³ The representatives of the various unions and parishes which made up the Central London Sick Asylum District did not always see eye to eye, and in its first year the Westminster guardians tried to break away. The Poor Law Board made it clear that it did not envisage a further reorganisation. Instead, one of the board's nominees, Sir Sydney Waterlow,* became chairman in 1870 to pull the authority together. Sir Sydney had been one of the more active guardians of St Pancras. He became Lord Mayor of London in 1872, treasurer of St Bartholomew's in 1874, and was the first president of the Hospital Sunday Fund. Under his leadership the Central London Sick Asylum District opened its first infirmary at Highgate in 1870, and a second one in Cleveland Street in 1874-5 which contained a further 211 beds.

Steady and unobtrusive work by Louisa Twining and the Workhouse Infirmary Nursing Association also began to show results. In 1880 a second Lancet commission on workhouse infirmaries reported on the 'distinct advance in the treatment of the sick pauper' as a result of the new separate infirmaries and congratulated the guardians on 'the noble manner in which they have carried the scheme into effect'. *The Lancet* said that the new infirmaries were the equal of any hospital it had visited, both in accommodation and equipment. Only in the size of the medical and nursing staff to deal with the 'overwhelming amount of sickness and suffering had the guardians been niggardly'. *The Lancet* suggested that assistant medical officers should be appointed and that medical students should attend the infirmary for six months. Great advances had been made in nursing and to the journal's astonishment the ignorant, rough, well-meaning pauper nurse was being replaced by a class of intelligent, trained, paid nurses who performed their onerous duties skillfully. A matron or lady superintendent controlled a staff of head nurses, one to two or three wards, with an assistant nurse in each ward. *The Lancet* felt that the staff should be increased and suggested a fixed proportion of nurses to sick, not less than one nurse to eight to ten patients, and an increased number of probationers, 'for there could be no better training school than an infirmary.

The development of the infirmaries into true hospitals was taken a step further in 1886 when their superintendents met at the Lambeth hospital. They petitioned the guardians and drew attention to the increasing degree of specialisation in medicine. They recommended the appointment of 'specialists of eminence' as honorary consultants to the infirmaries." Slowly and patchily the infirmaries were developing into true hospitals.

*Sir Sydney Waterlow (1822-1906); stationer and printer; Lord Mayor of London 1872-3; Liberal MP 1868-1885; founder of the Improved Industrial Dwellings Company to provide dwellings for the poor, which came to house nearly 30,000 people.

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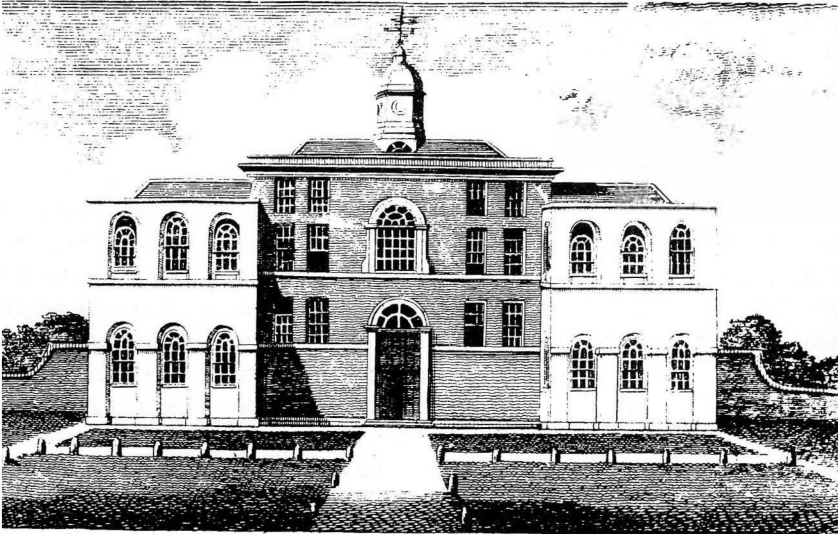
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The Smallpox Hospital near St Pancras where King's Cross station now stands

Chapter 5 The Smallpox and Fever Hospitals

Fevers, including smallpox, typhus and enteric fever, were one of the greatest problems with which cities had to deal. The problems were made even worse by the arrival of cholera in London in 1832. The size of epidemics and the risk to the population led many cities to establish some form of 'house of recovery' or 'pest-house', but the size of London meant that the few facilities which existed were inevitably overstretched. At times of crisis the hospitals might admit some patients, others would be cared for in the workhouses, but many died or recovered at home. Those who were wealthy were invariably looked after at home, where they would be more comfortable and could receive better care, as well as being isolated from others.

There was little agreement within the medical profession about the best way either to treat patients or to organise care. In 1850 the General Board of Health commissioned a study into methods of prevention and treatment and whether the risks to the staff were least if patients were spread evenly throughout a hospital or were

concentrated in a single block.¹ The rules of many of the general hospitals excluded patients with fevers altogether but hospitals varied in their admission policies, and would change their practice over the years.

In 1746, by 'the benevolence of a few generous individuals', a charity was established to receive persons of all ages and denominations who were suffering from smallpox. The charity intended not merely to provide every facility for treatment, but also to study alternative methods of treating the disease. A house was taken in Windmill Street, Tottenham Court Road, and was soon filled. Others were procured in Coldbath Fields and Old Street.² Expansion proved necessary and Rocque's map of London (1769) shows the new smallpox hospital at Battle Bridge, where King's Cross Station now stands. It was rebuilt yet again in 1846 as the London Smallpox and Vaccination Hospital on Highgate Hill in Upper Holloway and the building now forms part of the Whittington Hospital. Patients were admitted by presentation of a governor's letter, or from the hospitals and workhouses of London on the payment of a fixed sum.

The London Fever Hospital

Another voluntary hospital for infectious diseases (other than smallpox) was founded in 1802. It was originally established in Constitution Row, Gray's Inn Lane, 'to the great horror of the neighbours who threatened indictment and prepared for litigation', and for a time it provided the main facility for fever patients for the whole of London. In 1815 the hospital shared accommodation with the Smallpox Hospital, moving into the west wing at Battle Bridge, where it remained until 1848 when the Great Northern Railway required the land. With the compensation received the hospital was rebuilt in Liverpool Road, Islington. Once more there was a public protest and Thomas Wakley was invited, as the local Member of Parliament, to address a meeting. Wakley used *The Lancet* to attack Dr Southwood Smith, physician to the London Fever Hospital, for supporting the governors in their plan to locate 'a deadly pest-house' for patients with the most malignant form of fever in the midst of a population of 60,000. The fact that Dr Smith was also the medical member of the new General Board of Health made his conduct, in the view of *The Lancet*, all the more reprehensible.³

In spite of the protests, the London Fever Hospital opened and it

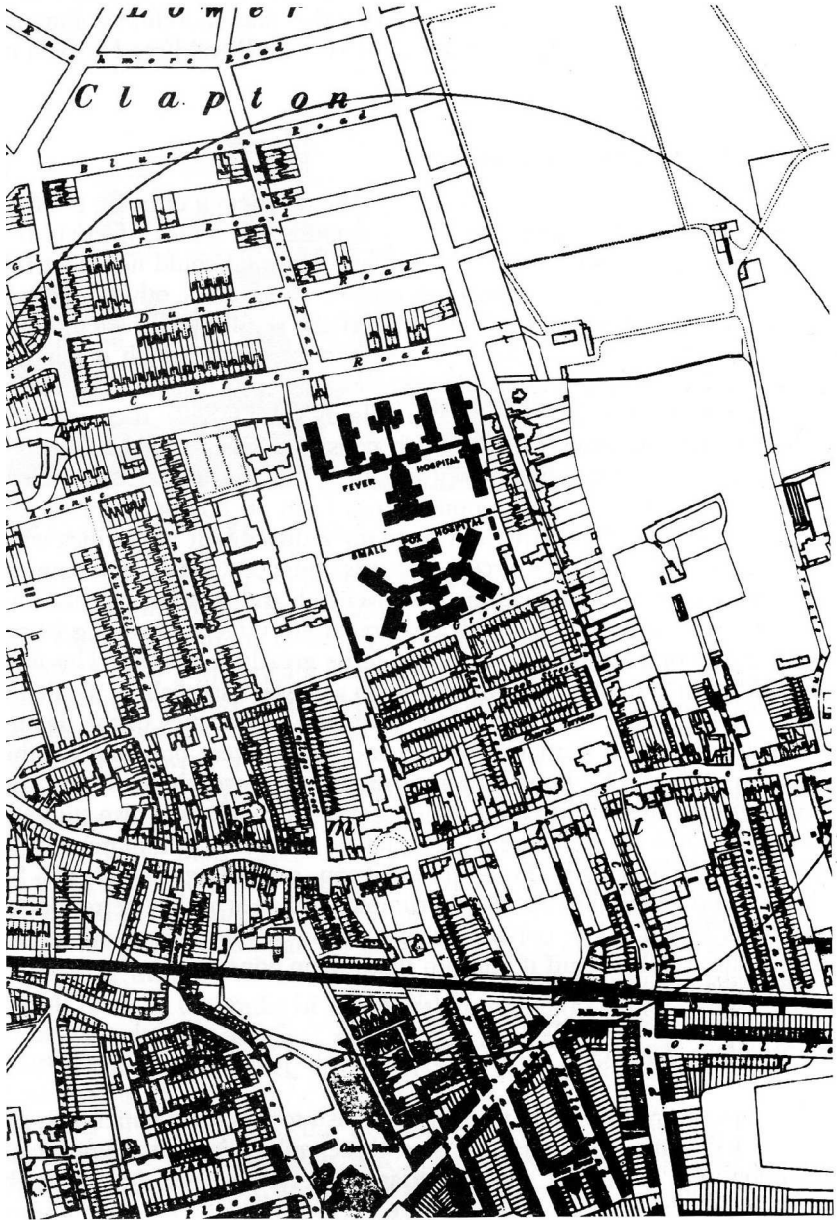
proved less of a hazard than had been feared. Most patients were admitted by parish order, at a cost to the guardians of one shilling a day. In its later history - after the Metropolitan Asylums Board was formed - the hospital concentrated on patients above the pauper class, servants of the upper classes and better-off people living alone. The charity found it hard to attract voluntary support and its patients - even if they survived - were not always good payers. Financial crisis was therefore commonplace. The Fever Hospital amalgamated with the Royal Free Hospital in 1948.

The Metropolitan Asylums Board

To the poor law fever hospitals belongs the distinction of being the first centrally planned hospital service in London. At times of crisis the London Smallpox Hospital and the Fever Hospital could not meet the demand. Parishes cared for patients in their workhouses, other buildings would be taken over, or tented hospitals would be erected. The unsatisfactory nature of this supplementary provision, which depended on the varying policies of the different boards of guardians, was one of the problems solved by Mr Gathorne Hardy's Act (1867). It created the Metropolitan Asylums Board, which consisted of 45 members representing parishes or unions and 15 from the central Poor Law Board. The new board assumed responsibilities from 30 boards of guardians which 'could not be carried out by many independent authorities with varying needs and resources'. It was financed from a common metropolitan fund to spread the cost over rich and poor areas, based its policies on the professional advice it received, waged a running battle with the Poor Law Board, and came to be greatly respected. The new board began systematic planning as soon as it was established. To do so it needed to know the extent of the problem, so statistics of the deaths from fever in each parochial district in London were obtained for the previous years. The Poor Law returns from the workhouses, and the number of admissions to the London Fever Hospital, were also studied. The logic of the system was later explained to a select committee of the House of Commons by Dr Francis Sibson, consulting physician to St Mary's and one of the central government nominees to the Metropolitan Asylums Board.⁴

The population of London at the time amounted to about three million and it fell into three main zones:

Figure 3 Map showing the Homerton Hospital



The site of the Eastern Fever Hospital

Hospital Commission 1882

	North Eastern District	967,000	North
Western District	793,000	Southern	
District	1,276,000		

The maximum distance it was thought wise to transport patients in an exhausted state from smallpox was three miles. As the diameter of London was about six miles a triangular system was devised with hospitals at the apices, six miles apart. A circle of half a mile was drawn around each angle, and sites were sought within these near Elephant and Castle, Victoria Park and Regent's Park. Advertisements led to the offer of sites, but the Board had to proceed quietly and circumspectly for as soon as its interest was known there were protests from local residents. Sites had to meet several criteria. They had to be as near as possible to the great mass of the population without being within it, so that they enjoyed clean air; and the ground had to be about eight acres in extent. Sites had been located by early 1868, but in each case there was a deputation in protest. The Metropolitan Asylums Board therefore sought the agreement of the Poor Law Board to proceed, and this was granted. In each case the plan was to build a pair of hospitals, one for smallpox and the other for fevers. The architects' plans can still be seen in the Public Record Office. The Homerton fever hospital was designed with one ward for scarlet fever, one for enteric fever and three for typhus. Building began at Homerton and Stockwell but construction at Hampstead was delayed at the suggestion of the Poor Law Board because the demand for accommodation was uncertain and it seemed reasonable to learn from the experience of the other two pairs of smallpox and fever hospitals.

However, events overtook the Metropolitan Asylums Board. An epidemic of relapsing fever in 1869 forced it to negotiate with the London Fever Hospital to erect a temporary ward at Liverpool Road, and to use the ground it had purchased at Hampstead. Two hundred and twenty men were put to work and within five weeks the green slope south of Hampstead Heath Station was covered by a hundred-bed hospital. It consisted of galvanised iron huts on a concrete base and included kitchens, accommodation for doctors and nurses, and a mortuary. It cost £8,000. 5

The paired hospitals at Homerton and Stockwell were still not ready in

Opened	Later names & current use	Smallpox or fever	Smallpox	Fever	Acreage
Hampstead 25 Jan 1870	North Western now the Royal Free	300			8
Homerton 1 Feb 1871	Eastern Hospital now Homerton Hospital		102	200	6
Stockwell 21 Jan 1871	South Western demolished 1996		102	198	7
Fulham 10 March 1887	Western Hospital Closed 1979	240			6
Deptford 17 March 1887	South Eastern, later New Cross Closed 1988	310			9
Total		850	204	398	

The first hospitals of the Metropolitan Asylums Board

1870 when a very severe outbreak of smallpox swamped the existing facilities. The London Smallpox Hospital on Highgate Hill was quickly filled and many patients had to remain in the workhouses of the East End. More huts were erected at Hampstead to the increasing alarm of the residents. In February 1871 the construction work at Homerton and Stockwell was advanced enough for the accommodation designed both for fevers and for smallpox to be put to use to admit patients with smallpox. Ground for further hospitals was desperately needed. Part of the Lillie Bridge racing ground in Fulham was acquired for the Western Hospital, and at Hatcham, a market garden off the Old Kent Road for the South Eastern Hospital. In April 1871 the Admiralty granted temporary use of the old hospital ship Dreadnought. By May additional space was created by the erection of marquees in the grounds of the hospitals at Homerton and Stockwell.

Another smallpox epidemic in 1877 again swamped the board's accommodation. 'It would seem', said *The Lancet* 'that the vastness of the metropolis and the incoherence of its government precludes it from taking advantage of the teachings of experience'. As a result of the

shortage of hospital accommodation many deaths occurred at home. The Fulham and Deptford Hospitals, the latter in temporary wooden huts, opened in the middle of the crisis and by the end of the 1870s the Metropolitan Asylums Board had five paired hospitals, all on large sites. Yet accommodation proved inadequate once more in 1881.

Tents were erected for convalescent patients at Darenth and the Admiralty lent the battleship 'Atlas' for conversion into a floating hospital. This was positioned at Greenwich and later moved further down river.

The risks from the hospitals

A proposal to build a fever or smallpox hospital invariably led to protests from local residents, but at first there was little evidence that the hospital harmed the health of a locality. From the outset the inhabitants of Hampstead, led by Sir Rowland Hill, fought against the admission of cases of smallpox. The result was an enquiry into the Hampstead Hospital by a select committee of the House of Commons in 1875.^{4,6} Evidence showed that patients had communicated with people over the walls and that ambulance men and relatives called at The George, which still stands on Hampstead Hill, for refreshment. The committee concluded that the Metropolitan Asylums Board had acted properly and that such risk as there had been was due more to individual carelessness and poor control of patients - caused by crowding in an emergency - than to the presence of a smallpox hospital in the community.

The board did in fact take all reasonable precautions and the regulations of the hospitals were severe. When a new ambulance station was established at the Eastern Hospital, providing accommodation for nurses, coachmen and male attendants as well as the ambulances and horses, the *British Medical Journal* praised the regulations. 'At the hospital the ambulance is unloaded and then thoroughly disinfected; the nurse changes her outer clothing, and all blankets are left at the hospital for washing. After this the ambulance returns to the station. Besides this disinfection at the hospital we are informed that the nurses and officers bathe and change their clothes before they are allowed any leave of absence. There is not much fear, we apprehend, of the station becoming a centre of infection.'⁷

Nevertheless there was increasing anxiety that the incidence of smallpox was higher in the vicinity of the smallpox hospitals. In December 1880, the Local Government Board, learning that the Fuiham Hospital was about to be used for smallpox cases, asked Mr W H Power, a medically qualified inspector, to enquire into the matter. ⁸ He showed that there had been a marked change in the local distribution of cases each time the hospital had admitted smallpox. The nearer a household was to the hospital the more likely it was to suffer from the disease.

Evidence was accumulating that there were dangers in siting smallpox hospitals in residential neighbourhoods and in 1882 the House of Lords settled a lengthy legal action in favour of the Hampstead residents.^{9,10} A thorough and independent investigation was called for and the Local Government Board applied for a Royal Commission to examine the whole subject of hospital accommodation for infectious disease in the metropolis. The commission examined Power's evidence, and other information from Stockwell, Homerton, and Datcham which confirmed the risk of living near a smallpox hospital.¹¹ It recommended that cases in future should be transported by river to hospitals situated on the banks of the Thames and that only those too ill to be moved should be treated in the metropolis. For the severely ill, small 30-40 bed units should be provided in the fever hospitals and used only for patients from the immediate neighbourhood. Sensitive to the opinion of local residents about the value of their property, the Metropolitan Asylums Board renamed its hospitals, using postal divisions instead of the older names of Hampstead, Fuiham, Homerton and Deptford.⁹

Under the chairmanship of Sir Edmund Hay Currie, the Metropolitan Asylums Board adopted the new policy 'in a manner which did them credit'. Throughout 1884-5 architects were hard at work designing wharves for Fulham, Poplar and Rotherhithe.¹² Ambulance steamers were built and a series of floating and riverside hospitals were established so that patients could be sent down river for treatment. [Managers Street, Poplar, was built to connect the main road to North Wharf, and existed until the redevelopment of Docklands].

The epidemics of 1881 and 1884 confirmed that smallpox spread from hospitals. ^{13,14} In 1886 the Metropolitan Asylums Board decided that it would no longer receive smallpox cases in hospitals within the urban

areas.⁸ Nevertheless for financial reasons the Local Government Board was slow to agree to the construction of a convalescent hospital at Darenth for 600 patients. The old Highgate Smallpox Hospital building was sold to the local guardians and the hospital moved to Clare Hall, South Mimms.

The debate continued about the route of communication of smallpox - whether it was by aerial infection or direct person to person contact. A report to the Local Government Board in 1894 pointed out that even when the Metropolitan Asylums Board had tightened all its regulations and communication with the outside world was at a minimum, smallpox inexplicably appeared in nearby houses when cases were admitted to the Fulham hospital.⁸ Once the policy of riverside hospitals was adopted the problem ceased. The managers of the board, with their excellent ambulance and ambulance steamer system, telephonic communication and disciplined staff, had found the solution. The poor of London showed an increasing tendency to seek hospital treatment. The annual reports of the Local Government Board demonstrated that fewer and fewer were dying of smallpox in their own homes:

	1871 -2	1877-8	1881
Total mortality from smallpox	9,742	3,960	2,371
Mortality in private houses	6,509	1,932	797

The original smallpox hospitals had been of moderate size. It became necessary to provide for larger numbers of patients and the Poor Law Act of 1889 further increased the demand for accommodation by making admission possible without the stigma of becoming a pauper. The new fever and smallpox hospitals which were built on the periphery of London were larger as well as being further from the centre.

The willingness of the Metropolitan Asylums Board to act on the best professional advice available, and the efficiency of the ambulance and hospital services it provided, were the foundation of the respect and reputation that the board enjoyed. It might be chided for the grand scale of its expenditure, but *The Lancet* said that it provided, if not a perfect system of isolation accommodation, the nearest approach to a perfect system which the world possessed.¹⁵ Its administrative staff earned a reputation for competence, and were regarded as a cut

above those employed by the guardians. 'They were up to LCC standard' said one county council man. As a result the remit of the board was gradually extended. From the beginning it had a responsibility for 'harmless insane paupers of the chronic or imbecile class' and later it treated conditions which might have been cared for in hospitals or infirmaries. In time it came to provide services for venereal disease, encephalitis lethargica, tuberculosis and uterine cancer. In part it became a general hospital authority, albeit one which worked under the Poor Law.

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Chapter 6 Defining problems and debating solutions - 1860 -1889

'The nineteenth century is nothing if it is not critical. Nothing escapes. The most precious beliefs and the most benevolent institutions have to undergo the ordeal'
The Lancet, 1881

By 1860 all the great general hospitals had been founded and the basic structure of the metropolitan hospital system was well established. Some earlier difficulties were on the way to solution. Nepotism was far less blatant and the establishment of the General Medical Council had provided the profession with a new stability. Yet the decade of the sixties was a period of rapid political change, indeed political unrest. The debates about education and the franchise, like those about Poor Law reform, were national in character. Advances in science - the publication of *The Origin of Species* is often quoted - and in medical specialisation posed problems for hospitals throughout the country. Other issues were essentially metropolitan, for the rising population and the pattern of growth of London increasingly revealed the inappropriate locations of hospitals. There was no consensus about the nature, let alone the solution, of many of the difficulties; for example the basis on which patients were selected for admission, the way to finance the hospitals, or questions of governance and authority. No easy solutions were to emerge in the next thirty years, but the many interests involved and the constraints within which the hospitals worked became more clearly defined.

In 1862 *The Lancet* reviewed the expansion south of the Thames.

'In 1745 - subsequently to the foundation of Guy's — only a narrow strip stretching a little way above and below London Bridge was built upon. In 1818 this area was about doubled. In 1834 the area of 1818 was doubled; and in 1857 the inhabited area had doubled again. A dense population had stretched below Greenwich, as high as Battersea, and far to the south. Still, for a hundred years, no new hospital had been erected.'

The hospital accommodation for south London amounted to 1,130 beds for an area of 70 square miles and a census population of 773,000. Further, the counties of Surrey and Kent sent 'large

contingents to the crowds of sick and maimed who throng the gates of the two hospitals at the foot of London Bridge.’ *The Lancet* contrasted this pressure with the services enjoyed by the more fortunate population on the north of the Thames. Here, in fifty square miles were two million people, twelve hospitals, at least 2,656 beds and the vast majority of the special hospitals. Philanthropy had been lavish in the north with 70 beds per square mile, one for every 536 inhabitants. The south housed a larger proportion of the ‘labouring population’ and had 16 beds per square mile, one bed to every 700 inhabitants.

The removal of St Thomas’s Hospital

The buildings of the old St Thomas’s Hospital in Southwark had been known to be substandard for many years. When the government proposed to move its offices from Somerset House in the 1830s it was suggested that the hospital should move into the building in conjunction with King’s College. The medical staff themselves wrote to the governors in 1832 suggesting that the hospital should be rebuilt ‘in a more eligible situation’ to promote the benevolent views of the founder and the supporters. The staff pointed to the ‘decayed state of the existing hospital, the great improvements in hospital design, the growth of London which required a more equitable distribution of hospitals, the increased accommodation at Guy’s, and the notoriously smaller number and less urgent importance of cases applying for admission now than formerly.’² The development of the Greenwich Railway from 1837 onwards posed a more direct threat to the hospital’s site, and the problem became acute in 1859 for the rails were going to cut across it passing fifteen feet above ground level within a yard or two of the wards. The disputes which followed brought problems facing the hospitals to public attention. A threat concentrates the mind and many beliefs were re-examined: the sanitary and professional arguments for the town or country location of hospitals; geographical distribution within London; the objectives of the medical charities; and the influence doctors should have on the hospitals’ governors.

When it became clear that the extension of the railway might force St Thomas’s to move, an influential group which included the treasurer and many of the governors favoured relocation in an accessible London suburb to the east. There might be an experiment ‘collecting the sick at a receiving house and sending them for treatment as soon

as they could be moved into the pure air of the country'.³ The resident medical officer, Mr R G Whitfield, the third of his family to hold this post, favoured this course of action. He believed that the new forms of transport and the changes in the distribution of the population could not be ignored. The population of Greenwich and Lewisham was increasing more than any district south of the Thames, whilst in some parishes in Southwark the population was falling. He argued that the locale of the poor would alter and they must emigrate from necessity, just as the rich had done from choice. He thought that parents would sooner send their sons to a medical school in a neighbourhood more savoury than Southwark and that as most medical treatment was carried out by resident staff a short train journey for visiting staff would prove no hardship.

Whitfield had two campaigns to fight, first to ensure the sale of the whole site, so that the hospital obtained the maximum compensation from the railway company, and secondly to achieve relocation outside London in the country. Distrustful of the motives of the visiting staff, he was at times in almost daily communication with Miss Nightingale, who had a freedom of action which he did not enjoy. Miss Nightingale wrote to him that there was an opportunity to build the finest hospital in the world, but that if St Thomas's stayed in Southwark it could be no fit place for training nurses. Whitfield replied that he wished he could whisper in Prince Albert's ear that the prince should interest himself in the debate, and its sanitary importance.⁴ Shortly after, in March 1859, the prince spoke to the treasurer on the subject, and he wrote formally to the governors. Whitfield obtained the admission tickets of accident cases from the steward, analysed the patients' addresses showing that many came from places some way to the south-east, like New Cross, and provided Miss Nightingale with the figures. A few days later the analysis appeared in *The Builder*, a journal on cordial terms with Miss Nightingale, to support the case for removal to the east. An analysis, when repeated in 1980 showed how little change had taken place in the origin of patients seen in St Thomas' Street at Guy's Hospital. Southwark, a century later.

In July 1859 Whitfield took a convalescent holiday in Paris and wrote copious reports to Miss Nightingale about the ventilation and sanitation of the hospitals at Lariboisière and Vincennes.⁴ Florence Nightingale opposed the construction of hospitals in towns on sanitary grounds and believed that while special wards might be needed centrally for

accident cases and sudden illness, patients should be sent on to suburban hospitals as soon as they were fit to make the journey. A wider distribution would not only make hospitals healthier, but would improve their accessibility to patients.⁵ The medical press took different sides in the dispute. *The Lancet* favoured central location, whilst the *Medical Times and Gazette* believed that the benefits of removing St Thomas's from the Borough to a healthy situation in the country, with its pure and invigorating air, would outweigh the inconveniences.

The medical staff at St Thomas' did not share Whitfield's views. The governors were bombarded with printed leaflets for the best part of a year. After discussion with Miss Nightingale, Whitfield organised a survey of patients which showed that more came from the south-east than from the 'home district' or from the south-west. The south-west seemed a poor place to be in any case, for 'numerous unhealthy factories saturated the atmosphere with their noxious products making the place perfectly unsuitable for a hospital.' Each governor received an attractively coloured map of South London and statistics of patient flow purporting to show that the main catchment of St Thomas's was to the south-east. They were presented in a way designed to lead to the conclusion Mr Whitfield favoured.⁸

John Simon and the medical staff remained opposed to a move and Whitfield was forced onto the defensive, saying that he was convinced that 'by the close of the present century succeeding generations would do full justice to his opinions.'⁹ A decision was delayed until the last moment and when the purchase price of the site had been settled by arbitration at £296,000, the hospital had to find a new home as a matter of urgency. Many possibilities were examined, some of which were unsuitably sited near factories and knackers' yards. Ultimately the governors took a lease on the old Surrey Music Hall in Surrey Gardens, off the Walworth Road immediately to the south of the Elephant and Castle. The old buildings were rapidly converted and this, like the removal, went smoothly. The capacity of St Thomas's in its new and temporary home was greatly reduced; the buildings themselves were excellent and stood in pleasant grounds. The hospital reopened within weeks and the wards filled rapidly, confirming in the minds of many the need for a central site. Guy's, now standing alone, came under heavy pressure.

The immediate problem had been solved but there remained a division of opinion about the ideal permanent site. The governors continued to favour relocation in the country, perhaps in Lewisham, whilst the medical staff wished to stay in London. The City of London and the local vestries were alarmed at the prospect of losing the hospital and organised a campaign to keep St Thomas's in Southwark. The Social Science Association listened to an address in which an idyllic picture was painted of hospitals pleasantly located amidst herds of cows on the southern slopes of the Surrey hills.¹¹ The doctors pointed to the need for the hospital to be accessible to sick and injured people, rather than cows. In their view a country site would turn the institution into a convalescent home and undermine the medical school. The staff maintained that the death rate in a hospital had little to do with the type of air it might enjoy. Country air did not of itself reduce mortality for the cause of hospital sepsis lay in the organisation of the hospital itself, not in its surroundings. In a 'memorial' addressed to the president, treasurer and governors of the hospital, the medical staff drew attention to the damage which would be inflicted on the hospital and medical school 'if the new hospital were to be planted in any locality where physicians and surgeons of high metropolitan standing could not be expected to serve it with assiduous attention.'¹²

Throughout 1862 *The Lancet* ran a campaign against a country site, pouring scorn on the 'outdated sanitary ideas of the governors' and comparing the results of English and French hospitals. Dr Bristowe, a physician at St Thomas's, repeated the arguments in favour of a central London location when he gave the opening address of the academic year in the presence of the treasurer, and appealed for improved communications between the governors and the medical staff.¹³ Indeed, whilst it was quite true that the suburbs were expanding rapidly, the central boroughs south of the river were themselves desperately in need of hospital accommodation.

The governors gave in to the pressure to remain in central London. Seven sites were short-listed, one of which was the nearby Bethlem Royal Hospital which some believed should be moved into the country in the interests of the long-term residents. Surrey Gardens itself was in many ways ideal, not least because of its size and the wish of the owner to sell to St Thomas's. Instead the governors chose the Stangate site, part of which was to be reclaimed from the Thames as

the Board of Works constructed the embankment. *The Lancet* was not entirely happy - it seldom was - for as a riverside site it suffered from the stench of the Thames and it was not the healthiest of places. When *The Lancet* introduced its sanitary report on the Thames it said 'We have a certain feeling of satisfaction that the Chancellor of the Exchequer, Mr Gladstone, has been forced to beat an ignominious retreat from the Committee Room, handkerchief to nose.'¹⁴ Worst of all, the Stangate site was costly and required special foundation work. Miss Nightingale also disapproved. She wrote that the position at Westminster Bridge was 'the worst about London, only 2 feet above the water mark'. It was 'a place totally unfit for the sick'.¹⁵

Opposition to the Stangate site only ceased after a court case brought by the City of London in March 1864. The governors presented evidence on the healthiness of a riverside location based upon the experience of the Seamen's Hospital, the Millbank penitentiary and the Hotel Dieu on the banks of the Seine. The court concluded that it had no reason to disturb the deliberate choice of the governors, even though Surrey Gardens was nearer to the original site of the hospital as well as being cheaper.

The governors had been to France to see Lariboisière and Florence Nightingale had been consulted about the plans. Henry Currey's pavilion plan was settled upon and details published in *The Builder* and in the medical press. On 13 May 1868, with the solemnity of prayers and psalms, the clang of martial music and the roar of cannon in salutation, the Queen laid the foundation stone. The medical staff looked forward with pleasure to the great new hospital. By current standards it was vast but a system of electric communication was installed 'to diffuse intelligence'. Some accused the governors of over-lavish expenditure¹⁶, but in general comments were favourable and Queen Victoria returned to open the hospital in 1871. The new St Thomas's was described by the *Illustrated London News*: 'The range of buildings has a frontage of 1700 feet, nearly equal to the length of the Crystal Palace. The style of the architecture is Palladian, with rich facings of coloured brick and Portland stone, with carved balustrades for the balconies.'¹⁷ The clinical accommodation provided everything necessary for the work of a great hospital. But the cost had been enormous and the building committee reported on it to the court of the governors. Neither, in spite of all the advice that had been taken, was the hospital free from the infections which its advanced sanitary design

was meant to obviate. There was still much to be learned about hospital construction, hospital management and the need for fastidious cleanliness, commented *The Lancet*.¹⁸ There was a risk that the new hospital might be regarded as a model which could be copied with confidence.

The Westminster: reconstruction or removal?

There had been no choice for St Thomas's, but less dramatic measures were open to other hospitals which were also in need of improvement. *The Lancet* believed that the alterations which had been made to St George's, Charing Cross and St Mary's merely proved that money spent on 'tinkering with old buildings' instead of partial reconstruction was money wasted. The old hospitals could not be made hygienically perfect and rebuilding on a 'scientific plan' would have been preferable.

The Westminster Hospital, although it had been built only forty years before, was in need of upgrading for sanitary reasons by 1877. The estimated cost was £13,000 and an alternative proposal to move the hospital to Pimlico, Chelsea, Battersea or Wandsworth appeared in the newspapers. *The Lancet* considered the matter from the point of view of the needs of the population and examined the bed-ratios on the basis of the 1871 census. Bearing in mind the differing levels of poverty in the various areas, *The Lancet* did not see that a case had been established for the removal of the Westminster Hospital. Neither did the house committee of the hospital nor its chairman, Sir Rutherford Alcock. The hospital proceeded to carry out the necessary alterations, closing completely for three months. *The Lancet*, however, urged the governors to try to erect a new building in future which more nearly approached sanitary perfection.¹⁹

Nursing and advances in hospital care

There were vast improvements in patient care between 1860 and 1890. Hospitals which had been 'places which healthy people should avoid and sick people should shun' ²⁰, became the best places for sick men and women to be. Ether as an anaesthetic had been introduced into the London hospitals in the first quarter of 1847. Antiseptic methods were introduced more gradually between 1870 and 1880, so gradually in fact that *The Lancet* in 1875 could still question

whether the improved results being obtained were due to better sanitation or Listerian methods.²¹ As a result of specialisation and the introduction of laboratory methods doctors could achieve far more. Lastly, there was the great improvement in nursing.

In no department of hospital management, said *The Lancet* in 1864, had there been greater improvements than in nursing.²² Steele, the medical superintendent at Guy's, thought that the change began around 1850.²³ New techniques in medical practice made greater demands upon those caring for patients and 'it was properly maintained that in every hospital the best possible system of nursing that could be devised should exist, since it was second, and second only, to having the best medical skill'. A nurse now had to be technically trained to assist doctors and, simultaneously, to perform her duties with tenderness, sympathy and kindness - for which it was necessary to raise her social and moral character.²²

There were never enough nurses. To attract staff of a suitable calibre was a constant problem and Dr Elizabeth Garrett told the Social Science Association that hospitals should pay better wages and not rely on religious dedication.²⁴ Florence Nightingale disagreed, for she believed that one did not necessarily obtain a better article merely by paying a higher price.²⁵ Nevertheless the shortage of applicants forced hospital governors to improve conditions, employ ward-maids and scrubbers and provide better accommodation. One way to improve standards, which was widely adopted, was to appoint more ladies - or at least women with superior education - to act as ward sisters. Ladies could maintain discipline more easily, and with less show of force, but caused expenses to rise.²⁶ Lady-sisters wanted more staff, their standards of cleanliness were higher, the wards were more frequently scrubbed and the costs for washing increased. Food costs were also higher, for 'the sisters would suggest delicacies to those with poor appetites, until patients suffered dyspepsia from over-eating.' Nevertheless, the *British Medical Journal* thought that while it was always difficult to combine cheapness with efficiency, lady-sisters were the basis of the best system of nursing yet introduced.

In an attempt to improve standards, parties of governors visited each other's hospitals. In 1864 a group from the Norfolk and Norwich Hospital visited St Thomas's, King's College Hospital, University College Hospital and St Bartholomew's. They wished to transfer the better features of nursing in London to their own hospital and Mr

Whitfield provided them with the instructions issued to the probationers at St Thomas's.²⁷

The Middlesex Hospital reviewed its nursing in 1864-5. The doctors suggested that Miss Twining might introduce the probationers of her institution, St Luke's, but the governors, having visited other hospitals, proposed instead to appoint a lady-superintendent, build a nurses' home, introduce a uniform, institute nurse training and make other arrangements for the menial duties to be performed. At the Westminster Hospital a committee chaired by Sir Rutherford Alcock was established in 1872 to assess the alternative systems of providing nurses and to improve the standard of the hospital's nursing. It reported that no amount of medical skill or expenditure of money was effective in treating and curing the sick if good nursing was wanting. Without intelligent training under superior guidance good nursing could not be expected. The idea of employing a sisterhood was rejected and, liking the results produced by the Liverpool Royal Infirmary training school, Miss Elizabeth Merryweather was invited south to become matron in 1873.²⁸

Steele, of Guy's, believed that every major hospital would benefit from having its own training institution.²⁸ The Nightingale Fund, though first in the field, did not escape criticism. 'With all these efforts to provide additional trained nurses', said *The Lancet*, 'one cannot help asking "what is done with the Nightingale Fund?" It was supposed to be devoted to training hospital nurses for all our public hospitals ... We must confess to have never come across a specimen of a Nightingale nurse except in the wards of St Thomas's.'²⁹ By the early 1870s almost all the great London hospitals, with the exception of St Mary's, professed to train young women as nurses.³⁰ Yet a survey carried out in 1875 by a Nightingale nurse, Florence Lees, showed that in most of them probationers were merely placed in the wards to pick up what knowledge they could. Only at the Middlesex, the Westminster, the Royal Free and St Thomas's was some attempt made to provide systematic training. St Thomas's training programme was adopted by some other hospitals - such as the Middlesex - but the Nightingale School was not the only pace-setter. St Bartholomew's established its new school in 1877 and appointed a physician and surgeon as instructors, so the teaching could be both practical and systematic. Sir Dyce Duckworth, who took a particular interest in the school, delivered the inaugural lecture on 'Sick Nursing, a Woman's Mission'. He exhorted the nurses to be obedient, observant, cheerful and clean in

their work. He did not urge total abstinence on them, but suggested that nurses only drank with their meals.³¹

The Lancet described the two plans which had been introduced into London hospitals. One was training by sisterhoods or religious orders, as in Catholic countries on the continent and at the Protestant Kaiserswerth. By 1864 twenty six sisterhoods of this type had been established in England, one of the largest being St John's House which provided the nursing at King's College Hospital at a cost of £1,000 per year, and at Charing Cross. Another order, All Saints, nursed at University College Hospital. One hospital, the Prince of Wales at Tottenham, actually developed out of a Deaconesses Training Institution, established in 1868 in the Kaiserswerth tradition. Here evangelical dedication and low pay were found at their most extreme. The other approach, which *The Lancet* favoured, was the one in vogue at St Thomas's, where the Nightingale Fund, which had been collected at the end of the Crimean war, had been used to establish a training school. The object of this fund was to train women thoroughly for all the practical duties of hospital nursing, to find them situations and to train those who would in future train others.²²

The Nightingale School, which admitted its first probationers in 1860, had no easy time. King's College Hospital, the London and the Royal Free were considered as a base, but the Nightingale Fund Committee eventually selected St Thomas's for the quality of its nursing and its matron, Mrs Wardroper. Writing after her death, Florence Nightingale said that Mrs Wardroper weeded out the inefficient, morally and technically, and put her finger on some of the most flagrant blots, such as night nursing. During Mrs Wardroper's lifetime Miss Nightingale was not always so complimentary and detailed studies of the school's history have shown that in terms of discipline and educational matters much was often left to be desired. There was no immediate revolutionary improvement on the wards. For many years the school's probationers represented only a small proportion of the hospital's nursing staff.

The best nurses, in Mrs Wardroper's opinion, were to be obtained from amongst women of the respectable classes, who had had the benefit of a fair education, and who had been accustomed to the performance of household duties. In the search for 'raw material' one should go neither too high nor too low in the scale or one would be disappointed. Such ladies as possessed the gift of organisation and arrangement

would prove valuable assistants as superintendents, sisters or head nurses, but to be of real use as nurses in the sick wards ladies too must qualify for the work by training for it.

While the sisterhoods were necessarily restricted to one form of religious persuasion in the selection of their probationers, this sectarian exclusiveness was not allowed at the Nightingale School. Technical instruction and proper supervision was the objective. Ward teaching was considered crucial, for Miss Nightingale believed that surgical nursing could only be learned thoroughly in the wards, and that the perfection of nursing might be seen practised by the old-fashioned sister of the London hospitals.³³ The Nightingale School always wanted their probationers to be considered in some senses supernumerary, so that there was time to absorb the teaching. Ward teaching was supplemented by theoretical instruction from the resident medical officer, Mr Whitfield, although he did not lecture to the nurses as often as he was supposed to. Simultaneously the probationer's social and moral character was uplifted, at least in theory, by living in the nurses' home.

A revolutionary feature of Florence Nightingale's plan for nurse training was the demand that the entire control of the nursing staff should be taken out of the hands of men, whether doctors, governors or chaplains, and placed in the charge of a woman, herself a trained and competent nurse. Hospital governors did not always accept the necessity for this. Female control was more important to Miss Nightingale than whether nursing was secular or controlled by a sisterhood. From her book *Notes on Hospitals* it is clear that she approved of religious nursing orders with their female heads.³⁴ In most hospitals the nurses were controlled as to discipline, education and work by the hospital managers and the medical staff; to change this was Miss Nightingale's fundamental aim.³⁵ Yet Miss Nightingale did not encourage nurses to usurp the medical role, and it was made clear that the Nightingale Fund was not there to provide women with an entry to medicine. 'The nurses are there, and solely there, to carry out the orders of the Medical and Surgical Staff... the whole organisation of discipline to which Nurses must be subjected is for the sole purpose of enabling the Nurses to carry out intelligently and faithfully such orders as constitute the whole practice of Nursing. ³⁶ These ideas were not entirely understood by the doctors who suspected the desire for nursing autonomy. A rise in the standard of nursing was desirable, but doctors saw dangers in over-trained nurses

who sought to mimic medical students or even to question doctors' decisions. Not all nurses distinguished as clearly as Miss Nightingale did - from her sick bed - between medical and nursing duties. Nurses, remarked the editor of the *British Medical Journal*, should remember that they were the doctor's hands and eyes, not his brain.³⁷ The potential for a confusion of roles clearly existed. Steele pointed out that the syllabus of the Nightingale School, if extended somewhat, would have satisfied the medical licensing authorities only a few years previously.²³

Systems of nursing

Florence Nightingale had discussed the way in which nurses might be controlled by governors, doctors, a religious body or by a nursing hierarchy.³⁴ With the exception of the hospitals contracting their nursing to a sisterhood, in most of the London hospitals the chief nurse was responsible either to the board of governors, the house governor, or the doctors.³⁰ Braxton-Hicks, the physician-accoucheur to Guy's, wrote in 1880 that doctors had probably not taken as much interest in the development of nursing as they should have done. He described alternative methods of nurse management by ward-based or centralised systems.³⁸

Under the ward-based system, seen before new ideas were introduced by matrons appointed at St Bartholomew's and The London, the probationers would pass through the general and special wards, and if they were competent they would be appointed to a particular ward where they would become a fixture. Similarly, sisters would be appointed to specific wards by the hospital authorities. While the matron might recommend dismissal if she thought fit, she did not have this power herself. As a result the ward sister was supreme in her ward, responsible to the lay management and the medical staff, the embodiment of the hospital and the support of the junior doctors. Sister and medical staff would work heartily - even affectionately - for the common good. It was a decentralised system developing the habit of self-government. Nevertheless, wrote an anonymous correspondent in the *British Medical Journal*, the training of nurses could be totally without method, and the nurses were often of a lower standard than the sisters. Indeed some, at Guy's, had been recruited from the venereal disease ward, or might have illegitimate children.

However, in hospitals with centralised systems the ward sister was

mainly or entirely responsible to the matron or lady-superintendent who had the power of appointment or dismissal. The nursing sisterhoods at Charing Cross, University College Hospital and King's College Hospital were an extreme form of this pattern of organisation. In these hospitals the farming out of the nursing created an empire within an empire. The matron undertook a sharp supervision over the whole of the nurses, the sister was less trusted, and, in the view of Braxton-Hicks, while the services might never fall to a very low standard they could not rise to the highest.

While it might be possible to maintain tight central control in a small hospital the task was immense in one of 600-700 beds. There were other problems with the central system. The medical staff might lose influence over nursing on the wards. Nursing associations might withdraw the probationers as soon as they were proficient, putting them to private nursing for profit, and leaving the hospitals with too many young and inexperienced staff. Nothing could be done to prevent this.²⁶ Nevertheless London's hospitals moved slowly from the ward based to the centralised system. In some ways this was inevitable as training schemes were introduced into the hospitals.

Part of the *raison d'être* of the Nightingale Fund at St Thomas's was to 'train the trainers'. But when matrons' posts were advertised Nightingale-trained nurses did not always get the positions. Sometimes when they did they were a conspicuous failure. A new generation of matrons was bringing new ideas into the great hospitals. Mrs Thorold at the Middlesex (trained with All Saints' at University College Hospital), Miss Liickes in 1880 (trained at the Westminster); and Miss Ethel Manson at St Bartholomew's in 1881 (trained at the Manchester Royal) were amongst them. They did not follow St Thomas's slavishly and each hospital differed significantly in its approach to nurse training. At St Bartholomew's Miss Manson (later Mrs Bedford Fenwick) introduced a three year course with examinations at the end of the first and third years. A certificate of efficiency was then issued. More and more hospitals came to appreciate the advantages of a nursing staff whose training enabled them not to supplant the medical attendant, but to see how they 'could best be subservient to him, and so to be of the greatest help to the patient.'

The trouble at Guy's

Hospital policies are sometimes only discussed when there is a crisis. The various nursing systems were widely debated in the course of a conflict which followed the appointment of a new matron at Guy's in November 1879. Miss Burt had trained with St John's House, worked as a ward sister at Charing Cross and then became lady-superintendent at Leicester Infirmary where she reorganised the nursing. On arrival at Guy's she rapidly introduced a number of changes without discussion with the doctors. A uniform became mandatory, jewellery was banned, feeding arrangements were altered, a new training system was established, and, worst of all, the sisters and nurses were re-allocated within the hospital every three months to broaden their experience. A number of sisters and about fifty nurses resigned, most finding new employment in the other London hospitals with little difficulty. 'Without any premonitory symptoms' wrote a doctor, 'we find our nurses scattered about and our sisters leaving ... other derangements of a like kind have been startling us day by day and soon, no doubt, the system will be complete'.³⁹ The medical staff protested to the treasurer, the governors and to the press in most intemperate terms. Matters were not improved when Margaret Lonsdale, one of the new lady probationers, wrote an article in *Nineteenth Century* which not only described the old nursing system in the darkest of terms, but implied that the medical staff wished to be rid of the moral restraint exercised by nurses of a higher class. Practices and experiments in which the doctors indulged were more difficult to carry out, wrote Miss Lonsdale, in the presence of a refined and intelligent woman. The doctors wrote rebuttals in the next issue of the magazine, but the indictment and imprisonment of a Guy's nurse for the manslaughter of a patient added further fuel to the flames.⁴⁰

A stream of letters and leaders in the medical and lay press throughout 1880 made the key issue plain; it was the introduction of a new element, the nurse, between the doctor and his patient. The doctors regarded the interests of the patient as synonymous with obedience to their instructions. They did not object to lady sisters; many of the existing sisters at Guy's came from respectable or eminent families. Neither was the training of nurses objectionable if it did not get out of hand. As the *British Medical Journal* expressed it, 'The doctor is responsible for his patient and the nurse must be a person who owes strict allegiance to him, who pays blind obedience to his orders as a

private soldier the command of his senior officers.’⁴¹ *The Lancet* said it was needless to argue with nurses about their duty or to define it - they must obey.⁴² Many of the new lady-superintendents, coming from good families, were on influential and intimate terms with the lay governors. The doctors might not be. Henry Bonham-Carter, as secretary to the Nightingale Fund, drew a distinction between the need for implicit obedience to the directions of the medical staff about the treatment of patients, and matters of discipline, behaviour and conduct ‘when nurses should be responsible to their own female head’.⁴³

The *British Medical Journal* was at first more active in supporting the doctors than *The Lancet*. Dr Habershon, the senior physician at Guy’s, was president of the Metropolitan Counties Branch of the BMA. His presidential address, at the height of the dispute, was on ‘Nurses and Nursing’. He said that the well trained and efficient nurse was one of the profession’s most valuable assistants, but he then caricatured the problems faced by doctors confronted with nurses who were conceited, pretentious, meddlesome or officious, lethargic, obstinate, worn-out, intemperate, unsympathetic or heartless. Women who were sober and of good character should be selected and they should be trained properly, with the provision of practical instruction.

The ‘trouble at Guy’s’ reflected a general dissatisfaction of doctors with the power structure of the hospitals; the medical staff felt unable to exert the control they felt to be their right. The progressive move towards centralised systems of nursing, and the way new methods of nurse training tended to exclude medical students from their traditional role as dressers, added to their anxieties. ‘Hospitals,’ said *The Lancet*, ‘are in a special sense medical charities. Medical aid is not a combination of medicine and nursing ... the whole charity from first to last is medical.’ As institutions wholly medical in purpose, hospitals must be under direct medical control. Medicine must be paramount and the lay governors should refrain from interfering in professional matters like the care and treatment of the sick. The matron should be strictly limited to the control of the nurses and the domestic business of the hospital; she had no place or function on the wards save to see they were cleansed and the general arrangements were in good order.
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In the view of *The Lancet* the root of the problem was unsatisfactory systems of management. There should always be sufficient medical men on a board of governors to ensure that the medical staff were

party to every aspect of the *general* business of the hospital. As for the *professional* business that was a matter for the doctors alone. The *British Medical Journal* agreed: 'The fact is that the whole government of the City hospitals will sooner or later require revision ... It is essential for the truly harmonious and effective working that medical officers should sit at the governors' board with the lay governors.'⁴¹ What began as a dispute about nursing ended by raising deeper issues of governance. The doctors at Guy's were forced to accept new methods and concede to the governors, but they were granted membership of a weekly management committee, and extended their influence. Similar but less dramatic conflicts arose in other hospitals.

To contract a hospital's nursing out to sisterhoods was also fraught with difficulties. The division of power between the council of the sisterhood and the hospital committee created 'an empire within an empire'. Nurses, administrators and doctors fought with each other. In 1883 the governors of King's College Hospital, convinced by the arguments of the medical staff, dismissed the matron. The sisters went on strike in her support. This led to a schism within St John's House, and many of the sisters left to form a new body, the Sisterhood of St John the Divine, and later joined the Community of All Saints. King's College Hospital finally parted company with St John's House in 1885, its new matron, Miss Monk, having worked not only with St John's House but in Edinburgh and at St Bartholomew's. Charing Cross Hospital also ended its contract with St John's House in 1889, appointing a matron from Liverpool. All Saints took over the management of St John's House in 1886, and succeeded in obtaining the contract to nurse the Metropolitan Hospital two years later.⁴⁵ They continued to work at the Metropolitan until 1895, and took their leave from University College Hospital in 1899 at the time of the rebuilding. The nurses at University College Hospital then came under the control of the hospital committee, and from amongst many applicants an ex-assistant matron from St Thomas's was appointed as matron. The uniform was changed from the black of All Saints to dark blue, and chairs replaced benches in the nurses' dining hall.

In her annual letter to the probationers of the Nightingale School in 1872 Florence Nightingale wrote that 'our Nursing is a thing, which unless in it we are making progress every year, every month, every week, take my word for it we are going back'. Nobody doubted that the sisterhoods had raised the standard of nursing in the hospitals with which they were associated. But later they found it difficult to make

progress, and to come to terms with new developments in curative medicine and the need for improvement in nurse training.

The antivivisection campaign

Campaigners against vivisection had a significant influence on the development of nineteenth century hospital policy. The laboratory work which provided the foundation for a scientific approach to medicine included work with animals. Such studies made more headway on the continent than in England during the earlier part of the century. Only in 1849 did the house committee of The London Hospital agree to a request from the medical staff for the purchase of a microscope. Harrowing accounts of operations on live unanaesthetised animals, published by the Society for the Prevention of Cruelty to Animals, dealt with events in France.⁴⁶ In the next twenty years scientific work in London began to catch up. At first there was little animal experimentation, but by the late sixties the medical press was beginning to discuss the ethical dilemmas posed by physiological investigations. A distinction was drawn between procedures which yielded new information and those which merely demonstrated to students facts already beyond controversy.⁴⁸ The adoption of scientific method was part of a revolution in medical practice, which increased both the workload and the prestige of the hospitals. The issue of vivisection became one of general debate with the publication in 1873 of the *Handbook for the Physiological Laboratory*, which was designed to assist students new to the field.⁴⁹ This, and a demonstration of somewhat doubtful utility at the 1874 meeting of the British Medical Association, inflamed public opinion. An unsuccessful prosecution followed and a powerful antivivisection lobby emerged, supported by Lord Shaftesbury, Cardinal Manning and many other ecclesiastics. The movement was based upon a new Society for the Protection of Animals from Vivisection which, unlike the Society for the Prevention of Cruelty to Animals, was opposed to any vivisection whatsoever. The premises of the society being in Victoria Street, it rapidly became known as the Victoria Street Society.

In 1875 a royal commission was appointed, with a balanced membership, including medical scientists of renown like Thomas Huxley. The Cruelty to Animals Act was passed in 1876, but although clauses were inserted into the bill as it went through the House permitting work by bona fide investigators, the continuous agitation by the antivivisection lobby both inside and outside Parliament made the

Home Office loath to grant licences under the Act. The Victoria Street Society's campaign was of increasing concern to the medical profession. Lister himself was forced to transfer experimental work to the veterinary college at Toulouse, and antivivisectionists began to try to persuade hospital subscribers to boycott any hospital with a vivisector on its staff. The International Medical Congress of 1881, held in London, provided an opportunity to present the other side of the case, and speakers denounced the antivivisectionists as people who often engaged in blood sports while opposing those who were trying to help humanity. John Simon, by training a pathologist, said there was a grave risk to the advancement of medical science in Britain.⁵⁰ When David Ferrier's work on cerebral localisation led to his prosecution by the Society, the British Medical Association undertook his defence and the case was dismissed. The campaign was unceasing, the issue being kept in the public eye by a stream of magazine articles, pamphlets and books. In defence the medical profession formed the Association for the Advancement of Medicine by Research, which by adopting a low-profile attitude and lobbying the Home Office effectively, made it easier to obtain licences for animal work. The antivivisectionists, however, attempted to couple animal and human experimentation. Hospital finances suffered, for in the minds of many medical science became associated with vivisection. Queen Square, where David Ferrier worked, lost many thousands of pounds in this way.^{51, 52, 109, 110.}

Reforming hospital administration

Hospital administrators have never been greatly loved. The authorities at St Thomas's were much criticised for lavish expenditure when the new hospital was built, and the cost of care was a perennial matter of concern. In 1857 the Statistical Society, of which William Farr was a member, published a report on the costs of the London hospitals. It showed that £300,000 was being spent annually on the sick poor of the metropolis, one tenth by the dispensaries and nine-tenths by the hospitals. Two important facts emerged: the number being relieved was greater than had previously been imagined, a total of 647,815; and there were considerable differences between the costs of the hospitals. Even allowing for faulty systems of counting patients, perhaps one in five of the population was receiving relief. And out of 14 general hospitals, three accounted for more than half of the total expenditure on the hospitals.

The most recently established hospitals were the cheapest. *The Lancet* published the statistics of a year's work in the hospitals. The reformers had a new cause, 'hospital abuse' and the 'million a year' who were receiving free care.

The campaign for medical reform had been underway since the eighteen thirties. Now the proper use of charitable monies and the effect of charity on the morals of the poor became issues. Hospital statistics showed the number of casualties and outpatients seen was rising, and since 1850 the rise had been very rapid indeed.⁵³ In the words of one hospital governor: 'We have a competition between rival charities, a fictitious demand for new institutions, a hawking about of gratuitous medical service amongst classes who do not require it, and a total number of medical charities larger than the public can be induced to support'.⁵⁴

The hospitals attracted the attention of groups and associations which were seeking to improve the condition of the nation by analysing problems, debating solutions and bringing political influence to bear. These groups included the Charity Organisation Society and the National Association for the Promotion of Social Science - or the Social Science Association as it was usually referred to.

The Charity Organisation Society

The Charity Organisation Society was founded in 1869 to promote cooperation amongst the charitable, to prevent pauperism by promoting thrift and self-help, to make careful enquiries into those seeking assistance and, in cooperation with the poor law authorities, to give suitable help. The doctrine of the society was that the gift of money to relieve distress involved responsibility on the part of the donor for the way in which it was employed. Not for it was the promiscuous distribution of soup without thought for the effect this had on the morals of the poor. It was a cardinal principle to withhold relief which was inadequate, unsuitable or which would not benefit the recipient permanently. Misguided charitable relief was seen as harmful, and the society believed that scientific principles could be established to guide the employment of charitable funds. Endowed charities came in for particular criticism, for they distributed their funds to people who met criteria laid down many years previously rather than to those who would benefit most. Following the whims of a long-

deceased benefactor was considered by the Charity Organisation Society to undermine the sound work of those trying to improve the tone of the nation.

It was clear from the first that a movement with such principles would be unwelcome to many. However, fortified by a firm belief in the soundness of its objectives the society was prepared to face hostility. It had many friends, quite literally, at court. Two dukes, four marquesses, and an earl were vice-presidents, as was Mr Goschen, who as president of the Poor Law Board circulated a minute urging charitable organisations to cooperate systematically with poor law guardians.⁵⁵ Such was the society's standing that it was considered quite proper for a government minister to be publicly associated with it. In 1874 the society appointed Charles Loch, a Balliol man, as its secretary. His enthusiastic idealism, strong common sense and gift of oratory were incalculable assets. His writings and speeches expounded a philosophy of charity, and the evil it could produce if administered with inadequate consideration.^{56,57} The Charity Organisation Society covered the whole range of personal social services and hospital affairs were only a small part of its activities. Following its own principles of good organisation it worked through district committees whose boundaries matched those of boards of guardians. Each district committee kept a file of personal information on applicants for relief.

In 1871 a medical sub-committee was established, chaired by Sir Rutherford Alcock of the Westminster Hospital, to 'deliberate and advise on medical charities.' The sub-committee showed a particular interest in the provident dispensary movement.⁵⁸ Sir Charles Trevelyan, an ex-treasury man, showed how the society's principles could be applied to medical charities in general. He believed that the existing system not only failed to meet current needs but 'exercised a depressing and corrupting influence on the character of the working classes.'⁵⁹ To relieve pressure on hospital outpatient departments and on hospital funds he proposed a system of provident dispensaries based on the insurance principle. He said that people should be compelled to adopt habits of self-respect and industry, so that outpatient departments could be rid of medical mendicants.⁵¹ At an early meeting the subcommittee discussed the influence which could be applied to the government to enquire into the publication of hospital and dispensary accounts. In 1874 it proceeded to examine the advantages and disadvantages of governors' letters, and concluded that the system should be abolished as soon as public opinion was

ready for the change.⁶⁰

Hospital affairs were also discussed at meetings of the National Association for the Promotion of Social Science. This was founded in 1857 and met in a different city each year. One of its sections was public health.⁶¹ *The Lancet* rather unfairly castigated its members as a group of talkers who liked to combine food for the mind by day with food for the body in the evening, and implied that the membership consisted largely of those in positions of power, rather than of men who were 'daily and hourly engaged in tracing the cause of disease in its habitats.'^{62,63} Nevertheless, over the years the membership included Bristowe, Burdett, Florence Nightingale, Farr, Holmes, John Simon and Louisa Twining. The campaign to end hospital abuse took a new turn after a meeting of the London branch of this association in January 1869. A Dr Fleetwood Buckle presented statistics supplied to him by 22 metropolitan hospitals. While those at the meeting disputed the details it was agreed that hospital statistics and accounts should be presented in a uniform shape and a committee was appointed to draw up a scheme to be recommended to hospitals.

The Lancet and *The Times* took up the issue. *The Times* said: 'The declared object of a medical charity, when abstractedly considered, appears so good and useful that it is at first sight unlikely that such charities may, in the aggregate, be sources of evil. We do not say that they are, but the fact that they encourage nearly two millions of people to be dependent upon alms is one that calls for examination into their conditions and limits of their utility.'

Necessary though hospitals were for medical education, need they be so small? Could not 64 small ones be superseded by twelve large ones each with 400 beds? If special hospitals were unnecessarily costly and were detrimental to medical education, what could be said in favour of having four or five of the same sort? *The Times* suggested that patients should be charged a shilling for each attendance, and that assistant physicians and surgeons should be salaried. Some central control or organisation was wanted, perhaps a board. Inquiry must precede action and a royal commission might be a fitting way to proceed. 'At present' said *The Times*, 'the relations which should subsist between hospitals supported by voluntary contributions, and hospitals for paupers that must be supported by the state, do not seem to be settled on any fixed or recognised principle.'⁶⁴

The Metropolitan Counties branch of the British Medical Association summoned a meeting to discuss these issues which were of great importance to their general practitioner members. The meeting was addressed by Mr Ernest Hart, editor of the association's journal, but the speeches served chiefly to air views already largely accepted, that an impartial inquiry was needed to reform hospital administration and reconcile the conflicting interests of the sick poor, the subscribers, the medical students and academic staff, the hospital physicians and surgeons, general practitioners and wider public. A committee was formed to investigate and report on the whole question but it failed to agree on a report or produce recommendations.⁶⁵

The Lancet revealed its own scheme for reform in which a national system of attendance on paupers and a national system of provident dispensaries would be affiliated to a national hospital system. Hospitals would be financed by a contributory sick fund and supervised by local governing boards, standards being maintained by a Ministry of Public Health. There was nothing new in the idea of state intervention; in the field of elementary education state grants-in-aid, school boards and systems of public inspection were well established. Private patient accommodation would also be provided by the hospitals. *The Lancet* considered the location of London's hospitals and suggested that a convenient arrangement conducive to economy, efficiency and ease of access might consist of Guy's, St Thomas's, St George's, St Mary's and The London, with two more hospitals near Euston and Shoreditch and one other on the north side of the Thames to serve Central London. With certain exceptions the special hospitals would be swept away.⁶⁶

At this point a dispute arose within St Bartholomew's Hospital where a house physician was suspended for protesting about the administration of the outpatient department. *The Lancet* launched a commission to enquire into outpatient management at Great Ormond Street, St Bartholomew's, Guy's, the Royal Free, the Great Northern and St Thomas's. The investigation showed that the number of patients had increased rapidly and that they were being dealt with at great speed. Sometimes senior students rather than doctors were seeing them. At some of the hospitals improvements were rapidly made.⁶⁷ Following these disclosures a public meeting of the staff of the metropolitan hospitals was convened at the rooms of the Royal

Medical and Chirurgical Society. After a heated debate it was decided to establish a committee to study the outpatient problem.

The Fergusson committee (1870)

In later years the Fergusson committee was frequently instanced as an example of a group which laboured hard, produced sensible recommendations, and altered nothing. It was chaired by Sir William Fergusson FRS Bart, Professor of Surgery at King's College Hospital and President of the Royal College of Surgeons.⁶⁸ Fergusson 'wished to do all in his power to assist medical men attached to hospitals.' Amongst the members of his committee were Timothy Holmes, a life-long supporter of the provident dispensary movement, Ernest Hart and Spencer Wells. The committee formed subgroups which considered general hospitals, special hospitals, poor law dispensaries, and free and provident dispensaries.

The committee reported that many outpatients either had trivial illnesses, or could afford to pay for care. It believed that the reform of outpatient departments depended upon improved poor law medical relief under the Metropolitan Poor Act 1867. All free dispensaries should be placed under the control of the poor law authorities to ensure that there was proper enquiry into patients' means. To encourage a feeling of self-respect among the working classes the provident dispensary movement should be extended. To make this system work and improve the standard of clinical medical education in outpatient departments, the number attending the hospitals should be curtailed. This might be done by excluding those able to pay, and by selecting cases of particular clinical interest. The committee favoured the payment of the medical staff attending outpatients and the abolition of the system of governors' letters. The committee did not reach a unanimous conclusion about whether patients attending the hospitals should pay a charge.⁶⁹

The *British Medical Journal* commented on the painfully small attendance at the meeting called to endorse the report, and the apathy of the profession. The journal felt that leaflets should be printed for patients and subscribers to discourage the abuse of medical charity. The question was a simple one. Working men were increasingly well off. Should they be encouraged in habits of providence and self-reliance, or allowed to believe that they need make no provision for illness, which sooner or later was bound to affect them or their

families? 70, 71 The apathy of the medical profession on the issue was reflected in its response, when asked to contribute to the cost of publishing the committee's report. A total of only 12s 6d was received.

The Charity Organisation Society's medical subcommittee invited 'the most active' members of Fergusson's committee to join them and organised a conference on hospital abuse. King's College Hospital examined its practices and, concluding that there was serious abuse, accepted the offer of the Strand branch of the Charity Organisation Society to second an officer. St Mary's also proposed to send suspicious cases to the Charity Organisation Society offices. Other hospitals, like St George's, thought that their outpatient departments were well managed and there was little abuse. The British Medical Association established a hospital reform committee which visited hospitals to argue its case, but on the whole the governing bodies of the hospitals were unconvinced about the need for a change of policy. Nevertheless they continued to receive unsolicited advice about the management of their affairs from Timothy Holmes and the Hospital Reform Association, which instructed them to enquire into patients' means and cease the provision of free medicine.⁷³ They took little notice.

Financing the hospitals

After 1873 the financial position of the hospitals began to deteriorate. The poor harvest of 1879 was followed by an agricultural depression lasting several years, which had a particularly grave effect on hospitals like Guy's and St Thomas's whose endowment income was dependent on farm rentals. They were faced with overwhelming demands for care and the tragedy of turning seriously ill people away. In April 1878 the Lord Mayor of London appealed at the Mansion House for £100,000 to support The London Hospital, but the financial darkness surrounding the hospitals grew thicker and thicker. By April 1882 the annual deficit at St George's was £6,500, the Middlesex £10,000, University College Hospital £6,400 and The London £26,000.⁷⁴

Hospitals varied in their techniques of handling the problem. St George's recognised the importance of balancing income and expenditure. In April 1883 the hospital launched an appeal for £22,000 at Grosvenor House under royal patronage. Less than £300 was raised on the day. Simultaneously The London Hospital, which was 'managed on the principle of administering an ever-increasing and practically

unlimited amount of gratuitous medical relief, without providing in the first instance funds to pay for its maintenance', enlisted the support of the Lord Mayor of London and a member of the royal family, held a meeting at the Mansion House, and asked for £150,000. It received nearly £40,000 in the room. *The Lancet* commented that if the direction in which the gifts of the charitable flowed was taken as evidence, philanthropy and intelligence were seldom to be found combined in the same individual.⁷⁵ Both were excellent and much needed institutions, but St George's was, in *The Lancet's* view, more worthy of the support of the thoughtful philanthropist.

At Guy's the treasurer recorded, year by year, the diminishing income from the hospital's estates.⁷⁶ Beds were closed to restrict expenditure and by 1887 150 were out of use. Contributions were sought from the governors and their friends and a special appeal was launched. In the annual report for 1890 the treasurer stated that the hospital must in a large measure depend for its maintenance on the voluntary assistance of all classes of the community. The Hospital Saturday Fund was thanked for its contribution, noted as being larger than that of the Sunday Fund.

The burden of the payment of rates was particularly resented, for the hospitals were providing free care for people who might otherwise be a charge on the guardians. Only the special hospitals seemed to be weathering the financial storms, for most of them were energetic and innovative money raisers.

Payment by patients

The financial problems facing the hospitals led to reconsideration of whether patients should pay when they could towards the cost of their care. The pros and cons of pay hospitals began to be discussed in the press. Most large cities in other countries had a hospital where one could pay for treatment, like the French Maisons de Santé's. This was unusual in London, although a few hospitals, the special hospitals in particular, allowed paying patients into certain wards. The traditional principle of the voluntary hospitals was to provide free care on a charitable basis to those considered to be eligible. But some people, though fit objects for charitable care, could nevertheless make a small contribution to the hospital's funds. Others might be able to meet all the cost. As hospital care became more effective and more desirable, the rules of the charities were debarring many who could benefit from

being admitted. A pauper could be treated in an infirmary, the poor in hospital, and the wealthy in their own homes. But the middle classes, and clerks or men in the early stages of a professional career, often living in lodgings, had nowhere to turn.

In 1877 Henry Burdett, the superintendent of the Dreadnought Seamen's Hospital, began to canvas the idea of a separate 'pay hospital', a concept of which *The Lancet* approved.⁷⁷ Supported by men of suitable eminence, he approached the Lord Mayor of London for permission to hold a meeting at the Mansion House. The influential people Burdett assembled included representatives of the Charity Organisation Society and they agreed to form a Home Hospitals Association to develop a chain of pay hospitals.⁷⁸ Initially there were difficulties; negotiations broke down with St Thomas's about the use of wards which were closed for financial reasons, and St Thomas's developed its own scheme. Residents in the west end opposed the establishment of a hospital nearby. But by June 1880 Fitzroy House was equipped and open for inspection. The regulations were designed to avoid 'abuse' and were approved not only by the presidents of the two Royal Colleges but also by the Metropolitan Counties Branch of the BMA. Fitzroy House was devoted entirely to those wishing for private care, who paid upwards of three guineas a week and employed their own medical men. Characteristic of the enterprises with which Burdett was associated, it thrived and made a modest profit of five per cent.

The voluntary hospitals had been founded to treat the sick poor. But if wards were closed for want of money was it wrong to reopen them for those who could pay their way? St Thomas's, in debt from the rebuilding, and Guy's, impoverished by the effects of the agricultural depression on its revenues, opened private wards after negotiation with their medical staff. The financial results were satisfactory and other hospitals followed their example. A large and influential meeting held in 1884 to discuss the removal of the Great Northern Hospital from Caledonian Road to Holloway agreed that paying wards should be provided in the new building so that the richer classes of the community were not deprived of the best medical advice obtainable. Burdett believed that those who could afford to pay some or all of the cost of hospital care should be allowed the privilege of doing so. He felt that pay wards of voluntary hospitals should be restricted to poor people who could make a modest contribution and that those better off should use entirely separate pay hospitals such as his own. Part

payment by patients would, he believed, go a long way to solve the financial problems of the hospitals. *The Lancet*, casting consistency and its previously expressed views to the winds, considered it a scandal for 'once the commercial principle comes in the charitable principle begins to walk out'. Beds created for the sick poor should not be appropriated by the rich. Its remarks about Burdett's private hospital which had been created especially for those wishing to pay were kinder although *The Lancet* considered that the charges were rather high.⁷⁹

Distinctions were becoming blurred. Hospitals were beginning to offer services which were needed by rich and poor alike. New methods of treatment 'were more and more difficult to apply in a private dwelling house with the assistance of an amateur nurse'. The family medical man could no longer do as much for his private patients in their homes as could be done in hospital. While it might be wrong to apply charitable funds to those well able to pay their way it was also becoming inappropriate to deny hospital care to those above the poverty line. The distinction between the pauper, the patient for whom charitable care was justifiable, and those who should make a contribution to the cost of their care was no longer so clear as the reformers would have it.

The Hospital Sunday and Hospital Saturday Funds

The development from the 1870s onwards of central hospital charities was significant because of the role they played in systematising hospital organisation. As they made grants to many hospitals, they came to collect information about them, and wished it to be on a comparable basis.

The Sunday Fund, founded in 1873, was essentially a middle and upper class organisation which ran an annual collection on a Sunday in June. Its introduction to London owed much to Dr James Wakley, editor of *The Lancet* and son of its founder. Wakley supported the idea in the journal and arranged for *The Times* to carry the same paragraphs. He made repeated approaches to successive Lord Mayors of London and at length Sir Sydney Waterlow, who became Lord Mayor in 1872, took up the idea. He also spoke to the Duke of Westminster, who feared that such a fund would diminish contributions to hospitals like St George's of which he was treasurer, and to the Bishop of London who thought that the different religious bodies would

never be willing to combine. Both changed their minds and the Fund was launched at the Mansion House in January 1873. *The Lancet* saw the possibility of sweeping away abuses in hospital management and reconsidering the existence of so many independently managed institutions. In its view, the new fund might 'bring the hospitals under the most effective control yet devised' and for this reason the selection of the distribution committee would require great care.⁸⁰

The Charity Organisation Society made an immediate attempt to influence the policy of the new fund. Sir Charles Trevelyan was on the Sunday Fund Council but was also on the Council of the Charity Organisation Society. He had been assistant secretary at the Treasury and had played a major role in the reform of the Civil Service. At the first meeting of the council of the Sunday Fund he proposed resolutions which, if carried, would have forced the voluntary hospitals to demand 'a moderate payment from all who could not prove themselves unable to pay'. He received no support from the other council members, and the Lord Mayor pointed out that the council had been elected to aid the hospitals, 'as they are now conducted'.⁸¹ Within a few months the organisation of the Sunday Fund was complete. Extensive cooperation had been achieved between the various religious bodies, and the first Hospital Sunday in London was held on 15 June 1873. One clergyman said in his Hospital Sunday sermon that the new movement had implications for the relationships between rich and poor, for the strongest counteraction to communistic and revolutionary ideas was brotherly help and sympathy.⁸²

Initially there was some disappointment at the small size of the sum raised in London compared with the collection in provincial cities. There were also disputes about the methods of distributing the money and the position of dispensaries. In the first five years the sums collected diminished each year, but after 1878 the trend was reversed and the fund made steady progress.⁸³ Collections were made on Hospital Sunday in churches of all denominations and *The Lancet* produced a Hospital Sunday supplement for free distribution. Hospital Sunday became an annual event. *London Catalyst* is a vestigial remnant of this charity.

The money was distributed amongst hospitals and dispensaries according to their 'needs'. Their three-year average of expenditure on clinical services, as opposed to administrative overheads, would be calculated, from which income from investments would be deducted.

Allocations would then be made to institutions in proportion to the 'needs' thus determined.⁸⁴ The fund's distribution committee would sometimes modify the allocations if, after interviewing the hospital's managers, it felt that there was inefficiency, but in general the fund did not seek to influence hospital policies. Indeed it was criticised in some quarters for its unwillingness to do so.

The Hospital Saturday Fund was different from the Sunday Fund in its nature and political motivation. Established in 1874, the Saturday Fund believed that hospitals were founded for the benefit of all working men, not merely the destitute objects of charity. Working men should therefore support hospitals as far as their means allowed by collecting money on Saturday - pay day - on their behalf. The *British Medical Journal* and the British Medical Association objected to the idea that hospitals were intended to serve the working classes as a whole; men with money in their pockets should consult general practitioners or join a provident dispensary.⁸⁵ In spite of opposition the fund began to collect money in factories, workshops and in the street. Boys dressed in fancy costume invaded the main streets and raffled their collection boxes. Unlike Hospital Sunday, the Saturday Fund could not rely on free and voluntary effort and it therefore had higher administrative costs, for which it was criticised. Because experienced hospital committee members could not be enlisted easily the fund had to work out its policies for itself. A method of allocation was developed which reflected hospital efficiency. High running costs, excessive overheads or a secretive style of management would lead to the allocation of a smaller grant. This method was necessary because nobody on the committee had the detailed knowledge of hospitals enjoyed by the Sunday Fund, and which made qualitative judgements easier.

The Saturday Fund expected to have a voice in the management of the hospitals it supported, and to receive a fair share of governors' letters. If a working man with one of these letters was refused treatment the fund would want to know why, as Hospital Saturday worked on the assumption that by purchasing letters or contributing to hospital funds it had bought the right to treatment. The *British Medical Journal* disagreed, saying that the money the Saturday Fund handed over to medical charities was taken from the pockets of general practitioners.^{86, 87} Sir Charles Trevelyan, of the Charity Organisation Society, thought that working men should shoulder their individual responsibilities through membership of a provident dispensary before handing over money to the hospitals, which too often paid for the care

of the idle and improvident.⁸⁸

The competition between Hospital Sunday and Hospital Saturday was by no means always friendly, Hospital Sunday feeling that money given to hospitals should be a charitable gesture and that its competitors sought more influence over the hospitals than its contribution warranted. Suggestions of amalgamation fell on stony ground because of difference in attitudes.

Conferences of 1881

There were two significant hospital meetings in 1881, the International Medical Congress in London, and the 25th annual meeting of the Social Science Association in Dublin. The Prince of Wales opened the Congress which was attended by more than 3,200 doctors from all over the world. They heard men like Volkmann, Lister, Jenner and Charcot. Many of the papers pointed out the beneficent effect of science on medical progress, and the coverage of the conference in the newspapers provided an opportunity to counter the attacks of the anti-vivisectionists. There was an extensive programme of hospital visits, and a reception at the Mansion House. To help visitors The Lancet published a map of medical London, which showed the size and type of all London's hospitals and infirmaries. The map had been produced by Frederic Mouat, in connection with a series of articles on hospital design written for the journal.⁸⁹ Mouat, a professor of medicine with an interest in explosives and opium, had recently retired from service in India where he had been concerned with the development of a medical school. He subsequently joined the staff of the Local Government Board. He was interested in the organisation of London's hospital service, developing his thoughts for later publication in book form. 'Considered by itself,' said The Lancet, 'the map alone shows at a brief glance the extraordinary incongruities which characterise the distribution of hospital accommodation over the metropolis. It enables us to grasp more fully than has hitherto been possible a subject which has long occupied the minds but which has proved the despair of statesmen and philanthropists alike.'⁹⁰

The Social Science Association heard a paper by Henry Burdett on hospitals and the state, at its Dublin conference.⁸¹ Burdett was a man with a future. He had helped the British Medical Association to compile evidence on hospital abuse ten years previously and his paper recalled the past delegations to the Home Secretary seeking a

commission to consider the management, government and funds of the London hospitals. He said there was a singular and surprising unanimity amongst those knowledgeable about the need for a commission. He instanced the inexplicable differences between management and maintenance costs of the hospitals, their poor geographical distribution in London, and the squandering of money by the richer ones. Crowded outpatient departments provided the briefest of consultations for most of those attending; ineffective governors often failed to consult medical staff; cooperation between institutions was lacking; nursing suffered numerous crises; some of the hospitals failed to give sufficient weight to the needs of their medical schools. Petitioners to the Home Office had included treasurers and boards of major hospitals and the British Medical Association. The Hospital Saturday Fund had also sought a commission to consider the imperfect distribution of the hospitals, the large revenues of the endowed hospitals, and the rearrangement of the areas 'over which their usefulness should extend'.

Burdett's paper was forthright, designed to shake the complacency of his audience. He ended by suggesting that there should be an annual conference of the representatives of the hospitals, a common agency to purchase provisions and to collect annual subscriptions, and the appointment of a 'controlling authority' with powers to sanction, restrict or prohibit the establishment or extension of hospitals. A lengthy summary appeared in the *British Medical Journal* and the paper was reprinted in book form with the addition of financial and statistical tables.^{91,92} Burdett had outlined the problems which were central to the debates of the next twenty years. Neither he nor the Social Science Association committed themselves to the desirability of placing the hospitals, in one sense or another, under state supervision, but the meeting agreed that a Royal Commission was desirable.

The Association accepted Burdett's idea of a hospital conference, which he had previously suggested in a letter to *The Times* in 1878. Such a conference would not lack for subject matter, hospital administration being a live issue. *The Lancet* itself published a series of articles on good practice in administration in 1883.⁹³ A further request for a commission was addressed to the Home Secretary in May 1882. The Home Secretary replied that the public mind was scarcely ripe on the subject. The reformers had to wait.⁹²

The first conference on hospital management

The first conference of hospital managers, governors, administrators, doctors and nurses, held on 3 and 4 July 1883 at the Society of Arts, provided a forum for debate about the hospital services of London.⁹⁴ It was organised by Burdett, who had contributed an article to the March issue of *Nineteenth Century* advocating the establishment of a central controlling authority for hospitals and infirmaries.⁹⁵ *The Lancet* and the *British Medical Journal* encouraged their readers to attend, fourteen papers were delivered, and the meeting culminated in a session on the need for a royal commission.

Sir Rutherford Alcock, chairman of the Westminster Hospital and the medical committee of the Charity Organisation Society, called for a better distribution of the metropolitan hospitals and their funds. He maintained that a fourth of London's population received charity from the hospitals each year, that many people were obtaining benefits to which they were not entitled, and that they were being pauperised in the process. He believed that the funds of the endowed hospitals should be redistributed, not 'locked up in obsolete charities'. The endowed hospitals were guilty of extravagant building and excessive maintenance costs. St Thomas's had cost £800 per bed to build, while the Poplar and Stepney Sick Asylum had cost less than £100 per bed. Money which was intended for the sick poor was being spent on medical education; St Bartholomew's had spent £50,000 on its medical school, Guy's £40,000 and St Thomas's £30,000. The five Royal hospitals had been endowed by an act of confiscation; their resources should not be 'beyond the reach of enquiry as to their proper use'. Mr Nelson Hardy, a general practitioner interested in hospital abuse, spoke in a similar vein.

Burdett was more conciliatory. He spoke about comparative costs and the need for audit, advocating a uniform accounting system. He said that to delay a commission would injure the best managed hospitals and increase abuses in the others, while to appoint one would be in the interest of the suffering poor. Few representatives of the endowed hospitals were present, so they missed Rutherford Alcock's brisk proposal to reallocate their funds, but such remarks were responsible for the opposition of the older hospitals to reformers and their schemes.

The Hospitals Association

The conference asked the council of the Social Science Association to form a committee to arrange future meetings and this it did. The group chosen laid the foundations of the Hospitals Association which was established the following year. The objective of this new association was to facilitate discussion of hospital management and decide what was to be done. The members included many of those already active in the cause of the hospitals, Bristowe, Burdett, Holmes, Alcock and Gilbert Smith, and it must have seemed to its founders a great improvement on the Social Science Association, very few of whose members were greatly interested in hospital matters. The formation of the Hospitals Association was welcomed both by the *British Medical Journal* and *The Lancet*, which prophesied that it would have a useful career advancing the reforms which were necessary for the public.⁹⁶ Its monthly meetings were held in London and problems of management, finance and nursing were soon discussed.

Crowded conditions in outpatient departments were a prime cause for concern; an article by Robert Bridges published in 1878 attracted considerable attention by describing the speed with which doctors had to work at St Bartholomew's.⁹⁷ At the first meeting of the association Mr Nixon, house governor of The London, said that his department had existed as far back as 1742 and the number of attendances was continually rising. Because of faulty case registration the often-quoted figure of 'a million attendances a year in London' was an over-estimate, but some control on numbers was necessary. He believed that instead of imposing a charge or limiting the number to be seen, patients should be inspected to see that they were deserving of charity and would benefit from the attention which only a hospital could bestow. Enquiry into means should be 'charitable and applied with discerning intelligence.' Timothy Holmes said that outpatient departments should be consulting centres only, seeing patients referred by doctors working nearby. Sir Andrew Clark disagreed, as he felt that they were needed as a means of teaching students about the early stages of disease.⁹⁷

While general practitioners saw outpatient departments as unfair competition, hospital staff were divided in their views. Many believed the medical school argument that they were a necessary part of student education. Subscribers to the hospitals valued the privilege of

referring patients, especially their own domestic servants. Administrators regarded the outpatient departments as a basis for appeals to the public, while the Charity Organisation Society, interested in the morality of the poor, feared that free care was the first step on the road to the workhouse. The Sunday Fund Council members were caught in the conflict. They were under pressure from the Charity Organisation Society to enforce enquiry into patients' means before free treatment was made available to them, but they did not wish to encroach on the right of the hospitals to determine their own policy. The Sunday Fund therefore encouraged the establishment of systems of enquiry, but did not attempt to impose its will. Burdett wrote that the growth in numbers attending outpatient departments must be accepted by the profession as a judgment on the quality of care available elsewhere; perhaps hospital treatment was better than most people could obtain from private practitioners.

Mouat's solutions

In 1881 Frederic Mouat wrote articles for *The Lancet* and prepared a map showing the poor distribution of hospitals, and supporting the call for a royal commission. Two years later in a book rushed out for the 1883 hospital conference he suggested his own solution. It was a state financed service.⁹⁸ Mouat's was a minority view as most agreed with Burdett that to accept state funds would not only lead to a loss of charitable subscriptions, but would deny people the opportunity to serve others.⁹⁵

Mouat's views may have owed something to his background in the public service. He felt that state aid, or support from the rates, was essential and that medical care should be divorced from destitution relief. Poor law infirmaries should be converted into general hospitals and a royal commission might consider how rate supported and voluntary hospitals could be harmonised into an effective system. He revised his map and divided London into five districts corresponding to those of the Registrar General. Each could have a separate board of control to regulate the management of the hospitals and the care of the sick within its boundaries. A general board could be formed from the district boards to cover the metropolis as a whole. By gradual evolution, unified government of London's hospitals would make it possible to correct the problem of maldistribution, affiliate dispensaries and special hospitals to the leading general hospitals in each district, develop an ambulance system, ensure that all hospitals in London

were used for medical student education and nurse training, and scrutinise hospital accounts to ensure that grants were fair. Mouat's statement of the problems may have been acceptable at the time; his solutions were not. Others were prepared to opt for less radical measures, believing that more effective organisation of fund raising and charity might suffice to ensure the continuation of the voluntary system. *The Lancet* thought a central body with the interests of the sick poor at heart, like the Sunday Fund, might be able to control the rivalries of the hospitals and attract more subscriptions from the wealthy. But if private funds were not forthcoming the state would have to step in. *The Lancet* felt that hospital managers should establish a comprehensive system of finance, be more energetic and bring 'exact facts' to the notice of the charitable.

The uniform accounting system

Unfortunately obtaining the 'exact facts' was not easy. The endowed hospitals in particular were loath to provide any facts at all about their finances. There was no standard method of keeping accounts and it was not unusual to find that a hospital secretary had absconded with funds, or that an inexplicable deficiency emerged on his death. Poor law institutions suffered their share of such scandals, and the Eastern Fever Hospital was the subject of recurrent enquiries. 'That hydra-headed monster' was Burdett's description of it. The staff had a strange habit of ordering large quantities of delicacies, and if the hospital was not overflowing with milk and honey, it certainly had more than its share of burgundy and champagne. It seemed to be a major duty of a hospital secretary to arrange for the accounts to show a deficit, a crisis which could then be made the basis of an appeal. These erratic methods of accounting led to proposals for a uniform method of presenting accounts.

The Uniform System was designed in 1869 by Burdett who believed that no charity should publish misleading accounts for short term benefit. With the help of a local accountant he introduced a system into Queen's Hospital Birmingham, where he then worked. On moving to the Seamen's Hospital he took the system with him and developed it with the help of two men he trained there. Both of them, Mr Michelli who was responsible for the glossary of definitions, and Thomas Ryan, later of St Mary's, obtained senior posts with the passage of time.

Burdett published the details of the system and arranged for appropriate ledgers and account books to be printed. The three men demonstrated the system at their hospitals to those interested.⁹⁹ In 1890 Ryan summoned a meeting of hospital secretaries to discuss the system, but was met by apathy. Shortly after, the Hospital Sunday Fund, under pressure from the Select Committee of the Lords ¹⁰⁰, sent out its annual request for information about the hospitals' financial position and based it upon Burdett's system. This pushed the secretaries into action and they produced their own variant which was agreed with the Fund's distribution committee, of which Burdett was a member. In 1892 the Sunday Fund approved the model scheme for general adoption and made it clear that grants from the Fund would be dependent upon its use. The new system was soon adopted throughout London. Not all hospitals liked it; but even a wealthy hospital such as Guy's could not risk losing assistance from central funds like Hospital Sunday and Hospital Saturday. However the treasurer of Guy's asked to be allowed to observe that the form appeared to him in many respects inferior to that previously in use. It appeared to him, 'better adapted to the accounts of voluntary hospitals than those of an endowed hospital deriving the greater part of its income from landed property.'

The provident principle

Working men as well as hospitals were urged to demonstrate their financial probity. Schemes involving an insurance or 'provident' principle were frequently advanced to reduce hospital abuse. The Charity Organisation Society re-established its medical subcommittee in 1884 to press the campaign.¹⁰¹ In conjunction with the Metropolitan Provident Medical Association, whose object was the establishment of a chain of provident dispensaries, a conference was organised in 1886 to elaborate a scheme coupling hospitals with provident dispensaries and allowing medical students to study common diseases both in hospital and in the community.^{101,102} Such proposals were seldom successful in practice. Provident dispensaries seemed to attract the better-off working man who could have paid for the services of a general practitioner. They did little to improve the financial position of local doctors.

In 1887 there was a new opportunity to apply the provident principle. The Metropolitan Free Hospital closed in 1885 when its site was

required for Liverpool Street Station. With the proceeds a new site was purchased in Kingsland Road and the hospital rebuilt. However it proved impossible to re-open it because of shortage of funds. Sir Edmund Hay Curie, a city business man with experience of the management of the Metropolitan Asylums Board and The London Hospital, suggested that the Metropolitan should be worked on the provident principle, patients contributing regularly so that the costs of treatment would be prepaid. The older governors led by the chairman Joseph Fry, the son of Elizabeth Fry, were much against the idea. A special meeting was called, there were furious arguments, and for several months there was a boardroom battle. Eventually Curie's terms were accepted and both he and Lieutenant-Colonel Montefiore of the Charity Organisation Society joined the Board. The name was changed to the Metropolitan Hospital, for the word 'free' was no longer appropriate. It reopened and a provident dispensary was attached to it.

Critics and problems

Little had been achieved by the years of disputes and debates. In its first editorial of 1888 *The Lancet* listed the unresolved problems, medical reform, local government reorganisation, legislation concerning lunatics, and academic difficulties. Degrees for London students on the same terms as could be obtained in Scotland and the provinces remained a pressing issue. *The Lancet* considered this an injustice to the largest centre of medical teaching in the world. A London teaching university - as distinguished from the existing University of London - was no more available to students than a castle in Spain.

The Lancet also believed that the critical attacks on the hospitals were excessive and merely provided the benevolent with excuses for buttoning up their pockets. Did the critics agree, *The Lancet* asked, that there was an enormous mass of physical disease intensified by scanty means; that it was one of the prime duties of the healthy and comfortable to make generous contributions to the hospitals; and that by maintaining the hospitals they were advancing skills by which their own lives might be saved?

'The Charity Organisation Society, the Social Science Association and a variety of other bodies have come into existence not so much for the purpose of charity as of criticism. The hospital has been attacked as if it were the very foundation of pauperism, demoralising one out of four

people in the community, or at least in the metropolis. It has been assailed as if it were a dram shop, contaminating all who come within its influence.'

The debates were more remarkable for the harm they inflicted upon the hospitals than the good they had done the poor.¹⁰⁵ Burdett was of the same opinion; what the hospitals needed was more cash and less criticism. *The Lancet* accepted that the hospitals were not beyond criticism; some of the most densely populated parts of London were several miles from the nearest hospital. But since many hospitals served people living a long way from London they were actually more accessible where they stood, near the main railway termini. It was also essential for them to be reasonably near the doctors' residences, as the hospitals were served free of charge by the best medical skill in London.¹⁰⁶

One of the most hopeful signs was the growing activity of those holding official positions in the hospitals, chiefly through the new Hospitals Association. The Association was collecting facts and data concerning hospitals, appointing committees, holding meetings and establishing a journal. One committee had been appointed at the suggestion of the lady superintendent of Great Ormond Street to consider hospital nursing, and it was contemplating the introduction of a nurses' register. *The Lancet* hoped that the work of the Association might lead the public to open its purse and relieve the anxieties of those administering the splendid hospital charities.¹⁰⁷

The charitable were also urged at the Mansion House to help the hospitals and to make Hospital Sunday a success. The Archbishop of Canterbury and Sir Arthur Clark, President of the Hospitals Association, said that England would have taken a long step backwards if the hospitals of London were ever to be supported by the state. It would be hard to conceive of a greater disaster.¹⁰⁸

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- 101 Charity Organisation Society. *British Medical Journal*, 1886, i, p 520.
102. The conference chaired by Sir Arthur Clarke on provident dispensaries. *Lancet*, 1886 ii, pp 1138, 1146; *and* *British Medical Journal*, 1886, i, pp 223, 366.
- 103 Archives of the Metropolitan Hospital held by St Bartholomew's Hospital. Ha/S 6/6.
- 104 The forecast for 1888. *Lancet*, 1888, i, p 26.
- 105 The critics and claims of the hospitals. *Lancet*, 1881, ii, p 800.
- 106 The claims of the medical charities. *Lancet*, 1888, i, p 1164.

- 107 The Hospital Association. *Lancet*, 1886, i, p 797.
108 Hospital Sunday. *Lancet*, 1888, i, p 1164, p 1215.

Further reading on hospital abuse

A fascinating insight into 'abuses' may be found in two books written under a pseudonym by Edward Burdove, who trained at The London in 1875 and entered practice in the East End. Burdove, who later became medical adviser to the Victoria Street Society, wrote a romantic novel about a medical student. Designed to be a popular success, Burdove incorporated much information about malpractices in the London hospitals, which he wished to bring to the attention of a wider public. The second book provides references from the medical press to support the statements he made in the first.

109 *Aesculapius Scalpel*. St Bernards: the romance of a medical student. London, Swan Sonnenschein, Lowrey and Co, 1887.

110 *Aesculapius Scalpel*. *Dying scientifically: a key to St Bernard's London*. Sonnenschein, Lowrey and Co, 1888.

Chapter 7 Reviewing the past and shaping the future 1889-1914

*'London has hitherto been the despair alike of statesmen, politicians and philanthropists. Its political apathy no less than the appalling mass of squalid destitution it contains is a positive danger to the commonwealth.'*¹

Sidney Webb, *The London Programme*, 1891

The vast improvement in care since the middle of the century as a result of anaesthesia, antisepsis and the introduction of trained nurses increased the numbers seeking hospital care and was associated with a reduction in the time patients stayed in hospital and an increased admission rate. Developments in hospital administration were less impressive. As a result there was a series of wide-ranging reviews in the twenty five years preceding the Great War (1914-1918).

A comparable situation existed in municipal government where the metropolis lagged behind provincial cities. The London boroughs were not formed until 1899 and there was no single elected body which could speak for the capital as a whole. In the absence of borough councils most duties devolved on 29 administrative vestries, 44 non-administrative vestries, 12 district boards, 1 local board of health, 12 burial boards, 19 boards of library commissioners, 10 boards of baths and wash-houses commissioners, the boards of guardians and the Metropolitan Asylums Board. Since the 1860s a campaign led by the London Municipal Reform League had urged the case for a single central elected authority, a demand opposed by the City of London and the vestries who sought greater municipal dignities for themselves. After many reverses, the Local Government Act (1888) established the London County Council and abolished the unlamented Board of Works which had achieved the doubtful distinction of the nickname, 'Board of Perks'. Mr Punch, in his almanac for 1889, presented an allegorical picture of a dignified, triumphant and Amazonian London driving a crowd of usurers, jobbers, vestrymen, councillors and jerry-builders from the banks of the Thames. In her train followed Music, Art, Education, Science, Light, Ozone and Literature. 'The Old order changeth, yielding place to the New', said Mr Punch.²

Twenty years of academic dispute and debate culminated in the restructuring of the University of London to permit the University both to examine and to teach. Sidney and Beatrice Webb, and the Liberal

politician R B Haldane, were prime movers in this, but the measure was so far from satisfactory that a Royal Commission was established to re-examine the question within a few years. Finally, against the background of changing social and political attitudes, the principles of the Poor Law were re-examined by the Royal Commission of 1909.

The Charity Organisation Society and the enquiry into the hospitals

Since the 1850s, dissatisfaction with hospital management had been growing. Continuous lobbying by the Charity Organisation Society eventually obtained an enquiry. It also ensured that the society would maintain an influence over the proceedings. 2

The society had established a special committee on the reform of the metropolitan medical charities which met weekly from the end of 1888. Timothy Holmes of St George's was invited to join and agreed to do so, although he said that he did not expect to receive much support from the medical profession at large. Ernest Hart, editor of the *British Medical Journal*, offered its support. The committee collected detailed information, sought the support of men of eminence, selected potential witnesses and, after taking soundings, drew up a petition seeking the appointment of a commission. In January 1889 the society's secretary, Charles Loch, was instructed to write to the press to ask those who were interested to contact him. Neither Sir James Paget nor Henry Burdett favoured an enquiry but many others did, including Sir Sydney Waterlow, treasurer of St Bartholomew's, and Sir Spencer Wells. Henry Burdett wrote in *The Hospital* that what was really needed was a short Act of Parliament which would prevent a hospital being opened unless there was a need for it, that the bona fides of its protagonists were beyond question and that funds were available to support the new institution. 4

In April 1889 the petition was widely circulated to hospital governors, doctors, boards of guardians and the newly formed London County Council. An editorial in the *British Medical Journal* welcomed the move and in particular the chance to examine the relationship between voluntary charity and poor law medical relief. 5 There was considerable discussion within the special committee about who should present the petition to the Lords and several members of the upper chamber were approached without success. Lord Sandhurst, the chairman of the Middlesex Hospital and himself a leading member

of the special committee, ultimately did so. On 29 July 1889 he addressed the Lords and presented the petition, now signed by many members of the medical profession including Sir John Simon and Sir Spencer Wells and eminent laymen on behalf of various charitable organisations. In his speech Lord Sandhurst outlined the size and expenditure of the voluntary hospitals and infirmaries, criticising the special hospitals in particular. He said that the origin and management of many of them were suspect, and implied that they were started for the private advantage of those who wished to make themselves consulting physicians, or purely for speculative reasons.

The Society's petition was in fact a plea for an enquiry into the possibility of organisation in medical charity, but it was seen as its usual type of attack upon the hospitals. The Hospitals Association, whose members were working hard to improve matters from within, were not enthusiastic about an enquiry. The British Medical Association, as Hart had promised, welcomed the Charity Organisation Society's proposal for an enquiry at its annual meeting. Indeed many branches of the Association wished it to be extended to cover the entire country, a proposal which was resisted by the London committee of the Charity Organisation Society.⁶ While the Government was considering its response, the special committee drafted the evidence to be given to an enquiry by its secretary. Lord Sandhurst suggested that it should be prepared to produce some scheme for the better management of the metropolitan medical charities. He also discussed matters with ministers. By March 1890 the Charity Organisation Society had drafted and agreed proposals for improving the administration of the medical charities. At first sight the welfare of the hospitals was not a party matter, but the great hospitals were particularly sensitive about the possibility that a royal commission would be established. Lord Cranbrook, the minister responsible, decided instead upon a select committee of the House of Lords. On 28 April 1890 a motion in the House established a select committee, to be chaired by Lord Sandhurst himself. It was agreed that the remit of the select committee would be:

'to enquire with regard to all hospitals and provident and other public dispensaries and charitable institutions within the metropolitan area for the care and treatment of the sick poor which possess real property or invested personal property, in the nature of endowment, of a permanent or temporary nature; and to receive, if the Committee think fit, evidence tendered by the authorities of voluntary institutions for like

*purposes, or with their consent, in relation to such institutions: and further, to inquire and report what amount of accommodation for the sick is provided by rate, and as to the management thereof.*⁷

The establishment of the select committee was a victory for the Charity Organisation Society and those of like mind. However others were apprehensive. Burdett said that the pressure for reform came from 'disaffected persons with axes to grind' and was not in all respects altruistic. One of the chief axe-grinders was Dr Robert Rentoul, a Liverpool general practitioner with British Medical Association affiliations, who published a book on voluntary medical charities whilst the Lords' committee was sitting.⁸ Rentoul said that four groups were bringing discredit to the hospitals - hospital committees who would 'sell charity' in the form of letters of recommendation to anyone willing to purchase them, well-to-do workers who would accept charity as a right, those who bought governors' letters and tickets of recommendation to provide cheap care for relatives, friends and employees, and doctors who used the charities for the purpose of self-advertisement.

Another undercurrent was the campaign for a national register for nurses, led by the British Nurses' Association. Partisan conflicts emerged in the evidence given to the committee and heralded the thirty year 'battle of the nurses'. Against registration were most hospital governors and doctors, the matrons of many of the large hospitals like the young and energetic Miss Lückes of The London, Miss Monk of King's and Miss Nightingale herself. 'Twenty or thirty years hence, when progress has been made', said Miss Nightingale, 'this registration might do'.⁹ Other opponents included the majority of those actively involved in training, who pointed out that training had only existed for a couple of decades, and properly trained nurses were in a minority. The profession was in a state of transition. There was a fear that an 'unrepresentative organisation would enforce a uniformity of theoretical knowledge which would be contentious and would leave out the qualities of gentleness, quick observation and quiet self-control which could not be assessed by examination'.¹⁰ Miss Lückes believed that registration would injure the status of the 'well-trained nurse' by making it hard to distinguish between those with first-rate and those with second-rate qualifications. Nearly all metropolitan hospitals and very many large provincial hospitals had much to lose and nothing to gain by levelling down standards. She thought that the qualities of a nurse could only be assessed by her training institution,

and that a register would give a false sense of security.¹⁰ On the other side were many of the younger nurses who wished for professional advancement and relief from autocratic rule. They were led by Mrs Bedford Fenwick, the ex-matron of St Bartholomew's, and editor of the *Nursing Record*. She campaigned for a three-year training, like the course she had introduced at St Bartholomew's, with an objective assessment of the competence and knowledge of nurses.

The Lords' committee came to spend much time on a series of accusations against the matron and the nursing regime of The London Hospital, some of which reflected personal animosities. Members of the Charity Organisation Society committee expressed regrets that more attention which was paid to the internal affairs of a single hospital merely diverted the select committee from matters of greater importance.³

The evidence of the Charity Organisation Society

The Lords' committee had received a mandate to examine and report upon problems which had been of concern for many years. Lieutenant-Colonel Montefiore, who was the first witness and the secretary to the special committee of the Charity Organisation Society, gave his evidence with force but moderation. He said that his Society existed to improve the condition of the poor by propagating sound principles of administration, promoting the cooperation of charities, discussing practical questions, working for reform when necessary and promoting thrift and self-dependence. Speaking from a carefully prepared brief he was at pains to stress that the Society was not hostile to the hospitals which were 'glorious institutions' nor did it wish them to be rate-supported. But improvements could be suggested.¹¹

The Society was concerned about poor conditions in outpatient departments and their use by patients who were not entitled to charitable relief. The charitable organisations had little contact with each other and in any case free treatment was of little use to those without food and the comforts necessary to health. Most hospitals were in the centre of town and those living further out had no local service and a long distance to travel. Doctors in poorer areas had difficulty in making a living because of the many charitable and part-payment services. The continuous competition between hospitals, both for patients and to increase their services, drove them to all manner of contrivances to meet the debts they incurred. New hospitals were

being established without reference to the need for them.

The Society made constructive suggestions to remedy these defects. It believed that the infirmaries should be brought into closer relationship with the hospitals, and joint medical staffing should be encouraged. It envisaged a supervising council which would report either to the Charities Commission, the Local Government Board or the new London County Council. This would be formed from the chief professional, hospital and charitable interests and would be similar in composition to the Assistance Publique in Paris. It would arrange for visitors to inspect the hospitals and suggest necessary improvements. The supervising council would publish an annual report on the finance and management of London hospitals, reporting the action taken to achieve coordination and the suggestions it had made which hospitals had ignored. It would supervise the development of hospitals and the establishment of new medical charities; receive funds and legacies; and not only distribute money in its own right but advise the organised charities on the allocations they made. The slow progress which had been made by the Sunday Fund suggested that its composition and policies were not suitable for the task in hand.

The council would need to reduce the load on outpatient departments, to improve the quality of patient care and encourage the use of poor law infirmaries for teaching. It would seek economy of administration, uniformity of accounts and rationality in the establishment of new hospitals in order to develop a system of districts, each with its own hospitals.

Faced with such proposals the Lords quickly went beyond their financially oriented terms of reference. Witness after witness was asked to give evidence and the press recognised the care with which the select committee went about its task and the fundamental issues which it was exploring. Here would clearly be a document of stature, for the witnesses came from widely divergent backgrounds covering the entire spectrum of professional and administrative opinion. Yet the Charity Organisation Society influence remained powerful. The society designed and printed the questionnaire which was sent out to all the hospitals by the select committee and later analysed and arranged the printing of the replies. It prepared a map of the London hospitals for the committee and kept in close touch with its chairman. Charles Loch was instructed to list and contact the younger men on the medical staff of the hospitals.³ He did so, but reported that little would be gained

from them and that they showed 'a want of knowledge on the Hospital question'. The committee sat for two years and produced a four volume report. The evidence of the witnesses provides a wealth of information about the conflicting attitudes and the conditions of medical practice in London at the end of the nineteenth century. The last witness was Charles Loch, who reiterated the views of the Charity Organisation Society and summed up the case for change.¹¹

The report of the select committee

The final report was published in 1892 and appeared to be a vindication of the voluntary system for it stated that in general the hospitals were well administered, though in the endowed hospitals too much power and responsibility often rested upon one man - the treasurer. This accusation was not new.

Others saw the report as opening the door to sweeping reforms. The committee urged the need for coordination of the general and special hospitals and the poor law infirmaries:

'...so far from there being at the present time any general system of combination or any definite division of work among the various institutions they are on the contrary for the most part competing with one another at every point for public support, and to a great extent for patients. This condition of things is wasteful and prejudicial to the sick for whom these institutions exist and to the interests of medical science and education. The evils of the present system, or want of system, are generally admitted but little has been done hitherto to cure them. Much improvement might be affected by affiliating special hospitals to general hospitals but next to nothing seems to have been done. A scheme was proposed for dividing the whole of London into districts, each district to be supplied within its own limits with the necessary provision of hospitals.'

Their Lordships commented on the congestion of hospitals on the north side of the Thames and reported that 'the prevailing though not unanimous opinion seems to be that on the whole hospital accommodation in London is sufficient; but much inconvenience and a partial inability in some places to cope with demand for admission are caused by unequal distribution and want of organisation.' Some witnesses thought the difficulty might be met by transplanting some of the hospitals in the central district to places in the north, south and

east where they are more wanted. They recommended the establishment of a large general hospital in densely populated Camberwell, if a site could be found and the money could be raised.

The twelve general hospitals with medical schools in 1889

	Founded	Annual income £	Nurse staffing	Available beds
St Bartholomew's	1122	70,500	197	667
St Thomas's	1207	67,000	116	436
Westminster	1719	14,000	63	205
Guy's	1721	34,000	130	578
St George's	1733	28,000	90-100	356
The London	1730	59,000	218	776
Middlesex	1745	20,000	86	307
Royal Free	1828	6,000	40	160
UCH	1833	20,000	78	207
Charing Cross	1834	6,000	51	175
KCH	1839	11,000	80	220
St Mary's	1845	14,000	60	281

Source: Report of the Lords' Committee, 1892.

The use of poor law infirmaries for educational purposes was advocated. The committee stated that 'the infirmaries afford a field for the study of precisely those chronic and intermittent cases which the young doctor will most frequently meet when he goes out into private practice and which he has the least opportunity of studying in the wards of the general hospital, where all cases are severe and acute. Just as the outpatient shows to the student the beginnings of disease, so in the Poor Law Infirmaries he ought to watch its continuing and closing phases.' The committee heard conflicting views on the role of outpatient departments, but concluded that they were necessary, if only for educational purposes. However the number of patients seen each day should be restricted and the use of departments for consultative purposes should be encouraged. The question of a nurses' register went to a vote; Lord Sandhurst was in favour but he was outvoted and no recommendations were made. The committee recommended that the University of London should be enabled to teach medicine as well as to examine, and that the medical schools should be affiliated to the University.

The report received a favourable reception and it was summarised in the medical press. Burdett discussed the findings in the introduction to volume three of *Hospitals and Asylums of the World*, which appeared

Districts	Area in acres	Population (1881)	Persons /acre	Hospitals /district	Hospitals /square mile	Beds	Beds to population
West District	10,399	669,633	64	27	1.7	4,497	149
North District	13,468	905,947	67	29	1.4	4,289	211
Central District	2,132	282,238	132	17	5.2	1,979	142
East District	5,500	692,738	126	15	1.7	5,717	121
South District	43,835	1,265,927	29	23	0.3	7,555	168
Total	75,334	3,816,483	51	111	0.9	24,037	159

Mouat's proposals for five districts

in 1893. The worst fears had proved groundless. Each group fastened on the recommendations most to its liking, although the *British Medical Journal* accused their Lordships of being far from thorough in their consideration of abuse of the outpatient departments, dismissing the accusation in a light and airy way.¹² The special committee of the Charity Organisation Society ceased to meet. It had finished its work. Charles Loch wrote in *The Nineteenth Century* about the need for action.¹³ Mouat wrote four articles in *The Lancet* saying that he hoped that a central board would be formed with all the power over the general hospitals that the Metropolitan Asylums Board had over fever hospitals. He repeated his proposals for five districts based upon the registrar general's five districts.

The attempt to establish a central board

The Lords committee had agreed with the Charity Organisation Society that there should be a central board. This would act as a watch-dog, audit accounts, describe operational policies, publish and comment upon proposals to remove, expand or open hospitals, and act as a central charity for the receipt and distribution of endowments and contributions. The board's power would be limited and it would not interfere with local management; neither would it receive a government grant for this would reduce the flow of voluntary contributions. Nevertheless the Lords believed that people would heed a board's comments on proposals to build 'useless hospitals', and on the quality of a hospital's administration. A central board would help in times of

financial difficulty, the Lords fearing that without one the time would come when voluntary hospitals would need government or municipal aid. Sidney Webb, in *The London Programme* which was prepared with London County Council elections in mind, also thought that a separately elected Board was desirable. But he saw a Board as a first step to the replacement of private hospitals by public institutions. 'London', he said, 'must systematically undertake the care of London's sick.'¹

The chairman of the select committee, Lord Sandhurst, did not consider his work complete with the publication of the report. Wishing to oversee its implementation he invited representatives of the central funds and the hospitals to a conference at Spencer House in July 1892, to consider the formation of a central board. The invitation gave rise to much discussion in hospital circles for while many were opposed to cooperation there was little desire to offend the noble Lord. Burdett, who was invited to the conference, noted 'a want of genuine interest in the proposals, much doubt as to the practicability of devising a scheme for cooperation, and an undercurrent of desire to do nothing.' He predicted that a committee formed by the conference to consider how a board might be established would have a 'thorny path to traverse'. He wrote in *The Hospital* that a central board without the power of the purse or the authority to enforce its recommendations would probably accomplish little, whilst its power for evil might be considerable.^{15,16} A proposed pattern of membership was rejected by the hospitals as biased towards the medical charities and unrepresentative of the voluntary system. The opponents of a board included many who objected to centralism in all its forms. They feared an infringement of the rights of hospitals to continue to act as separate units, and wished to preserve absolute individual freedom.

Nevertheless Louisa Twining, a veteran campaigner, said that she was convinced that there was something in the hospital system which could be made more in accordance with modern needs and modern ideas.¹⁷

Regular meetings were organised by the Charity Organisation Society and in January 1897 its secretary outlined the principles he believed to be generally accepted:

i Any board should be representative of the main interest groups

- ii Reliance should be placed upon cooperation and publicity rather than on legal measures and compulsion.
- iii A central fund should be formed as a permanent endowment of the hospitals.

Opponents of a central board were given the chance to make their case at a meeting called to consider the proposition, but as those present were largely the protagonists the vote in favour of a board was 121 to 12. The view of the majority was that a board was necessary to maintain the health of the voluntary system, and it was the only way to ensure that London's hospital and medical needs were considered as a whole.¹⁸

The Society established a sub-committee to produce a new scheme giving the hospitals the increased representation they demanded. Each hospital would have direct representation, with additional seats for the central medical charities and general practitioners. The result was a board so big that an executive committee would also be necessary. Deputations to the hospitals received little encouragement. Few hospital representatives turned up at the meeting convened to consider the scheme. A central board with two hundred members seemed so impracticable that they were not prepared to spend time discussing it. Those seeking autonomy for the hospitals believed that if a board controlled funds it would be dangerous, and if it did not it would be useless. Instead, the twelve hospitals with medical schools met separately at the Westminster Hospital and formed a Central Hospital Council for London, to consider matters in which they had a common interest and promote joint action.¹⁹

The Hospital Reform Association

Much of the pressure for a central board came from the general practitioners. The Hospital Reform Association, formed in 1896 'to concentrate medical opinion on reforming hospital administration', was largely a general practitioner body. The president had been president of the British Medical Association. The *British Medical Journal* was an ally, and those favouring provident dispensaries like Timothy Holmes and Charles Loch were members.

The Association set to work, organised conferences, and prepared a report on the management and financial arrangements of the special hospitals, demonstrating how much of their income came from payment by patients who did not require charity. The special hospitals were not even keeping to their own specialty. The Cancer Hospital was treating piles, fistulae, tuberculosis and syphilis, and the Chest Hospital anaemia and dyspepsia.²⁰

Lord Lister, in a private letter, described the Association as 'a most unwieldy and heterogeneous body in which the medical profession was chiefly represented by practitioners whose names carried little or no weight and whose outcry against hospital abuse was extremely exaggerated'.²¹ He was not alone in this opinion. Sydney Holland (later Lord Knutsford), the chairman of The London Hospital, also disapproved of it, saying that the Association was chiefly got up by some gentlemen from Wales. The reformers came to see that they could expect little support from the hospitals. Few of the hospitals' medical staff wished to restrict the flow of patients. Hospital administrators saw no advantage to the reputation of their hospitals or their funds from turning away patients. The Royal College of Physicians declined to take any initiative.

The Charity Organisation Society had more success in achieving the introduction of a system of enquiry into the means of patients in outpatient departments. In 1895 an experienced Charity Organisation Society district secretary was appointed at the Royal Free Hospital, her salary being paid by the society for the first three months. Miss Stewart, the first of the lady almoners, was followed by others trained by the society. Soon almoners were appointed at St Bartholomew's, The London and the Hospital for Sick Children. Some society members, also members of the council of the Sunday Fund, encouraged that Fund to regard the appointment of almoners as a 'merit' to be taken into account when money was distributed. The job of an almoner was not an easy one. They were faced by crowded departments seeing thousands of patients a year. The secretary of The London Hospital pointed out that the cost of employing an enquiry officer itself reduced the funds available for relieving the sick poor.²²

23

The London County Council and the Metropolitan Asylums Board

The quest for better methods of organisation was not restricted to voluntary hospitals. In 1893 the newly established London County Council asked a sub-committee to consider the overlapping activities of a number of centralised rate-supported bodies in the fields of health and education. The sub-committee's report was considered by the Council in June 1894. It dealt with the wide range of services provided by the Metropolitan Asylums Board, which by now included fevers, infectious diseases, the mentally handicapped and even groups like pauper children who were sent to training ships. The Hospital Commission on smallpox in its 1882 report, had recommended that responsibility for the sanitary state of an area should be in the same hands as the management of hospitals for fevers. The London County Council, debating its subcommittee's report, came to the same conclusion. The Council, of which Sidney Webb was a member, adopted the policy that all central metropolitan powers in the field of public health should be in the hands of 'the elected representatives of the rate-payers', and that the services provided by the Metropolitan Asylums Board should be transferred to the Council. *The Lancet* thought this proposal was 'absolutely sound'.²⁴ Before the formation of the London County Council *The Lancet* had thought that the Metropolitan Asylums Board had the potential to become the central health authority for London. Now that the Council was establishing a firm claim to this role it would inevitably become, sooner or later, the manager of the services provided by the Board.²⁵

The Prince of Wales' Hospital Fund for London

[The Fund did not become The King's Fund until the death of Queen Victoria]

Few of those who have devoted their lives to London's hospitals can have accomplished more than Henry Burdett. Because of his long established position in the hospital world he had been associated with Lord Sandhurst's attempts to form a central board, of which he did not altogether approve. In 1896 he was at the centre of discussions which bore more lasting fruit.

Throughout his life he was careful never to claim that he had played a key role in the foundation of the Prince's Fund. As one of the Prince's trusted advisers he may have believed that more is accomplished if one does not insist on claiming the credit. However many of the



"IN THE QUEEN'S NAME"

characteristics of the Fund bore Burdett's stamp upon them, and reflected ideas he had advanced for many years.

From his early years the Prince had been interested in hospital affairs. He had accepted the presidency of St Bartholomew's as early as 1867 and he regularly undertook to open new hospital buildings. He became patron of The Hospital Saturday Fund in 1896, and *The Lancet* said that scarcely a week passed without his making an effort for the public good. His interest and example 'might be the very saving of the voluntary hospital system'. Help was certainly needed, for in 1894 the Hospital Sunday Fund said that around £300,000 was vital to cover the liabilities of the London hospitals and dispensaries. It had taken 20 years for the Sunday Fund collections to rise from £27,000 to £40,000

a year, and an appeal by University College Hospital in 1896 produced so derisory a sum that the governors were forced to comment on the lamentable indifference in the district to a charity of vast importance to the poor of the neighbourhood. Another 50 beds were added to those already closed in London.²⁶

In 1896 the governors of Guy's decided to launch an appeal to 're-endow' the hospital and reopen beds which had been closed. Presiding at the festival dinner, the Prince thanked Henry Burdett for his efforts in the hospitals' cause, and for his work as a steward to make the dinner a success. It was Burdett who first suggested the idea of a fund to the Prince, who initially questioned the leadership of such an appeal by a member of the royal family, and the association of the fund with Queen Victoria's Diamond Jubilee. The risk of rivalry with Hospital Sunday arose, but at length agreement was reached.²⁷ Even before Jubilee year began rumours were circulating about the possibility of a commemorative fund. *The Lancet* expressed the hope that a group of wise and influential people might invite contributions, and that the money might go to the hospitals rather than to a district nursing fund as on the occasion of the Golden Jubilee.²⁸ By 16 January 1897 the name of the Prince was being coupled with the possibility of a hospital appeal. The rumours intensified when Sir William Broadbent addressed the Charity Organisation Society, mentioning the possibility of a gigantic scheme for collecting money for the benefit of the hospitals on behalf of the Prince of Wales. Gigantic it would be, for if its object was to provide the additional £100,000 a year the hospitals needed, either from annual subscriptions or as income from investments, the effort required would be enormous. Sir William pointed out the need for a distribution committee to obtain information from the hospitals and to allocate money on the basis of their merits. *The Lancet* thought that the committee established by the Charity Organisation Society to work for the formation of a central board could serve the Prince well. The Charity Organisation Society had never shown much of a tendency to help the hospitals with their financial problems, although it was ever ready with good advice. Now was the time for all to work together for the good of the hospitals.²⁹ The accuracy of the rumours became apparent when the Prince wrote to the press to launch the appeal.

Those invited to the first meeting of the general committee on 21 January 1897 at Marlborough House were mainly of high rank in the church, the City or the state. Burdett was present, and he became a



1897 issue

member of the Organisation Committee formed in February 1897, which met two or three times a week to get the appeal under way.³⁰ Burdett was a member from the outset of every significant committee formed by the Fund, and it was said that in twenty years he never missed a council meeting.

He personally undertook much of the early correspondence with the press, the savings banks and the printers, and he assisted in the selection of the first permanent officers.³¹ For these services he was awarded the KCB in June 1897.²⁷

Introducing the appeal the Prince said: 'Public opinion has shown itself on more than one occasion, and I think wisely, in favour of the voluntary system for support for our hospitals, combined with an adequate system of representation of the body of subscribers in their control and management. It is obvious, however, that if these institutions are to be saved from state or parochial aid, their financial condition must be secured.' The aim of the Fund was to place them on a sound financial footing with an additional assured income of £100,000 a year.³² The Prince himself took the lead in selecting the members of the general council, chairing its meetings. Lord Rothschild agreed to become treasurer, and wrote to city financial institutions seeking donations. The Lord Mayor of London pledged his support, Grocers' Hall and the Bank of England provided premises and facilities, and two conferences of the clergy supported the appeal. Unlike the councils of the Sunday and Saturday Funds, whose members were essentially representatives of the subscribers and subscribing bodies, members of the council of the Prince's Fund were personally selected. To be appointed to the council was a high honour

and feelings might be hurt when it was not forthcoming. Sydney Holland (later Lord Knutsford) at one time considered himself to have been passed over.

Hospital stamps were printed by De la Rue for sale to allow all class to subscribe with the minimum of difficulty; it was Burdett's idea. The plates from which the stamps were printed were smashed ceremonially when the run was completed. Each stamp bore the Prince's signature and a picture of Charity, after a painting by Sir Joshua Reynolds. The 1/- stamp was blue, the 2/6 orange, and they could be stuck in a small book which contained a message from the Prince. A second issue of charity stamps the following year was less successful, and this method of raising money was abandoned.

The development of the Fund's policies

There was widespread acceptance of the Prince's view that state control of the hospitals should be avoided. Even the radical and reforming *Lancet* had ceased to advocate the establishment of state hospitals, believing that patients were cared for better under a charitable system, that the management of individual hospitals was better than 'local municipal wisdom' and that state control would lead to the loss of charitable money.³³ The council of the Prince's Fund appreciated at an early stage that the great difficulty would be who was to administer the fund. If a board was constituted, the great hospitals, and probably the lesser ones as well, would claim representation on it.³⁴

The Fund received much free advice. The secretary of the Royal Westminster Ophthalmic Hospital suggested that the Coal, Corn and Finance Committee of the Corporation of London would distribute the money sensibly. C S Loch wrote to *The Times* to urge the Fund not to use the method adopted by Hospital Sunday, which had showed little inclination to use its power to stamp out hospital abuse. *The Lancet* wanted the Prince to limit the duration of his appeal to avoid undermining the existing central funds. Distributions should also be made in a way which would discourage abuse by those above the poverty line, doctors should have a say in the way the money was distributed, and the opportunity should be taken to initiate a central board. The British Medical Association believed that monies as vast as those of Hospital Sunday and the Prince's Fund should be distributed by a committee which worked in public, including representatives of

the hospitals themselves, akin to the central board for which the Charity Organisation Society was pressing. It would then become the parliament of hospital finance in London.^{35,36} The views of Stephen Coleridge, treasurer of the Victoria Street Society were predictable. In a letter to the Prince, released to the press, he asked that hospitals whose medical schools conducted experiments on 'helpless dumb animals' should be excluded from the distributions. On 8 May 1897 Sir Francis Knollys replied in His Royal Highness' name that there was no intention of devoting any part of the Fund towards the support of medical laboratories.³⁷

The Prince decided that the appeal should not be limited in its duration but to avoid trespassing on the sources of money of the Hospital Sunday and Saturday Funds appeals would not be made from the pulpit or in factories. Many feared that money given to the new fund would merely be diverted from the other central funds, or from the hospitals themselves. Because of the controversial nature of the Charity Organisation Society's proposal to establish a central hospital board, to which the hospitals were opposed, the Prince's Fund decided that it would be inexpedient to be associated with that movement, or with the Hospital Reform Association.³⁰ *The Lancet* came to believe that this was a sensible decision, for even the protagonists of the idea could not agree on the form a board should take.

As soon as the appeal had been announced letters began arriving; some enclosed donations, small and large, others asked for assistance. The Mayor of West Ham wrote saying that his borough was really part of London; he would launch a local appeal for the Fund if he was assured that West Ham's hospitals would be eligible for a grant. Less subtle correspondents, like some from Finsbury, were told that it was too soon to enter into questions of distribution.

Allocating the money

Amongst the Prince's advisers was Lord Lister, who was asked to give his views on the way the money should be distributed. Lister thought that while examining the management and financial needs of the hospitals would be a considerable task, the greater problem would be to decide which hospitals were run on a sound professional basis; poor decisions would bring the Fund into disrepute. An authoritative group of advisers was necessary and Lister thought that the Central Hospital Council, formed by the teaching hospitals after the outcry against

'hospital abuse', would serve the purpose. Its chairman, Sir Trevor Lawrence, agreed it should assist if asked.³⁸

To turn to outside bodies for advice was not what the Prince had in mind. Following a memorandum on methods of allocation written by Burdett ³⁰, a distribution committee was formed which in turn appointed a visiting committee to inspect the hospitals. The visiting committee consisted of physicians and surgeons of wide experience, with an equal number of laymen who were interested in hospital management. In the first year the Fund sought the assistance of Hospital Sunday, and in June 1898 asked the advice of the Central Hospital Council on the management of certain small and special hospitals. After that it relied entirely on the advice of its distribution committee, chaired by Lord Lister, and the visiting committee under Sir Trevor Lawrence. Hospitals lying within seven miles of Charing Cross were divided into four groups: north-west, north-east, south-east and south-west, and underwent 'thorough inspection and enquiry'.

The report on The London Hospital showed that much needed to be done, and it was agreed that if the hospital would spend up to £100,000 of its own capital on the necessary work, the Fund would make an annual grant of £5,000 - well above the level any other hospital received. Money was usually distributed for specific purposes, to open closed beds and to improve facilities, as well as a general grant-in-aid. The Prince wished capital sums to be allowed to accrue, only the income being distributed. The distribution committee was therefore able to provide more support year by year, and annual grants were reasonably secure. While the Sunday Fund's grants were used for general maintenance, those of the Prince of Wales' Fund were an instrument of change, strengthening the hospitals and the voluntary system. Hospitals were given a clear idea of what was expected of them, but the visitors' remarks were confidential as the Fund did not wish them used as evidence of need when an appeal was to be launched. Grants were in danger if the next report from the visitors indicated that no action had been taken. It became Fund policy to make grants of considerable size for major schemes of great importance. Guy's asked for assistance in the reconstruction of its outpatient department, and St Bartholomew's itself sought a contribution to its rebuilding fund.

Sir Savile Crossley, speaking about the new Fund, said that its work 'as an intelligence department, obtaining and collating information and

statistics relating to the hospitals, was of the first importance'. By degrees the examination of figures which had been verified by visits would enable the Fund to form useful opinions on many questions relating to hospital management. There was hope that this would be a means of preventing many of the mistakes and extravagances of the past.³⁹

From an early date the Fund made it clear that hospitals receiving grants were expected to maintain high standards of efficiency in organisation and equipment, and it was soon involved in advising hospitals on financial and architectural aspects of building schemes. Plans were sent to the Fund for comment in the hope that a capital contribution would accompany approval. When the annual accounts were submitted, the Fund would draw attention to above average expenditure. A patient's complaint or a press report which painted a voluntary hospital in a bad light would lead the Fund to ask the chairman of the hospital concerned for comments.

After Queen Victoria died the Fund became known as King Edward's Hospital Fund for London. The new Prince of Wales assumed the presidency but King Edward VII remained the patron, and donated the money which had been collected as his coronation gift. Further endowments in 1902 from Lord Mount-Stephen and Lord Strathcona brought the Fund to within striking distance of its target income of £100,000 a year. Regrettably by this time few still believed that even a sum of this size could keep London's hospitals solvent. In 1907 the Fund received a charter, under a private Act of Parliament, which established the constitution and governance. The royal presidents remained active in its affairs, approving minutes and expressing views on matters of significance. From the start the Fund was not merely a source of money but of good advice.

The Central Hospital Council for London

The Central Hospital Council, formed in November 1897 to defend the interests of the teaching hospitals, consisted of representatives of the management bodies and medical staffs, but proved to be ineffective and unable to influence events. It did not have the resources of the King's Fund, nor did it always command the support of its constituent members. It fought for a reduction in hospital rates (1898), considered 'hospital abuse' (1899) and discussed the anti-vivisection campaign (1900). It opposed the creation of a central bed bureau when the

Hospitals Association proposed one, as inexpedient and lacking 'practical utility' (1903). It opposed state registration of nurses (1904), and considered the charter of the King's Fund unsatisfactory (1907). It gave evidence to the Royal Commission on the Poor Laws (1908) and commented on the National Insurance Bill (1911). However the hospitals took little interest in its work, and the chairman, Mr Harben of St Mary's, resigned in 1910 because the council seldom gave a lead, preferring to delay discussion until the hospitals had already decided what should be done. Harben said that the council tended to shrink from the questions addressed to it, and he doubted if it could serve any useful purpose. Indeed major problems like the question of hospital relocation and rebuilding were not considered at all by the council. Nevertheless it continued to meet until the 1914-1918 war.¹⁹

Money and the medical schools

Because the London medical schools were essentially part of their parent hospitals the financial arrangements between school and hospital were close and complex. For example at the Middlesex the school had been incorporated into the hospital in 1895, and placed under the management of a council of lay governors, medical staff and medical school teachers. At Guy's, Herbert Eason the dean wrote in 1904 that the medical school had no corporate existence and no property. Out of the students' fees a fund was formed, but without doubt this belonged to the governors.⁴¹ Stephen Coleridge, Hon Secretary of the Victoria Street Society, became interested in the schools' accounts and their sources of income. He examined the accounts of Guy's in 1897, and it is probably significant that when the Prince of Wales opened the hospital's new medical school laboratory that year he said that the experiments conducted on animals were performed under anaesthetic and in the interests of suffering humanity. In May and June 1901 Stephen Coleridge and the *British Medical Journal* disputed whether teaching hospitals like Guy's, the Middlesex, The London and Charing Cross, which had received sizeable grants from the King's Fund, had thus been enabled to increase the sum they made over to their schools. Coleridge believed that contributors to hospital charities did not wish their money to be spent on animal experimentation. He raised the question of 'the appropriation by the medical schools of money raised for other purposes' at an annual meeting of the Sunday Fund.

The Metropolitan Radical Federation also petitioned the Prince of

Wales in 1900, objecting to the contributions voluntary hospitals made to medical schools, and implying that hospitals engaged in human experimentation.⁴² Sir Henry Burdett had little time for the antivivisectionists, but he agreed that it was wrong for a hospital committee to devote any portion of the funds subscribed for the relief of the sick to the purposes of medical education. He regretted that some hospitals had 'very weakly' given grants to their schools. The hospitals had suffered financially from Coleridge's attacks, and had it not been for the education issue the antivivisectionists would have had no case against the hospitals.⁴³

In the light of the pledge that the Prince of Wales had given,³⁷ the King's Fund established a committee in 1904 chaired by Sir Edward Fry and including the Bishop of Stepney and Lord Welby, to determine whether any money subscribed for the relief of the sick poor to any of the twelve teaching hospitals had been contributed to the hospital medical schools. The Fund gave the teaching hospitals less than a month to produce their accounts, and to comment on the mutual benefits the hospitals and schools gained from their association. At Guy's, the dean maintained that it was impossible to separate the provision made for the relief of the sick from the steps taken in the furtherance of medical education. Every dressing and every examination had as its chief purpose the treatment of injury or disease, but was also of educational value.

When he came to give evidence Stephen Coleridge tried to raise the vivisection issue, saying that had he not discovered that medical schools undertook vivisection he would never have become interested in their finances or started the agitation against them. He again insisted that the medical schools were only receiving support from their hospitals because the King's Fund had increased their income.

The committee worked rapidly and within a few weeks reported that two hospitals were not subsidising their schools out of hospital funds, two others were not clearly deriving a benefit from their hospitals, but that the remaining eight were receiving direct or indirect cash benefits. The report drew attention to the 'intimate and complex relations' between the schools and the hospitals, which made it impossible to draw up a cash balance of the more intangible benefits given and received by each. The committee felt that the mutual benefits balanced, and the hospitals should not, in addition, make cash contributions to the medical schools, save for specific services the

schools performed to assist the treatment of patients.⁴⁴ Mr Perry, writing from the Counting House at Guy's to Danvers Power of the King's Fund, said that whatever action the Fund proposed to take on the report should be taken promptly, at the next distribution. Otherwise Stephen Coleridge would have a reasonable grievance and would be on the warpath again, drawn sword in hand.⁴⁵

The Fund did not ignore the great importance of medical education, believing that the facilities afforded by the voluntary hospitals placed the whole community under a heavy obligation, but it became the Fund's policy to ensure that its grants were used solely for the purpose of patient care. Each year the hospitals had to submit a statement that no payment had been made to or on account of the medical school out of the general funds for the relief of the sick poor. Hospitals and schools were asked to keep separate accounts. During a dispute that rumbled on for a number of years the King's Fund withdrew its annual grant to St George's because the hospital appeared to be paying the medical school laboratories far more for their services than other hospitals.⁴⁶ Some hospitals wished to continue to assist their schools, not least because the schools annually supplied them with junior staff. The hospital authorities sometimes approached subscribers asking them to agree that in future their contributions could be paid into a 'discretionary account'. They could then be passed to the school if the house committee wished.²²

The King's Fund was always careful to maintain the distinction between the finances of the hospitals and those of the medical schools. Many years later it was still found necessary to produce a printed policy statement to issue to hospitals. In 1929 when St Bartholomew's launched a joint appeal for hospital and medical school it came into conflict with the King's Fund.⁴⁷ Yet medical school staff were not lacking in supporters. When the Research Defence Society was formed by the medical profession, Sydney Holland of The London Hospital became its chairman. He made it his business to satisfy himself that the research workers at his own hospital were not 'cruel monsters.' Thereafter he defended medical research in private, in public and later in the House of Lords. Year after year he fought a bitter controversy with Stephen Coleridge in the press, although in private they were good friends respecting each other's point of view. And when Stephen Coleridge himself lay ill, Sydney Holland made a point of visiting him.

University reform

The medical course became considerably stiffer during the second half of the nineteenth century. The facilities for scientific and clinical instruction were improved, at considerable cost. The private medical schools disappeared, and the medical schools of the great hospitals reigned supreme. The number of students entering the hospitals each year could be calculated from the information supplied to the Royal College of Surgeons, which collected the numbers for the Government Inspector of Anatomy Schools. The figures showed that the intakes rose progressively between 1850 and 1880, but thereafter the numbers fell.

London medical school intakes

1857	353 new students	(total 1,038)
1867	355 new students	(total 1,155)
1877	597 new students	(total 1,879)

By the early 1900s the London intake had fallen below 300 a year. While all the country's medical schools were affected, those in London were particularly hard hit. The financial viability of some of them was threatened. The dean of Charing Cross Medical School attributed this fall to the developing competition of provincial medical schools, the abolition of pupilage as a method of entrance to the profession, the effect of lengthening the course in 1894 from four to five years which had greatly increased the cost of a medical education and bad publicity resulting from the continuous campaigns to reform medical education in London.⁴⁸ A long standing problem faced by London medical students was the difficulty of the examination for the degree awarded by the University of London. The standard was recognised to be higher than that of the provincial and Scottish universities. Most medical schools therefore prepared their students for the more practical diplomas of College (of Surgeons) and (Apothecaries) Hall, or Conjoint. Only a small minority of students proceeded to take the university degree and schemes for university reform generally aimed to make it easier for students to obtain degrees, as well as to enable the university to teach in addition to examining.

Some reformers, believing that it would never be possible to change

the way in which the University of London operated, proposed the establishment of a second university in London or the granting of the right to award degrees to the Royal Colleges.^{49,50} The evidence given to the Select Committee of the Lords (1892) revealed the differences between those wanting a central academic establishment and those seeing medical education in more practical terms. Some favoured a degree of amalgamation of the smaller schools, particularly of their preclinical departments, and the Lords had recommended that if schools affiliated like the colleges of a university they might form a teaching institution able to afford and secure good lecturers. Much of the pressure for a 'teaching university' came from the need felt by the teachers to have some control over the content of examinations. Medical schools sometimes maintained that they were forced to follow a syllabus drawn up by university staff who might be less experienced than the schools' own teachers.

The constitution of the University of London was altered by Act of Parliament in 1900. The university rapidly established a faculty of medicine and appointed teachers, but the formal links established did little to alter the independence of the hospitals' schools. The curriculum was becoming crowded because of the pressure to include new subjects, and the expense of pre-clinical instruction was continuing to rise; indeed the cost of the pre-clinical course had trebled because of the need for laboratory facilities. As the schools had no financial reserves the teachers of pre-clinical subjects had to rely on the generosity of their clinical colleagues, or work largely at their own expense in the hope of future advancement. There was increasing recognition of the desirability of separating the pre-clinical subjects for which laboratories and specialised staff were required from the clinical years when students were mainly taught in hospital.⁵¹ In 1902 the faculty of medicine drew up a 'concentration' scheme for an Institute of Medical Sciences, to be located in South Kensington, which would teach physics, chemistry, biology, anatomy and physiology to all students, whichever hospital they proposed to enter and whatever examination they wished to take. An appeal was launched the following year and £70,000 was collected. However the concentration proposals met with opposition, notably from St Mary's, St. Bartholomew's and The London. King's College and University College also saw it as a threat to their well-established science faculties. In 1907 the faculty of medicine changed its mind, and the money collected had to be returned to the donors. Meanwhile, Sir Donald Currie gave £80,000 to University College Hospital to provide a

new medical school and, at the suggestion of the university, agreement was reached in 1905 that Westminster Hospital students would receive their pre-clinical education at King's College, and those of St George's either at King's or University College. Charing Cross made a similar arrangement in 1911, the students beginning their studies at King's College, 'enjoying the advantage of becoming University students in the true meaning of the term'.⁴⁸ Vacated space in a hospital seldom remains empty. As the students moved out of the laboratories the Charing Cross pathologists moved in.

The new constitution of the University of London was in the nature of an experiment, intended to reconcile conflicting interests by creating a body on which all were represented and which had supreme authority. It proved unable to conciliate the interests or exert authority - certainly not in medicine. Only three medical representatives sat on the senate, so nine schools had only the most indirect contact with policy making. In 1908 the possibility of a royal commission began to be discussed.^{52, 53} A commission was established the following year under the chairmanship of R B Haldane, the Liberal politician and a life-long friend of the Webbs. The remit of the commission covered all faculties, but medicine received particular attention. Three of the most important witnesses were the physiologist Professor Starling, Abraham Flexner and Sir William Osler.

Sir William Osler was a strong supporter of the university ideal of combining teaching with the advancement of learning. He had been concerned with the development of the Johns Hopkins Medical School and had precise ideas about the organisation of teaching, research and professorial clinical units. 'The hospital', he wrote, 'should become part of the university system. It is a great laboratory in which we collect for rectification the experiments which nature makes upon us. The study of disease is just as much part of university work as is the study of mathematics, and a close affiliation of the two institutions (school and hospital) is the best guarantee of that combination of science and practice which is the right of people at the present day to demand.'^{54,55}

Abraham Flexner, whose account of European medical education had been influential in the reform of medical education in the USA, drew attention to the unevenness of laboratory development, good at University College, reasonable at King's, Guy's and The London, but

otherwise inadequate. Flexner said that in the clinical departments the typical English physician was still of the intelligent empirical type; once on the staff he gave up the laboratory and with it the laboratory state of mind. Teaching offered incidentally by hospital staff could not be of university quality. The relationships of London students to their hospitals deserved to be copied, but the merits of the system were used as excuses for not attempting anything better.⁵⁶

The closely reasoned report of the royal commission appeared in 1913 and the unanimous conclusion was that the organisation of the university was fundamentally defective and that it could not develop into the type of university the capital city of the Empire should have. The report stated that the university had signally failed to gain the sympathy of the medical schools. The commissioners wished to see preliminary scientific studies undertaken at school and they did not want the preclinical sciences concentrated into a few institutions; Flexner had criticised the separation of pre-clinical laboratory sciences from the wards of a hospital. Radical changes were suggested for the clinical years. While paying tribute to the practical experience of London students, the royal commissioners said that such 'professional' training could never substitute for university education and the stimulus of working with teachers selected for their academic achievements, actively engaged in research. A consultant in busy private practice could not devote enough time to the development of his subject or serve adequately as a university professor. The main theme of the report was, therefore, the excellence of the London clinical tradition but the extraordinary inadequacy of support for laboratory work and the research required for the promotion of medical education.⁵⁷

The remedy proposed was to institute chairs in clinical subjects, form university medical colleges and introduce academic staff into the hospitals. A professor with a staff of assistants would control wards and an outpatient department, and would have laboratory accommodation for investigation and research. Students would be attached to the academic unit in the same way as they worked for consultants in active practice. It was suggested that perhaps three of the medical schools, with their attached hospitals, should be incorporated completely into the university.

These far reaching proposals aroused great controversy. How would the university obtain financial and educational control of one or more of

the medical schools which were in fact part and parcel of the hospitals? It would mean controlling the hospitals themselves while the hospital administration would have to continue to raise the money to keep the hospital going. The decision of the King's Fund following the report of the Fry committee to withhold grants from hospitals which made contributions to their schools from the general funds was an added complication. To run a medical school was no longer a profitable occupation. In many schools the staff had looked to the hospital for assistance in maintaining its viability. This had been the reason for the scheme to concentrate the preclinical sciences. House governors could see the economies which would result if every hospital did not have to support an expensive preclinical department.⁵

The process of selecting three schools out of twelve for full incorporation into the University was likely to be controversial. It would largely limit the selection of academic staff to those already working in the chosen hospitals, and there was more than a suspicion that the University would look no further than King's College and University College Hospitals. To divide the teaching hospitals into sheep and goats in this way was to few people's liking. It would also prove difficult to persuade governors, whose primary objective was the treatment of the sick poor, to continue to finance a hospital under university domination. Finally, if academic units were to be established they would require as many as two hundred beds to cover medicine, surgery and gynaecology. Only a very large hospital could provide this number if any room was to be left for the existing honorary staff.

The staff in many of the teaching hospitals did not accept that the picture was as black as Haldane had painted it, and teachers recoiled from the thought of entirely science-based and laboratory-educated doctors. The medical faculty of the university disagreed with the proposal that professorial units should be concentrated into three constituent colleges and thought they should be distributed amongst all the medical schools. The faculty concluded that it was undesirable to limit the scope of university influence by confining university medical education to three colleges.⁵⁸ However the Board of Education accepted the main thrust of the Haldane Commission and established a committee to consult on practicalities.

One new source of money appeared. In 1908 St Mary's Medical School successfully applied to the Board of Education for a grant

under the Regulations for Technical Schools. In 1909-1910 eight schools in London received grants. Sir Robert Morant at the Board of Education considered that medical schools were just as entitled to financial aid as courses in engineering, architecture and mining. The state now regulated the qualification of the profession through the General Medical Council, and directly or indirectly was increasingly becoming an employer of doctors. It had need of adequately trained medical men.⁵⁹

Postgraduate study

By the 1890s there was increasing recognition that the development of postgraduate study would benefit both doctors and their patients.⁶⁰ At first postgraduate education was mainly tailored to those with specific needs, for example those proposing to take up a post in the colonies. Jonathan Hutchinson started a series of afternoon demonstrations at his personal clinical museum in Great Portland Street and soon after, in 1899, obtained a building in Chenies Street. In association with some of the medical schools he organised the Medical Graduates College and Polyclinic. The West London Hospital was also early in the postgraduate field, beginning courses in 1893. These proved so popular that the hospital provided library and lecture theatre facilities in a new building specially erected in 1901.

At much the same time the London Postgraduate Association was founded 'to make the wealth of London's clinical material available to practitioners'. The Association made arrangements with Charing Cross, Guy's, King's College Hospital, St Mary's, St Thomas's, the Westminster and University College Hospital, as well as with some of the special hospitals like the Brompton, Great Ormond Street, the National Hospital for the Paralysed and the London School of Tropical Medicine. For ten guineas a ticket would provide admission to all of them for three months. Other courses became available at the North East London Postgraduate College at the Prince of Wales' Hospital in 1902, and the London School of Clinical Medicine (the Seamen's Hospital) in 1906. The value, and in some circumstances even the necessity, of postgraduate education, was so widely recognised that there was no need to dilate upon it, said the *British Medical Journal* in 1908.⁶¹ The rapid progress of medicine called for a system which would enable all experienced practitioners to keep up to date. There was more to know, a more widespread desire to know, and a greater readiness on the part of those who knew to teach.

Most of the courses did little more than provide local practitioners with an educational stimulus. The contribution made by the University of London to postgraduate study was even less than to the undergraduate course and organised postgraduate education was hardly a success story considering facilities which were available. An article by Hawthorne suggested that there should be at least be a central bureau to provide information on the courses available, and cooperation in time-tabling.⁶² The erection of a new hospital as a postgraduate clinical centre might not be a practical possibility, but some general hospitals had very few undergraduate students. Might not one see that it would do better as the clinical centre of postgraduate education? It would need to be in the middle of town so that it could work with the special hospitals which were valuable sources of clinical experience, often with schools of their own. Such a development would make London the centre of postgraduate education in the English-speaking world, but in *The Lancet's* view there were problems in Hawthorne's plan. A hospital which welcomed all the best teachers in London would place the existing medical staff in an invidious position, and ill-feeling would be inevitable. Nevertheless, said *The Lancet*, all practitioners had a right to expect facilities which would help them keep abreast of the strides being made in scientific medicine.⁶³

The distribution of hospitals

The clustering of hospitals in the middle of London had been the subject of adverse comment for fifty years. The point had been made by Florence Nightingale, for the third edition of *Notes on Hospitals* contains maps showing the concentration in the centre of London and Paris. A fall in the population of central districts occurred in every decade from 1871, partly as a result of slum clearance schemes and the development of railway and tram systems, exacerbating the problem. The 1891 census showed a dramatic change in demography of London and other major cities. Growth in London was concentrated in an 'outer ring', in places like Leyton, Willesden, Tottenham and West Ham. The population of the Cities of London and Westminster, the Strand, and St Giles, showed a marked decline. Ten years later a further census confirmed the trend and the realities of metropolitan development became widely recognised. No more than a third of the growth which had occurred within fifteen miles of Charing Cross had

taken place within 'London proper'.

In April 1902 Mr Peyton Beale, a surgeon at King's College Hospital, wrote to *The Lancet* that before the twentieth century was far advanced the problems of hospital accommodation in London would have to be faced. The residential areas had changed and cheap and rapid transport facilities had been developed. The sick poor should be able to obtain relief near where they were living; those seeking medical education should go to the places where the sick poor were, and not expect the sick to come to them from afar off. The alternatives were to transfer great general hospitals away from the centre of London, or to build new general hospitals further from the centre.⁶⁵

It was said that hospitals needed rebuilding every hundred years, as developments in medical science outstripped the facilities available. The clinical activities of the hospitals were changed out of all recognition by anaesthesia, antisepsis, specialisation, the growth of outpatient departments and subsequently radiology. St Thomas's had been rebuilt and, as a result of the generosity of Sir Blundell Maple, University College Hospital was being reconstructed. But Charing Cross, the Westminster, King's College Hospital, Guys's, St George's, St Bartholomew's and The London all faced problems.⁶⁵ The question of relocation was frequently raised but governors of a hospital had no obligation to areas other than their own. There was a fear that a new district might not give adequate financial support. A hospital might also lose its traditional supporters.

In spite of pressure from the King's Fund, Charing Cross Hospital held to a decision taken in 1896 to expand into new buildings in King William Street. The Fund's visitors reported in 1898 that nothing could make the present building suitable for hospital purposes, and that in their view it should be pulled down and rebuilt elsewhere.⁶⁶ The hospital did not agree. Alfred Saxon-Snell, son of Henry Saxon-Snell, was appointed architect and fund-raising began. (The firm of Saon-Snell & Phillips was active in the field of hospital design in London until 1964).

Members of the theatrical profession, with which the hospital was closely associated, gave their services and a grand bazaar was held at the Albert Hall. The report of the King's Fund for 1902 included a request that any proposal for a new hospital, or for reconstruction or a major extension of an existing one, should be submitted to the Fund

before definite action was taken, in the hope of improving the distribution of beds. The Fund's distribution committee adopted a policy of supporting amalgamations, setting aside £5,000 to assist in the process. During 1903 discussions were held with orthopaedic, ophthalmic and ear, nose and throat hospitals. The report for 1904 suggested that those hospitals which devoted themselves entirely to one disease should work 'under as few roofs as possible'. It was implied that a judicious reduction in the total number of small hospitals might be advantageous. The prince referred to the high sense of duty of those hospitals which, by amalgamating, subordinated their private interests to those of the whole system.

The argument for relocation was taken up in 1902 by the newly formed Hospital Officers Association, a group within which 'progressive ideas and practical information about hospitals' could be disseminated to arouse keener interest in the medical charities. Its inaugural lecture was given by Mr Adrian Hope, secretary of the Hospital for Sick Children, and was concerned with the future of the voluntary hospitals. Hope believed that the King's Fund would become increasingly influential. He also thought that some hospitals would have to consider selling their present sites and using the money to rebuild better premises on less expensive land. Many London hospitals were in need of rebuilding to modern standards, reflecting the demand from doctors for better conditions. Decisions should take account of rehousing; for instance, the London County Council was moving 40,000 out to Tottenham.⁶⁷

The medical press paid little attention to Hope's lecture, but the proposal to relocate hospitals was picked up by the *Daily Mail* which published a map on Thursday 27th November 1902, showing the value of the existing sites of the hospitals, and where they might be moved to. (Back Cover) 'Control and organisation is necessary in any case', commented the *Mail*. An active correspondence followed.⁶⁸ Correspondents were virtually unanimous that relocation was a financially viable proposition. The Westminster Hospital stood in Broad Sanctuary, opposite Westminster Abbey, on a site worth £750,000. If the sale could raise only half a million, the two hundred and twelve beds could be rebuilt for £168,000 at Tottenham on a site four times as large, leaving adequate money to endow beds and meet running costs. Charing Cross could be rebuilt to serve the new population around Woolwich for £145,000, providing 175 beds. St Bartholomew's, because it was 'a large hospital and could not be moved so far', might

go to Clapham - 'a good central position'.⁶⁹ The relocation would cost £550,000 but the sale should raise £1 million. Costs of rebuilding were estimated to be £700 per bed.

The secretaries of hospitals which had been relocated supported the proposal but the great hospitals, whose removal was being proposed, were rather less than enthusiastic. Sir Edmund Hay Currie of The London Hospital and the Sunday Fund told the Hospitals Association that the transplantation of ancient charities must be approached in the most gentle manner possible.⁷⁰ Sir Trevor Lawrence, treasurer of St Bartholomew's, wrote to the *Daily Mail* to point out that the dense local population, the ever increasing workload, and the need for West End physicians and surgeons to be near at hand - impossible if the hospital moved to Battersea, Greenwich or Tottenham - made its present position absolutely necessary. 'No greater injury could be inflicted upon the sick and suffering poor of the City of London than to move it from the site where it has done incalculable good.'

In reply the newspaper analysed the population of the City, Finsbury and Holborn and showed that it totalled 200,000; 'on the accepted basis of one bed per thousand inhabitants' the district was over bedded. Guy's, King's, Charing Cross and the Royal Free with a further 1,200 beds lay within one and a half miles of Bart's. They were able to serve a population of two million where barely half a million lived. The paper also ran a news item about an aged plate-layer who broke his legs on Bexley station and had to be transported to Guy's, fourteen miles by rail.

The secretary of the Metropolitan Hospital, which had already been relocated, wrote to say that his staff had no difficulty in reaching the hospital as they were on the telephone. The matron at Tottenham said that their surgeon could ride his cycle rapidly through the quiet streets at night. The correspondence had served to emphasise what those working in hospitals had known for twenty years: that the population which had been moved as a result of slum clearance or the construction of new buildings was often poorly served; the economics of removal might often be sound; and that hospitals which had been moved were generally content. There was no doubt that they had gained in usefulness and in most cases the costs of rebuilding had been paid off.

The Times carried two articles on 7 and 8 January 1903, commenting

on the cramped site of St Bartholomew's and the need for better accommodation if the future of the hospital and its school was to be assured.

An editorial in *The Hospital* referred to the press coverage and stated that some pains had been taken to ascertain the facts. However much was spent on reconstruction at St Bartholomew's the hospital could never be brought up to the standard of a newly planned building. In any case the census showed that the population of the City was falling. It would seem better to sell the site and rebuild in Old Street on the site of the old St Luke's Hospital, next to the City of London Lying-in Hospital.⁷¹

In March 1903 Sir Henry Burdett addressed the Hospitals Association on the removal of large hospitals to congested districts or to the country. Sir Henry gave bed ratios for five concentric districts:

City of London	1:40
Stepney, Shoreditch, Finsbury Holborn, City of Westminster, Southwark and Bermondsey	1:418
Poplar, Bethnal Green, Hackney, Islington, St. Pancras, St. Marylebone, Kensington, Paddington, Battersea, Lambeth, Camberwell	1:1,054
Stoke Newington, Hampstead, Fulham, Wandsworth, Lewisham, Greenwich and Deptford	1:1,877
West Ham and Romford, Tottenham, Edmonton, Barnet, Hendon, Brentford, Croydon, Kingston, Richmond, Bromley and Dartford.	1:2,482

Taken as a whole the ratio was 1:922, which is remarkably close to the usual estimate of the needs of a population - 1:1,000. South London, Battersea and Tottenham had the greatest problems. Burdett considered it difficult to define hospital districts, for many patients would travel long distances to a hospital which commanded their

confidence. Yet the London County Council's policy of slum clearance, housing residents outside its own area, created difficulties in places like Tottenham. Burdett believed that the London County Council should finance Tottenham hospital, as its planning had created new demands for care. In the event it was the King's Fund which came to the rescue by responding to the hospital's requests. Very large grants were made to assist expansion. Soon over 50 per cent of the hospital's income was derived from the King's Fund. Burdett also referred to a report of a scheme to supply South London with beds by moving King's to Camberwell, mentioned the possibility of moving the Westminster to Battersea, and hedged on the question of St Bartholomew's. In the lively discussion which followed one speaker said that though City sites might be costly, there could be no better use for valuable land than the saving of human life. Sydney Holland of The London supported the amalgamation of King's and the Westminster on a suburban site, but when Burdett was asked what the attitude of the King's Fund might be to this proposal, the question was ruled out of order.^{70, 72}

Amalgamation, rebuilding and removal

Each of the great hospitals was in a different situation and each had to decide how best to resolve its problems. St George's and King's were on cramped and crowded sites and reconstruction where they were was virtually impossible.⁷⁰ St Bartholomew's and The London had more ground and wanted to rebuild on site. Both found it necessary to launch appeals to finance modernisation and were in direct and bitter competition with each other. St Bartholomew's mainly needed a new casualty department and accommodation for the special departments. This was made possible by the acquisition of part of the adjacent site of Christ's Hospital, the remainder being purchased by the Post Office.

The decision provoked such public criticism that a committee was established by the Lord Mayor to review the question. Witnesses pointed to the large working population served by the hospital, but Sir Edmund Hay Currie thought money would be better spent on a new site in north or south London while retaining a small up-to-date hospital

in the centre for outpatients and casualties. Burdett was undecided — either Bart's should stay where it was or be rebuilt on the St Luke's site in Old Street. The committee settled for rebuilding on site with one dissenting voice - Sir Savile Crossley.⁷³

St Bartholomew's appeal for £400,000 was launched by the Lord Mayor, with the sanction of the Prince of Wales and the support of the press. Sir Trevor Lawrence spoke of the great difficulties which would be experienced by the sick poor if the hospital moved, and the appeal was supported by the Chief Rabbi and the Mercers' Company, amongst many others.⁷³

St George's Hospital established a committee to consider removal to a suitable site within the area it served, mainly to the south-west, but problems arising from dual ownership of the site, the difficulty of rebuilding and endowing a hospital on the sum which could be realised from the sale, and a division of opinion amongst the medical staff brought the scheme to a halt.⁷⁴

King's College Hospital

The chairman of the committee of management at King's College Hospital, Lord Dillon, opposed removal. However, many of the medical staff recognised that there was over-provision in central London and that the construction of Kingsway from the Strand to Holborn had led to the removal of many of the poorer inhabitants. The existing buildings were 'obsolete in design and inadequate in accommodation', the existing site was small and upgrading to modern standards was impossible. Finally, Charing Cross Hospital had recently been enlarged and the City of Westminster was over-rich in hospitals.

In May 1903 the hospital council asked a special committee, including representatives of the King's Fund and the Mayors of Camberwell and Southwark, to consider the practicalities of moving King's.⁷⁵ The report, presented in July, was favourable. A site near Camberwell was given to the hospital by the Hon W H D Smith MP. It was in an area which had been identified by the select committee of the Lords as in need of a large general hospital. The governors, knowing the views of the King's Fund and that the King himself was in favour, petitioned the King and the Prince of Wales in November 1903, seeking agreement to removal and help in raising the £300,000 it would cost. The Prince of Wales 'approved entirely' and the King's Fund made a large grant.

At a meeting at the Mansion House the following March the Archbishop of Canterbury proposed a motion approving removal, and financial support was pledged. The King's Fund made significant contributions to the removal fund each year. A notable fund-raising event was an Elizabethan Fair - 'one of the most brilliant social occasions of 1906' - held in the grounds of Lincoln's Inn Fields. The Duchess of Connaught, the Lord Mayor of London and the ambassador of the United States each opened one of the three days it lasted.

The King's-Westminster scheme

Shortly after the decision was taken to move King's College Hospital the relocation of the Westminster became an issue. The hospital, in Broad Sanctuary, had undergone major reconstruction in 1877 but the building was far from satisfactory. The first report of the visitors of the Prince of Wales' Fund drew attention to the need for greater space but expansion was impossible; the hospital was in a strait-jacket.⁷⁶ Some of the staff saw that a hospital of modern standard could only be achieved by relocation and Sir Henry Burdett thought it might be a good idea, despite the financial problems, if the Westminster could move to Battersea and amalgamate with the Bolingbroke.⁷⁷ A merger between the Westminster and King's College Hospital was suggested by Sydney Holland of The London, writing to Sir Savile Crossley at the King's Fund. Several of the London hospitals were appealing for funds and this amalgamation would reduce the number of appeals. Holland thought it was a real scandal to have so many hospitals crowded together, while other places had none at all. If the Westminster could be persuaded to throw in its lot with King's the joint investments of the two hospitals would guarantee the success of the scheme. Believing that his association with the proposal would doom it to failure - a merger would make the position of The London easier - Holland suggested that the idea should come from elsewhere. He thought that Burdett would oppose any proposal he made and a scheme of this magnitude could not be carried through by 'ordinary humdrum, respectable methods'. The Prince of Wales agreed to raise the matter at a council meeting of the Fund, but it provoked opposition and a communication from the palace in June 1904 recorded that the King was sorry to hear that the Westminster had decided to oppose amalgamation. However his majesty hoped that the number of medical schools might be reduced.⁷⁸ 'The path of the amalgamator is thorny', commented one member of the council of the King's Fund.

Westminster - St George's

The reunification of the Westminster and St George's - separated for 180 years - looked a better proposition, at least initially, when discussed in 1913. A committee was formed to consider the development of a joint hospital of at least 300 beds, either at Clapham or Wandsworth Bridge, using funds released by the sale of both sites. There was every chance of success. It was generally recognised that many of the patients attending both hospitals came from Clapham and Wandsworth. The poor had largely disappeared from the neighbourhood of St George's and the area round the Westminster was served by other hospitals like Charing Cross. The proposal was widely welcomed and Sir Henry Burdett supported it in *The Hospital*. *The Lancet* commented that hospitals could not now live by ministering to highly paid domestic servants whose needs were catered for by the National Insurance Act. The King, patron of both hospitals, commanded that a letter be written stating that their majesties were most gratified to learn of the proposed amalgamation, which was likely to be for the greater benefit of the sick and suffering poor. Early enthusiasm for the project faded once a dispute arose on the choice of a site.⁷⁹ The St George's representatives and the medical staff of the Westminster voted for Wandsworth where a piece of ground was available between the gas works and the distillery. This was opposed by representatives from the Westminster on the grounds that a site at Clapham was nearer the existing positions of both hospitals and also to Harley Street. An analysis of patients' home addresses showed that more lived near Clapham than Wandsworth. The Westminster house committee refused to ratify the majority decision, and the King's Fund offered its 'good offices' in an attempt to settle the difficulty. The King himself studied the papers with interest, and much preferred the Clapham site. Relationships between the hospitals became strained. The chairman of the Westminster, believing that his hospital could not wait for St George's, bought the ground at Clapham to keep the option open while discussions proceeded. By May 1914 the Westminster was designing a 300 bed hospital for the Clapham site with the agreement of the King's Fund. The outbreak of war put an end to immediate prospects of a building appeal and the opportunity to sell the site in Broad Sanctuary.⁷⁶

A successful amalgamation

Sometimes the King's Fund succeeded in achieving an amalgamation, as in the case of the small orthopaedic hospitals. There were three, the City, the National and the Royal. In 1903 both the City and the Royal wished to rebuild, but the Prince of Wales, strongly in favour of amalgamation, was unwilling to lay the foundation stone of either if they rebuilt separately.⁸⁰ A meeting of the Royal and the National with the City agreed in principle that there should be a joint development with a town branch and a convalescent branch in the country. Because of its financial resources the King's Fund was able to make grants contingent upon a merger and to see the hospitals through if their combined funds were insufficient. Agreement was almost in sight when the City hospital reneged on the deal. Not only was the King's Fund irritated but the recalcitrant hospital found that it had lost its grant from Hospital Sunday as well. The palace thought that the refusal to cooperate was 'monstrous' and the Princess of Wales intimated that she was unable to attend a charity performance in aid of the City hospital. The King's Fund decided to support the more limited merger. 'It will cost a great deal of money' said a council member, 'let us hope it will be money well spent.'⁸¹ The door was left open for the City to join on equal terms at a later stage and this happened. The amalgamated hospitals received a new charter in 1905 as the Royal National Orthopaedic Hospital. The new building in Great Portland Street was opened in 1909 by King Edward VII and Queen Alexandra.

The Fund worked hard from 1903 - 1914 to secure the unification of the five ear, nose and throat hospitals, but this proved impossible.⁸² However it expressed great satisfaction at the unification of the London Throat Hospital with the Hospital for Diseases of the Throat, Golden Square, two hospitals which were the result of an earlier feud. It supported the unification of University College Hospital with the National Dental Hospital in 1914, and with the Royal Ear Hospital in 1918.

The nature of the voluntary hospitals made amalgamations a slow process. The King's Fund was advised by its executive committee not to take the initiative with amalgamations.⁸³ It was widely believed that a hospital's income was intimately related to its site. Hospitals that moved some distance seldom seemed to take their subscription lists

with them. When King's College Hospital went to Denmark Hill it had great difficulty making ends meet, but Charing Cross which rebuilt in the Strand succeeded in paying off its debts, albeit after several anxious years.

The financial affairs of the hospitals

In spite of the hard work of the central hospital funds the financial position remained parlous. Revenues rose but the hospitals 'developed an increased appetite to spend'. Burdett demonstrated that the case load of the inpatient and outpatient departments was increasing faster than London's population and that the cost of treating each case was also rising, a poor return he thought for all the effort put into fund raising.⁸⁴ Sometimes the hospitals received massive individual bequests. In 1900 Professor David Hughes left something approaching £400,000 to the Middlesex, The London, King's College Hospital and Charing Cross. *The Lancet* praised both the intelligence of his choice and his wish that a third of the income from the bequest should be added to the hospitals' capital accounts. In the same year Mr Rudolph Zunz of Wimbledon left £100,000 for the endowment of wards in the name of his late wife Annie. Thirty four hospitals ultimately benefited and many have an Annie Zunz ward to this day.⁸⁵

Few hospitals were adding to their capital and most were increasingly in debt. Their managers seemed to make a trade of poverty and those who succeeded in spending less than they received took great pains to conceal the fact from their subscribers.⁸⁶ The leading and most successful exponent of the method of spending to the hilt and then appealing for support was The London Hospital, which, thanks to the energy and quality of its officials and chairman, was able to carry on this dangerous game with comparative success. Sydney Holland, speaking of the continuous efforts which had to be made to raise money, said that 55,000 personal letters produced only 2,500 answers. In his experience it took one mile of writing to raise £200. The secretary of The London believed that if a hospital was seen to be an asset to society, the money would be raised. For voluntary hospitals the rule was 'that income would follow usefulness and efficiency.'²²

With the unceasing anti-vivisection campaign hindering subscriptions, the cry for help became increasingly acute, 'implying a burden which threatened to become intolerable and imperil the voluntary system of

support which had hitherto been little less than a national glory'.⁸⁷ Speaking at the annual meeting of the King's Fund in 1906 the Duke of Fife said: 'There is one thing which nothing seems to overcome, and that is the apathy of Londoners with regard to their hospitals. The great majority of them do not subscribe and the plain truth is that the London hospitals are maintained by a small number of charitable people.'

The business of hospital maintenance

'There is a type of philanthropist', said Burdett, 'who deserves to rank as high as the cheerful giver — the careful giver.'⁸⁸ The task of the careful giver was made easier by the tables in Burdett's *Hospitals and Charities* which was now joined by a new publication, the annual statistical reports based upon the returns to the King's Fund. The first report, which analysed expenditure but not income, appeared in 1903 and contained details from 16 hospitals.⁸⁹ It was confidential and was circulated only to those hospitals who had contributed. Each hospital agreed that it would not publish the figures, which provided a useful tool for internal investigations. UCH discovered that its expenditure was above average and it was paying excessively for beef; an investigation was set in hand and the contract price was obtained from The London for comparison. The reports, issued to the public from 1908, were based upon a revision of the uniform accounting system which was used by all three central funds.⁹⁰

Comparison of cost per case and cost per bed became progressively easier but a series of articles on financial aspects of hospital management published in the *British Medical Journal* indicated the problems of comparing hospitals which differed in size, the seriousness of the cases admitted and the quality of their equipment and supporting services. *The Hospital* considered that two tentative conclusions emerged from the analyses.⁸⁸ One was that a hospital tended to be more expensive to maintain when a medical school was attached to it; the other was that outlying hospitals seemed cheaper per occupied bed than those nearer the centre of London. It had often been argued that the work students carried out as dressers saved on nursing costs, but the figures suggested that nursing costs might actually be higher in hospitals with medical schools. Neither was it clear that the free care provided by the honorary medical staff resulted in financial gain. A large and eminent staff 'often meant expense in many directions'. The lower cost of suburban hospitals was easier to explain; all kinds of work were carried out more cheaply away from the

centre. Useful though such comparisons might be, account had also to be taken of the effect on hospital costs of the advances in medical treatment.⁹¹ Listerian techniques had vastly increased the costs of operating theatres, although resulting in a widening of the scope of surgery and faster recovery for the patients. The London Hospital had doubled its throughput, halving the length of stay. Hospitals had evolved into a kind of business involving three partners, each possessing rights. These were the patients, for whose benefit the hospitals existed, the medical staff providing the skill by which the patients were treated, and, finally, those who voluntarily provided the funds to be used by the other partners.

Contributions were welcomed from all sources but the charitable were not always broadminded or altruistic. Contributors to Hospital Sunday took offence when hospitals, including The London, organised film shows on the Sabbath, to raise money and provide working men with an alternative to the pub.⁹² Working men, subscribing to Hospital Saturday, expected a quid pro quo as of right, and to have a say in management. They did not see their contributions as an act of charity but as a form of insurance.

Outpatient departments

The British Medical Association continued its attempts to protect the livelihood of general practitioners by restricting the size of outpatient departments and the income groups to whom they were available. The association held a conference of the medical profession and members of hospital management committees in March 1905. The following year it petitioned the Privy Council to withhold a charter of incorporation from the Hospital Sunday Fund on the ground that it did not use its influence to end hospital abuse and restrict outpatient departments to cases referred by general practitioners.⁹³ The Charity Organisation Society also opposed a charter, believing that the Sunday Fund and the King's Fund should amalgamate.

At yet a further conference called by the British Medical Association in December 1906 Sir Henry Burdett proposed a motion approving proposals to limit the size of outpatient departments, seconded by the chairman of the Hospitals Committee of the BMA. The teaching hospitals could not accept this limit upon their freedom and the chairman of St Mary's intervened. The meeting agreed that the proposals would receive further consideration, rather than a welcome.

94 Sir Henry Burdett clashed with Sydney Holland, chairman of The London Hospital, at a meeting of the Hospitals Association a fortnight later. Sydney Holland said that he was not dependent on the praise or blame of Burdett or his paper *The Hospital*; nor was he dependent upon Sir Henry for his position in the hospital world - he was afraid it would not be a very high one if he was. Sir Henry had stated that because the population of London had increased 6 per cent in the last decade while hospital patients had increased by 23 per cent there must be hospital abuse. That assumed that all patients had been treated ten years ago who ought to have been treated. Sir Henry failed to see that times and hospital care were changing. The special departments had a particularly high rate of growth. The hospitals had not added new accommodation for their own amusement, but because the sick had to be provided for.⁹⁵

The British Medical Association called one more conference in 1908 but the topic was becoming a little threadbare. Hospital representatives were conspicuous by their absence. Burdett said that the meeting was in the main a rebellion by general practitioners against hospital outpatient departments and did the hospitals little good.⁹⁶ The King's Fund decided to hold its own enquiry once the report of the Royal Commission on the Poor Laws had been published. It established a committee in December 1910 to consider and report 'upon the circumstances and conditions under which patients were seen at the outpatient departments of London voluntary hospitals and the precautions taken to prevent the admission of persons who were unsuitable'. It was an attempt to resolve an issue souring relationships between general practitioners and the hospitals.

The committee held 27 meetings and heard 48 witnesses. It was agreed that, ideally, outpatient departments should have a consultative role but witnesses could see no sharp distinction between suitable and unsuitable patients as far as their financial circumstances were concerned. The possibility of an external method of sifting the patients who were to be seen was considered, for example by relying on general practitioner reference. The argument for such a procedure was that once patients were allowed to come it was difficult to turn them away or to enquire into the means of the large number involved. However, the committee did not think it would be possible to close the free access of patients to hospital in the absence of a tried and trusted sifting mechanism. Instead preference was expressed for the approach of the Charity Organisation Society and the majority report of

the Royal Commission on the Poor Laws - to rely on the almoner system to exclude those able to pay and the truly destitute, as well as those able to subscribe to provident dispensaries. The committee wished to see the development of provident dispensaries on a large scale because, with a national insurance scheme of some type, they would help to reform outpatient departments by providing an alternative form of care. In any case it was essential that the hospitals adopted a uniform standard of acceptance in the outpatient departments.

But times and attitudes were changing. Increasingly people felt that the gospel of honest independence ignored the very reasonable view that society might choose to support those who, in bad times, could not support themselves - and without perpetuating the division between the destitute and the rest. The conception of the function of hospitals was widening; the introduction of new and costly medical treatments meant that only hospitals could treat some conditions, raising the income level at which a patient needing treatment had to be regarded as 'necessitous'.

The remedies proposed for 'hospital abuse' were ineffective. For thirty years the cry of 'hospital abuse' had been heard, said the Fabian Society, despite which there had been a steady rise in the numbers seeking relief. The solutions suggested were futile and displayed a great ignorance of human nature. Cooperation between general practitioners and hospitals was, in the Fabian view, only partially possible under the economic conditions of practice. A coordinated state service of medicine was the only solution they saw which would be in any way satisfactory.⁹⁸

The Royal Commission on the Poor Laws (1909)

This royal commission was appointed in 1905 at the very end of a parliamentary administration and reported four years later. There had been criticism of the poor laws from all sides, but precisely why the commission was established at this juncture is far from clear. Some saw a need to restate and reinforce traditional principles of destitution relief; others to challenge them. The remit of the commissioners was wide, and hospital affairs formed only a small part of their task. Although the two reports of the majority and minority had little

immediate or direct effect on either the poor law infirmaries or the voluntary hospitals, they set the scene for future developments. The commissioners themselves were people of experience, distinguished as practical reformers and creative social thinkers. Several guardians were selected as commissioners, and they were inevitably committed to the principles of 1834. The guardians had become a powerful lobby with strong esprit de corps. Four senior officials from the Local Government Board were members; there were two economists, Charles Loch from the Charity Organisation Society, and leaders in social study and research such as Charles Booth and Beatrice Webb, for whom William Beveridge acted as a research assistant.

The commission was far less successful in its early impact than its predecessor of 1834.⁹⁹ Then the principles gained widespread acceptance and were rapidly implemented across the country. In 1909 not only were the commissioners divided, but their divergences made the adoption of proposals based upon either the majority or the minority reports a serious and controversial matter. The campaign that the Webbs waged against the majority report, and in favour of the break-up of the poor law, further reduced the chances of legislation.

The two reports had much in common. They condemned the existing system and wished to see an end to the mixed workhouses. Neither wished there to be indiscriminate relief without detailed investigation of the applicants. The majority report reflected the views of the Charity Organisation Society. It recommended the abolition of the guardians and the transfer of poor law responsibilities to new public assistance committees consisting of county and county borough council members with the co-option of representatives of local charitable organisations. Beatrice Webb's minority report, instead of retaining the Poor Law in fact if not in name, wished the services to be divided amongst a number of expert and specialised agencies, so that the necessitous could be provided for alongside other members of the population. Underlying the minority report, and much of the Webbs' thinking, was a belief that a certain measure of discipline, even compulsion, might be necessary for the public good. Citizens had to remember that they had duties as well as rights. Both reports, in the event, proposed radical solutions although the effectiveness of the Webbs' campaign for the abolition of a destitution authority obscured to some extent the sweeping changes proposed by the majority.

With so many problems to consider, it is hardly surprising that neither

report said much about London's hospitals. There was some criticism of the overlap of services. One of the commissioners, Norah Roberts, conducted a survey of the extent to which outpatients at St Mary's, the Royal Free and St Thomas's were also receiving assistance from the poor law. She found 'an extraordinary antagonism between the two agencies'. Relieving officers resented the work created by hospitals who applied for the removal from their wards of the homeless and encouraged patients to demand relief. The hospitals complained of the slowness of the guardians in coming to the rescue by accepting responsibility for destitute patients. Norah Roberts suggested that the relationships between the two organisations should be clearly defined by a disinterested and authoritative power.¹⁰⁰

Both the boards of guardians and the voluntary hospital movement viewed the reports with suspicion. In April 1910 representatives of the voluntary hospitals met at Guy's to re-form the old Hospitals Association, which Burdett, not unnaturally, considered responsible for much good work while it was an active organisation.¹⁰¹ Cosmo Bonsor, the president of Guy's, became the president of the new association, and Burdett joined the council. Its objective was to provide a forum within which 'organised institutional opinion' might be developed, and its first action was to convene a conference in October 1910. The two key speakers were Charles Loch and Mrs Sidney Webb, representing the majority and minority factions. Each discussed the role they saw for the voluntary hospitals in the future, Loch considering that they might be institutions where people would be treated who could pay something towards the cost of their care, although not the full economic cost.¹⁰² Beatrice Webb started by postulating the existence of a 'unified county medical service' managed by local authorities. This service would include both the infirmaries, freed from poor law control, and those voluntary hospitals who wished to join. The voluntaries might treat particular types of cases within the scheme, perhaps those requiring the specialised attention available from their superb visiting staff. Mrs Webb said that any question of 'nationalisation' or 'municipalisation' was so remote from practical politics that it did not need to be discussed. If the voluntary hospitals treated patients free of charge, that would save the rates. If they wished to charge for their services, then the local health authorities might have the right to nominate a limited number of board members.¹⁰³

A united county medical service was still a long way off, but the guardians could see problems ahead. With progressive improvements in staff and equipment the demand had risen, as it had for treatment in the voluntary hospitals. Increasingly the poor law infirmaries were serving artisans on good wages, as well as the truly destitute. Mr Lockwood, the Metropolitan District poor law inspector, recorded in his reports that there had been no reduction in the numbers seeking indoor relief, even though there had been no severe winter nor a depression in trade.¹⁰⁴ He thought this was due to the excellent provision for the sick and the superior medical and nursing services now provided. Indeed he listed the many improvement schemes in progress: new infirmaries for Bethnal Green and Islington, extensions to Camberwell and Hackney infirmaries, and the purchase of a site for an extension in Whitechapel.

The new infirmaries were well designed and the building cost was reasonable. The Local Government Board insisted upon a site large enough to allow a free circulation of air around the ward blocks. Architects were involved from earliest stages which did not happen when a voluntary hospital was to be built; a site might be bought on the advice of anyone but an architect and later found to be too small, as happened at King's College Hospital, Denmark Hill.¹⁰⁵

Improved nursing standards

As a result of Miss Twining's long campaigns nursing standards were also improving. By the early 1890s, according to her evidence to the Select Committee of the Lords, it was rare for an untrained nurse to be appointed as matron of an infirmary in London.¹¹ Pauper nurses were being withdrawn slowly and were barred in 1897, although they continued to act as assistants. The Central Poor Law Conference discussed the best way of supplying and training infirmary nurses at the Guildhall in 1899. Infirmaries were increasingly setting up their own training schools. At Lambeth the medical superintendent, the matron and the home sister gave lectures to the probationers in their off-duty hours. Before receiving their certificates they had to pass an examination usually conducted by a doctor from St Thomas's.¹⁰⁶ Clinical services were expanding and although some patients would be transferred to a voluntary hospital if surgery was needed, serious operations were increasingly undertaken by infirmaries. In 1889, 128 operations were carried out at St Marylebone, of which 30 were major.

In 1909 the numbers had risen to 386 and 79.107 Nevertheless the wards were crowded, particularly in the winter, and extra mattresses might have to be put down. The guardians varied in their strictness in testing eligibility of those applying for relief. In Islington they turned to the Charity Organisation Society for help in determining which applicants should be assisted from the rates, which qualified for charitable assistance, and which were well able to help themselves. *The Lancet* praised this action for 'the rates of the parish were saved by it, and the poor were helped in a way agreeable to their self-respect'.¹⁰⁸

While some of the larger provincial cities had also separated the sick from the general pauper population, the separate infirmaries of London had carried the process further than most other towns. Yet there were wide variations within London. Dr Thackray Parsons, the medical superintendent of Fulham, presented tables showing the staffing levels and the nature of the equipment of each infirmary, when he addressed Central Poor Law Conference in 1910. He defended the more active boards of guardians like those of Hammersmith, who were criticised in the press for their expenditure. Construction costs of £350 per bed enabled the Hammersmith Infirmary to provide conditions of hospital standard for the treatment of patients 'who were curable under good conditions'. Dr Parsons pointed to the differences in the type of case admitted to infirmaries. The average length of stay in the City of London Infirmary was 113 days, whereas at Fulham it was 40.4 days. There were twenty deaths each year for every 100 occupied beds at the City of London, compared with 129 at Fulham, which was clearly admitting patients who were acutely ill. Equipment at the infirmaries compared badly with the voluntary hospitals; most had operating theatres but many did not have a bacteriological laboratory or an X-ray department. The number of beds per nurse varied between 2 and 2.6 in the voluntary hospitals, while 8-10 beds per nurse was the rule in the infirmaries.

Dr Parsons did not believe that the infirmaries should restrict themselves to chronic and incurable patients; there were so many acute cases in London that neighbouring voluntary hospitals frequently had to refer cases of burns, appendicitis, fractures and pneumonia to Fulham because their own wards were full. To solve the problem by doubling the size of the voluntaries was out of the question. Even were

this to be done at the expense of the guardians, problems would arise, for state-aid would raise questions of governance. A better answer seemed to be to improve facilities, staffing and salaries in the infirmaries. Parsons foresaw the growth of a large public medical service in each county, providing a system of hospitals with specialist departments, sharing the work amongst themselves. If the separate management of each infirmary ceased and the hospitals of the Metropolitan Asylums Board and the infirmaries were brought under one centralised body, many advantages would follow. Joint specialist staff could be appointed, nurse training could be improved and better use made of beds. Situations sometimes arose in which one infirmary was crowded whilst its neighbour was half empty. Dr Parsons told the guardians that there would be advantages in concentrating all the poor law medical, public health and lunacy work under one committee of the London County Council. He would grant that the guardians had done good work but further improvements required a new administrative structure. During the debate which followed it was clear that the guardians did not agree that their staff were underpaid, for there was no shortage of applicants. Neither did they think that a change of administration was called for. Dr Parsons was thanked politely for his address.

The National Insurance Act (1911)

Before the Poor Law Commissioners had reported, old age pensions had been introduced and other measures followed. Lloyd George's National Insurance Bill was an attempt to tackle the problem of ill-health which threw so many respectable people onto the poor law. The act provided insured workers with care from a 'panel doctor' but with the exception of sanatorium treatment for tuberculosis workers were not eligible for hospital treatment.

The main professional opposition came from general practitioners but hospitals also saw the legislation as a threat as it was likely that the demand for inpatient care would increase.¹⁰⁹ The Central Hospital Council met at St Thomas's and protested that it had not been consulted. A special committee of the British Hospitals Association drew up a memorandum to the Chancellor of the Exchequer stating that the act would reduce subscriptions and interfere with the training of students. Mr Lloyd George received a delegation and was asked if payment could be made to the hospitals for accidents, serious or unusual diseases and for those needing operations or skilled nursing.

Sydney Holland told Lloyd George that it was essential that the hospitals should not be hurt, but the chancellor did not believe that subscriptions to the hospitals would be reduced merely because employers were paying part of the cost of a general practitioner service.¹¹⁰

The Fabian Society established an enquiry chaired by Sidney Webb which reported that even in London the principal hospitals had long waiting lists. Non-urgent cases had to wait three months for admission. For its 8 million inhabitants London had no more than two beds per thousand, when the requirement was somewhere between two and five. Webb recommended that insurance committees should contract with voluntary hospitals to ensure efficient treatment, the cost being met by an additional parliamentary vote. He thought that the provision for tuberculosis was particularly bad. No treatment was provided in hospital for incurable cases even if insured, and none for the uninsured, even if curable.¹¹¹

Burdett thought that the state, as a matter of justice, should pay for the services which were the inevitable consequence of legislation, and that the hospitals should be given assistance without losing the dignity of their independent management. *The Lancet* said that this view was comforting if not quite convincing. The only alternative, however, was a system of state hospitals which would prove an enormous burden, estimated by the royal commissioners at £20 million per year. Was it a proposition any politician would dare to advance? ¹¹² Forty years previously *The Lancet* had supported the idea of a state hospital service; now it had second thoughts.

There was no consensus amongst the medical profession about the relationships which should exist between doctors and the state. An extreme right party believed that beyond securing the proper education of doctors, and providing a sanitary service to safeguard the drains and control epidemics, the state should leave the medical profession alone to carry out its beneficent work in absolute independence of all government control. These devoted individualists were prepared to die in the last ditch before they would sacrifice the smallest outpost of professional liberty. An extreme left party saw salvation in the Fabian socialist proposal of state employment for all doctors. Illness could then be treated, as Beatrice Webb had suggested, as a public nuisance to be suppressed in the interests of the community, by compulsion if necessary. Some believed that the government should

take responsibility for seeing that its medical employees carried out instructions faithfully to offer or force upon each member of the community the medical services the state considered necessary to maintain physical health.¹¹³

Between these two factions there was a large central party which recognised the impracticability of the ideals of the extremists, the disorder in medical charity, and the need for an honourable partnership between the state and the medical profession, to bring the benefits of medical science to individuals and society, irrespective of wealth or social position.¹¹⁴

The dilemma of the voluntary system

The supporters of the voluntary system were becoming increasingly aware of the strengths of the competing service. In 1866 Ernest Hart had drawn attention to the possible long term effects of rebuilding the poor law infirmaries. While the infirmaries could not match the quality of care and the contribution to teaching and research of the voluntary hospitals, the voluntaries no longer had the field to themselves. Lauriston Shaw*, a physician to Guy's, thought that functions might be divided, with the infirmaries handling day-to-day illnesses, while the voluntary hospitals developed specialisms to the highest level.¹¹⁴ This would make professional sense, whatever system of funding might ultimately be adopted. The *British Medical Journal* remarked that the public were coming to understand the convenience of 'throwing themselves upon the rates' and were doing so increasingly. In 1886 the Metropolitan Asylums Board had treated only one fever case in ten. By 1896, with a change in legislation which allowed the admission of patients who were not paupers, it was admitting 70-80 per cent. The population was being educated in the Fabians' municipal socialism.¹¹⁵

The complexity of the provision and the overlap of services for the sick had been criticised by both the majority and minority reports of the Royal Commission on the poor laws, and the two reports had this in common - that the system needed radical overhaul and that extensive changes must come. The reports had re-opened the question of a coordinated state hospital service, which was debated at the annual meetings of the British Medical Association in 1910 and 1913.¹¹⁶ A central hospital board to coordinate services had never been formed, and while the King's Fund was fulfilling some of its proposed functions,

it could not be regarded as a central board. It was not a representative body, as was pointed out by the Metropolitan Radical Federation. The Federation said that the working classes would have more confidence in the Fund if its council was elected, like the councils of other philanthropic bodies, by its subscribers at an annual meeting. The King's Fund pointed out that it was administered under the Act of Parliament specially passed in 1907. The Federation replied that if the act precluded the working classes from any participation it could always be amended.¹¹⁷ The Charity Organisation Society also criticised the fact that the Fund was not formed upon representative lines.¹¹⁸ Speaking to the Hospital Officers Association, the secretary to the Metropolitan Hospital said he wished that the King's Fund Council could be augmented by representatives of the hospitals and the other central funds. Then, if housed in fine offices, a visible sign of the public's wish to preserve the voluntary system, it would be a bulwark against municipalisation.¹²⁰ His colleague at The London Hospital also rallied to the defence of the voluntaries. 'Whatever may be the future of the voluntary hospitals', he said, 'nothing can rob them of their glory for the work they have done. They got on with the work while others were discussing.'²²

'We are indeed a very patient nation', said Dr Christopher Addison, the former dean of Charing Cross Medical School, who had become a member of parliament. Speaking at a dinner in his honour, with Lloyd George presiding, he said that it was impossible to survey the conditions of things in the capital city without coming to the conclusion that there was great room for improvement in the organisation of services.¹²¹ Sir Henry Burdett and Dr Lauriston Shaw* also believed that a coordinated hospital system was urgently needed, and that the future would bring the two types of hospital into closer cooperation. Burdett thought that the solution was nearer than many people supposed. It was predicted that London would need an additional 10,000 hospital beds as a result of the National Insurance Act, and if the voluntary hospitals were not funded adequately, the poor law infirmaries would have to be turned into state hospitals.

Sir William Osler, commenting on the prospects for the voluntary system at a conference in Oxford in 1913, was brief and direct. 'Give it up', he said. 'It is antiquated, out of date and it is not going to continue. Make up your minds that you must accept the principle of taking pay from patients. It answers admirably elsewhere.'¹²² An increasing number of hospitals began to charge patients who could afford to pay.

The poor law guardians were also engaged in self-examination. At their district and national conferences they debated the future, but fortified by their faith in the principles of 1834 they saw little need for the changes which had been recommended by both the reports of the Royal Commission. Reform might be necessary, but it should be reform from within, rather than the creation of an expensive new system.¹²³

The debates came to an end in August 1914. With the outbreak of war staff were mobilized and there were wounded needing care. The hospitals and infirmaries of London, like those throughout the country, put their wards at the disposal of the War Office and the Admiralty.

The hospitals were under contract to the armed services to supply a certain number of nurses in case of sudden need, and the first batch left The London Hospital on 4 August 1914. The Middlesex designated 80 beds for casualties, St Thomas's 200, St George's 100, St Bartholomew's 198 and UCH 100. The London, the biggest of the hospitals, promised 500, and had purchased extra bedsteads. On August 30, a Sunday, a request was received for the admission of 100 patients that evening, the hospital to arrange the transport from Waterloo. Mr Alfred Salmon, a board member and a director of Lyons & Company, lent dozens of the firm's vans. Whilst the patients were being received, with the mud of Flanders still upon them, there was a further request for the admission of another 200.¹²⁴

A large proportion of the resident staff and many of the consulting staff of the hospitals went on active duty. Many of those who remained were attached to territorial hospitals or base hospitals. The financial and organisational problems of the hospital system were put to one side for the time being.

*Lauriston E Shaw MD FRCP (1859—1923); physician to Guy's and Dean of the Medical and Dental Schools (1893—1901). Wholehearted believer in the economic and educational value of concentrating preclinical work; was secretary of the University of London's

Concentration Committee. Excellent clinical teacher. Sympathetic to the case of the Fabian Socialists, his support for contract practice and the National Insurance Bill led him into conflict with colleagues in the British Medical Association, for which he had previously been an active worker. 119

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Chapter 8 Developments in the hospital services between the world wars, 1918-1939

'But are we to compete? And is not that idea of competition the very mistake we are all making?'

Sir Ernest Morris, 1934 (House Governor, The London Hospital)

In medical terms the inter-war period was essentially one of consolidation. Methods of clinical investigation and surgical techniques improved, radium and radiotherapy became accepted in the management of cancer, and there were several major advances in therapeutics such as the introduction of insulin in 1922, sulphonamides in 1935 and blood transfusion services in 1937. Medical education improved as clinical units of a university nature were introduced into a number of London medical schools, and much thought was devoted to postgraduate education.

Hospital organisation and finance became critical issues. The financial crisis of 1920 slowed the campaign to break up the poor law, and was responsible for a drive for 'value for money' by coordinating the voluntary and poor law hospital systems which sometimes competed and always overlapped with each other. Ideas which had previously appeared almost revolutionary achieved a degree of respectability, and to overcome rivalries the organisation of all hospitals into a single system was suggested. Money being short, cooperation became the watchword.

The creation of the Ministry of Health in 1919, at the end of a hard fought inter-departmental struggle, was in some ways symbolic of new approaches to the provision of health care.¹ The Fabians had pointed to the confusion which existed between the health care activities of different government departments, the Local Government Board, the Board of Education, the Privy Council and the Home Office. The new Ministry gathered these functions together, under a Minister who was himself a doctor and a secretary and chief medical officer with deep understanding of medical and political realities. Sir George Newman, the chief medical officer, said that the Ministry reflected an understanding of the need to apply the principles of preventive medicine to the whole population. No longer would individual families receive services from several different organisations, which each worked in water-tight compartments 'along lines which never met,

covering the ground, or part of the ground, that others covered'.² The Ministry of Health had set an example in collaboration, and there was a political will to achieve cooperation between the hospitals as well. The new Ministry was given a guarded welcome by *The Lancet* and the British Medical Association, but its formation was seen in some quarters as a first move towards a state hospital service.^{3,4} The Minister, Dr Christopher Addison, reassured the hospitals that there was no intention of enforcing any particular principle or doctrine. But some senior civil servants, impressed by the organisational opportunities open to local government, saw the possibility of a chain of hospitals, united by motor transport, under local authority control. Taken to the limit, cooperation could eventually lead to the unified county medical service described by the Webbs, encompassing the health functions of local authorities, those provided under the poor law, and the voluntary hospitals great and small.

The British Hospitals Association, a successor to the old Hospitals Association, organised a conference at St Thomas's to consider the relationship of the voluntary hospitals to the new Ministry of Health. The association's secretary, Mr Buchanan, circulated a paper stating that the hospitals with their special and general departments, and their medical and nursing schools, must be maintained at the highest possible standard. A connecting link with the public hospitals was however necessary. The Association and *The Lancet* both agreed that the voluntary hospitals must be allowed to continue their great work, which stemmed from the individual freedom of the hospitals to undertake any enterprise which seemed to promise well.⁵

The experiences of the Great War demonstrated the form the connecting link might take. Men like Sir Robert Jones had developed systems allowing war wounded and soldiers with fractures to be evacuated for treatment, and doctors returning from the Forces had demonstrated their ability to plan and administer large medical organisations, cooperating in the provision of a unified service. Amongst them was Major General Sir Bertrand Dawson, physician to The London Hospital. In his Cavendish Lectures to the West London Medico-Chirurgical Society and during debates about the future of the medical profession held at the Royal Society of Medicine in 1918, Dawson maintained that an efficient service could not be self-supporting. Men and equipment must be distributed according to the needs of the community. Local hospitals and clinics should be related to central hospitals in larger towns which would provide specialist

services. These in turn might be subordinate to a larger provincial hospital, and all would be maintained by a health authority. Only the teaching hospitals might stand apart, for 'they served the nation whilst other hospitals served a town or county'.^{1,6}

Dawson pointed to the growing realisation that much disease was preventable and that the best means of preserving health and curing disease should be available to all as a right rather than by favour. He thought that administrative matters should be determined by a board consisting of lay and medical members; professional and technical questions by doctors alone. War service had taught the medical profession many lessons. During the early years of the war Dawson discussed grouping and regionalisation of hospitals, and later when he chaired the Council on Medical and Allied Services the military organisation of the country into 'commands' was seen as a possible model for health service organisation.⁶

Financial problems return

At the end of the war the financial position of the voluntary system was weak. Hospital subscriptions from the middle classes had declined and the formation of the Ministry of Health had led some to assume that the needs of the hospitals would soon be met in other ways. The voluntary hospitals no longer received payment for the treatment of war-wounded. Initially the hospitals had been worried about the acceptance of government support, for it breached the voluntary principle to receive state aid. The withdrawal of these funds left the hospitals in difficulty. Inflation during the war had increased hospital costs considerably. The King's Fund's distribution committee was particularly concerned with the expenditure of The London Hospital, which was the subject of a special report. Its costs had risen faster than those of the other great London hospitals. In vain did Lord Knutsford protest that his hospital treated more patients per bed than any other, and that the length of stay was the shortest.

Many hospitals had deficits despite the contributions made by local authorities as part of schemes for treating tuberculosis and venereal disease. In recognition of the problems the grants made by the King's Fund in 1918 were increased, and were the largest in the Fund's history. In spite of the difficulties a number of hospitals were preparing schemes for extension, which seemed to many a good form of war memorial. The annual report of the Fund for 1918 pointed out that the

combined effect of many developments, good though they might be individually, would be to add a large number of beds to the total in London. The Fund feared that the revenue available would not increase in parallel, and that the problem of closed beds which it had dealt with successfully at the turn of the century would emerge once more. The new beds might not be provided in the areas needing them most; the Fund therefore asked all hospitals to state what was proposed, for it believed that one of the advantages of a central fund was that it could form a clearing house for ideas of this type. Detailed enquiries were made about the ability of hospitals to support proposed extensions, in an attempt to ensure that beds once provided could be used, and that the new extensions reduced the worst inequalities of provision. By 1920 extensions totalling 3,445 beds were contemplated. Of these only 1,489 were 'passed' by the distribution committee, and were therefore eligible for support by the King's Fund. With perception based upon long experience, Henry Burdett had written in 1893 of the danger a voluntary hospital faced as its work expanded.

'Many instances might be quoted in the history of the world where a hospital originally supported on the voluntary system with adequate funds provided from the revenues derived from the original endowment, has gradually become hopelessly involved owing to the increase in population resulting in increased demands on its resources. Where this has occurred the government has often stepped in, first of all with temporary assistance or a special grant, to be followed later by further and larger contributions from State funds with representation in management, and ultimately by the practical taking over of the institution, and the absorption of its revenues by the State.'

7

Burdett repeated this warning in the thirtieth edition of *Hospitals and Charities*, the last he edited before his death in 1920. He sensed 'a sinister attempt for what would appear to be political motives to maintain that the voluntary system had failed,' and to substitute a state system.⁸ The Labour Party did in fact believe that, solvent or not, the voluntary system could never meet all needs adequately. It believed that local authorities should establish their own hospitals and, as a dual system would create problems, the voluntary hospitals should be absorbed.

Hospitals in London and the university towns with a national and even international reputation should be funded and administered directly by

the Ministry of Health, but there should also be a system of large central local authority hospitals linked to smaller local and cottage hospitals.^{9,16}

Matters came to a climax in 1920. Notwithstanding an emergency distribution of £250,000 by the King's Fund and a further £250,000 from surplus funds of the Red Cross and St John's, it seemed improbable that the voluntary hospitals could continue on their traditional basis unless immediate steps were taken to re-establish the pre-war position. The King's Fund decided to draw upon its capital resources, but Hospital Sunday did not do so. On 26 January 1921 the King's Fund considered and ratified its policy for the preservation of the voluntary hospital system.¹⁰ The propositions the Fund advanced were that the voluntary system was the most effective and cheapest method of providing the best treatment and advancing medical knowledge and practice; that at least a substantial part of the cost should be met by voluntary contributions; that the current receipts were inadequate to meet the present cost, let alone the debts of the London hospitals, or the need for redevelopment; but that no remedy should be contemplated which reduced voluntary contributions or removed independence of management. It was proposed that payment by patients, insurance schemes, and grants-in-aid by public authorities for specific work should be considered. Block grants were however deprecated, although pro-rata assistance was a possibility. *The Lancet* agreed that it was the duty of the state to supplement rather than supplant the voluntary hospitals, and to provide the care needed by many who were not 'an object of charity in the normal sense'. State support should not, however, deprive the hospitals of their independence of control.¹¹

The years 1921-24 were a period of continuing difficulty for the hospitals, and the possibility of the breakdown of the great voluntary hospitals and their medical schools led the government to establish the Cave committee, which first met in January 1921. The committee agreed that there was great merit in the voluntary system, that it was in the public interest to maintain it, and recommended as temporary assistance a state grant of a million pounds with a further grant the following year. The committee proposed the formation of a Voluntary Hospitals Commission to supervise the distribution of the grant, acting on the advice of local hospital committees.¹² The King's Fund agreed to act as the local committee to advise on distributions in the Metropolitan Police District. In its evidence to the Cave committee the

Fund had pointed out that its council consisted of people holding representative positions in national, metropolitan and city government, in religious bodies and the medical profession; and that it could be the channel for some form of public assistance.¹⁰

Continuing pressure to reduce public expenditure led to the 'Geddes axe', economy measures that reduced spending on education, health and social services. The government decided to provide no more than £500,000, and to give state assistance for a limited period only, simply to allow the voluntary hospitals a breathing space so that they could re-establish their position.¹³ The voluntary movement would have to meet some of the deficit itself, perhaps on a pound-for-pound basis. The Hospitals Commission recommended by the Cave committee was formed, under the chairmanship of Lord Onslow, and it supervised the distribution of the government's £500,000 grant.

A leader in *The Times* criticised the Minister for his parsimony and accused his department of seeking a 'great new experiment in State or municipal hospitalisation'. Letters were published from The London Hospital and St Mary's, drawing attention to the plight of the hospitals.¹⁴ His Majesty himself asked the Ministry for reassurance about the position of the London hospitals. In reply the Minister said that the first principle in the government's mind was that the voluntary system must be maintained in full force and vigour. Had he been so foolish as to wish to destroy the voluntary hospitals no surer way could have been found than unconditional deficiency grants. Voluntary support would then have diminished, state contributions would have risen by leaps and bounds and state control would have followed. The Minister's letters were difficult to draft. As he pointed out in a personal letter to the editor of *The Times*, painting the blackest possible picture was a traditional way of stimulating voluntary support. The Minister could say nothing which would reduce the ability of the hospitals to raise money.¹³ A combined hospitals' appeal by the King's Fund which aimed to stabilize the hospitals' financial position raised £480,000 fairly rapidly.¹⁵ The Labour Party used the opportunity of the financial crisis to re-state its hospital policy and advanced thirteen propositions which it believed should form the basis of a future hospital service.¹⁶

By 1924 the financial problems were easing and the King's Fund could report that the deficits of the London hospitals were becoming smaller each year. Hospital savings schemes had been inaugurated, and many hospitals could once more balance their books. In April 1924 a

conference was held under the auspices of the Labour Party, attended by a wide variety of organisations including the British Medical Association, the voluntary hospitals and members of professional staff associations. The conference was called to discuss the desirability of further state aid to extend and maintain the hospitals. In sending the conference his good wishes, the Prime Minister, Mr Ramsay MacDonald, said that the problems of the hospital system, if the existing chaos could be so described, was a symptom of inadequate civic organisation. It fell far short of the achievement its friends and supporters desired. He hoped that a common and wise policy might be the outcome of the discussions. Speakers from the left maintained that great though the efforts of the voluntary movement had been, it had failed to provide completely what the nation needed. The only way out of the impasse was for the state to accept the responsibility of providing hospital treatment for all who needed it, transferring the poor law infirmaries to the local authorities, and giving the voluntary hospitals the choice of remaining as they were, or of coming to an arrangement with the local health authority.

Lord Knutsford, however, thought that the record of the state in providing health care for the poor and the armed services showed that whilst it might do its bare duty, it would be done without grace. Turning to the Labour Party policy, he spoke scathingly about the statements which had been made. Hospitals were not pauperising agencies, patients were not admitted preferentially if they could pay something towards the cost of their treatment, neither were they afraid of entering hospital because they might be subject to experimental treatment. The voluntary hospitals abided by the Sermon on the Mount, not the cold code of the Charity Organisation Society. Lord Knutsford tartly remarked that the Charity Organisation Society had nothing to do with charity. The best plan would be to strengthen what was admittedly good, and not change to a system of state management which would satisfy nobody.¹⁷

Lord Somerleyton, representing the King's Fund, pointed to the improving financial position of the hospitals as a result of their steady efforts, and the final resolutions, passed by the conference without dissent, called for increased support and public assistance for the voluntary hospitals to preserve the best features of the voluntary system, a closer relationship between public and voluntary hospitals, improved geographic distribution, cooperation between the various institutions, and the 'removal of all taint of the Poor Law from the

infirmaries, throwing them open to all citizens'.¹⁷ Similar sentiments were expressed at a conference of the British Hospitals Association, and a conference of Local Voluntary Hospital Committees which had been established to work with the Onslow Commission.

It was announced in the House in February 1924 that the Onslow Commission was to seek evidence of the need for additional hospital accommodation, and the best means of providing and maintaining it. Most hospitals, although their financial problems were lessening, were still without the means to extend their facilities. The King's Fund pointed out the difficulty of trying to determine need for beds from information such as waiting list size, and the replies it received from the London hospitals only permitted an estimate of the number of beds which came into the range of 'practicable possibilities'. These were beds which would fit into the general pattern of provision, and which could conceivably be funded either at once or in the foreseeable future. The increase amounted to about 2,000 - to something a little over 15,000 in all.¹⁸ The Onslow Commission reported that even when the use of available Poor Law beds had been taken into consideration a shortage of beds existed. It favoured state grants towards building costs and a further measure of assistance to help the hospitals to overcome their arrears. However the government would provide no further money and the commission was disbanded in 1928.

The financial recommendations of the Cave committee and the inauguration of hospital savings schemes brought about considerable changes in the financing of voluntary hospitals. The needy continued to receive free treatment - the primary function of the hospitals - but it became usual to charge the more affluent. Financial organisation was increasingly based upon payment for services rendered. ^{20,21} The King's Fund had emerged from the financial crisis more powerful than ever as the spokesman for London's hospitals. In its evidence to the Onslow Commission it had said that it could fulfil the role of a central administrative body and cooperate with other coordinating bodies on the outskirts of London. It had channelled not only voluntary subscriptions but state grants to the hospitals; and being voluntary itself it respected the independence of the hospitals. Charing Cross Hospital, in its own evidence, suggested that the Fund be given still greater power 'to smash the hospitals into line as regards expenditure or amalgamation'. Such a dictatorial approach was not the Fund's way of working. At the zenith of its power, its 'friendly persuasion' was seldom ignored.

The voluntaries were keenly aware of the need to retain public sympathy if their financial and political interests were to be safeguarded. The King's Fund established a propaganda committee in 1924 to arrange lectures and produce leaflets and films. Exhibition displays were constructed and a miniature hospital was built to 1/16th scale, complete with a royal statue.²² One parent claimed that his son's eye had been injured by an ultra-violet lamp in a display of modern hospital equipment. A film was made called '*A Hundred Years of Progress*', and Ernest Morris, house governor of The London, delivered lectures on the pros and cons of nationalisation of the hospital service.

Developments in medical education

The recommendations of the Haldane Commission has been overtaken by the Great War. In June 1918 Sir George Newman, chief medical officer of the Board of Education and later the first chief medical officer of the Ministry of Health, submitted a report on medical education to his Board.²³ He expressed some diffidence in writing upon the subject, but in a carefully constructed document he proceeded to review the nature of university education and to identify four main deficiencies.

They were teaching at a level below university standard; failure of university departments to work with each other; inadequate medical research within the teaching system; and the need for better postgraduate education. The following year grants became available from the Board of Education to assist the establishment of clinical professorial departments where academic staff would work full-time in teaching and research, undertaking no private practice. St Bartholomew's Hospital had already decided to establish such a unit without waiting for further developments. A unit was also established at St Thomas's, and University College Hospital received a magnificent gift of £1,205,000 from the Rockefeller Trust for the same purpose. Academic units would not be concentrated into a few university-dominated hospitals as Haldane had envisaged, but would be widely distributed. Some schools, like Guy's, chose to maintain the traditional pattern and after the first units were established progress was slow. In its evidence to the Goodenough committee in 1942 the University of London listed those professorial units in existence at the

outbreak of war in 1939; none existed in half of the London medical schools.

St Bartholomew's	Medicine and surgery
St Thomas's	Medicine
The London Hospital	Medicine
London School of Medicine for Women	Obstetrics
St Mary's	Medicine and surgery
University College Hospital	Medicine, surgery & obstetrics

The academic staff was very much in the minority amongst the honorary consultants, and each professorial unit needed at least fifty beds, inevitably at the expense of the other clinicians who continued to teach students, but who no longer had the field to themselves. Slowly the schools began to move closer towards university-based education, and to adopt the pattern of organisation outlined by Sir William Osler in 1911. 24 The University of London came to the conclusion that the minimum number of beds essential to have an efficient medical school was 600, and every medical school came under pressure to increase its laboratories and service departments. Hospitals and schools could not function as they had once done with little more than a number of wards and an operating theatre. Another problem involved medical education for women. The establishment of the London School of Medicine for Women in 1874, in association with the Royal Free Hospital, was followed during the Great War by the admission of women to the majority of medical schools in London. After the war most hospitals reverted to their pre-war tradition, and clinical places were once more difficult to find in London.

Poor law reform and the boards of guardians

Amongst many other objectives the long campaign to reform the Poor Law aimed to achieve the transfer of infirmaries from boards of guardians to local authorities. Ever since the 1830's there had been increasing dissatisfaction with infirmary management, which varied from the enlightened to the apathetic. Mr Joseph Chamberlain, speaking in 1888 during the second reading of the Local Government Bill, suggested the inclusion of Poor Law administration amongst the duties of the new county councils.²⁵ However boards of guardians remained untouched, as they did ten years later when the London Government Act (1899) abolished the vestries and created twenty eight London boroughs. The Royal Commission on the Poor Laws

(1909) had pointed to the overlapping of hospital authorities, and the Majority and Minority Reports had agreed that boards of guardians should be abolished. The Maclean committee, established at the end of the Great War to consider the post-war planning of health services, also supported the transfer of functions.²

The Maclean committee pulled together the points on which the Majority and the Minority Reports had been agreed, and Sir Robert Morant, a senior civil servant with extensive experience of both health and education, added a note to say that he assumed that all the main forms of medical service would be brought together under one Minister, within a Ministry of Health, before such a transfer took place. This happened, the Ministry of Health being formed in 1919, but whilst the transfer of functions became accepted policy, the change was not to the liking of those to be abolished - the boards of guardians and the Metropolitan Asylums Board.

Although Burdett had little respect for state or municipal management, he wrote in the introduction to the 1919 edition of *Hospitals and Charities* that he looked forward to the time when county councils would take over the administration of the entire poor law system. Such a reform would make it possible to classify sick and healthy paupers, and persuade public opinion to insist on the best possible provision being made for pauper patients.⁸ Burdett also believed that the transfer would make it possible to provide better staff and equipment, to construct outpatient departments, and provide patients in London with the additional accommodation which was needed, particularly away from the centre 'in the areas where the working classes live'. London infirmary medical superintendents also supported transfer to the London County Council on the grounds of economy, better distribution of patients between institutions, the likelihood that better candidates would be attracted to the medical and nursing services, and the opportunity which would be created to develop specialised services. The superintendents envisaged district hospitals, providing one bed per 300 population, with associated outpatient departments. There would also be special institutions for ophthalmology, ear, nose and throat disease, tuberculosis, orthopaedics, fevers and radiotherapy.²⁶

The Maclean report had suggested that among the functions to be transferred to the London County Council should be those of the Metropolitan Asylums Board. The London County Council agreed,

believing that the health functions which were carried out by many different bodies should be united under its control, just as Parliament had united governmental health activities in a single Ministry. The Clerk was asked to report on the health functions of local authorities and other bodies in London, and the report recommended that the council should be the sole and central institutional body for health services in London.²⁷ It was adopted by the London County Council in December 1919, for it was consistent with the general thrust of council policy to extend its sphere of influence and centralise control. The council made cordial reference to the work of the Metropolitan Asylums Board and suggested that its institutions and its highly competent staff should be transferred en bloc. The council also suggested that the voluntary hospitals should establish a central voluntary hospital council with which it might negotiate, and sought a meeting with the new Minister of Health.

The representatives of the council were received by the Minister on 23 April 1920. Dr Christopher Addison had previous experience of the council's ambitions, in the housing field. Nevertheless after the council had presented its case he said it was clear that a good deal of muddle had arisen from the needless multiplication of authorities. While some services were best administered locally, others were not. The more specialised the services, the wider the range of the responsible authority had to be, and it was essential to have an authority to deal with some services over a considerable area. The Minister felt that the council's main principles were unassailable.²⁸ For the next twenty-five years the Ministry and its officers came to turn, more or less automatically, to local government when an extension of social services was envisaged.

Because of the financial crises of the early twenties, and public campaigns for a reduction in government expenditure, there was considerable delay before proposals for Poor Law reform could be considered. They were not circulated to boards of guardians and the Metropolitan Asylums Board until January 1926. It was proposed to abolish boards of guardians and with them the Metropolitan Asylums Board which derived its membership from 'destitution authorities'. In London the County Council would become the supervising and controlling authority for all health purposes throughout the administrative county, which covered essentially the same area as the Asylums Board. In its reply the Metropolitan Asylums Board stated that it was convinced that the London County Council would find it

impracticable to undertake the enormous task of managing all the hospitals and institutions involved, and that an independent body was justified.^{29, 30}

Neville Chamberlain and collaboration

In 1919 Sir Bertrand Dawson was commissioned by the new Ministry of Health to chair a council to advise on the systematised provision of health services. (the Dawson report is considered in more detail in the next chapter) The report proposed, with a good deal of post-war fervour, the linkage of hospitals into a single system. At the time it did not carry much weight. It was common knowledge that there was a substantial body of disagreement amongst the interests represented upon the council, and that the report had been prepared within a tight time limit. The report, admittedly an interim one, ignored costs, the existing system of local government, and the pattern of hospitals, clinics and dispensaries already in existence.²¹ Nevertheless collaboration became a consistent feature of government policy, for there was the potential for considerable saving if the two systems of hospitals would work together. The King's Fund had reported a shortage of around two thousand beds in London, and schemes to remedy this had to avoid waste where voluntary hospitals and infirmaries worked beside each other. How waste could be avoided without some form of health authority in each area was difficult to see. Sir George Newman, the chief medical officer at the Ministry, told the Royal Sanitary Institute in July 1925 that division of responsibility between so many authorities led to confusion, waste and inefficiency. What was needed in each area was a single unit of health government which brought together all health functions. In each district there should be a close association of voluntary and state institutions under one authority.³¹

Mr Neville Chamberlain, the Minister of Health, was equally explicit when he spoke to the Hospital Officers Association in December 1925.³² He did not believe that the voluntary hospitals should suffer extinction or come under state control, although he was often accused of wanting to take them over. However he told an audience in Coventry in October 1926 that public health provision could not be looked at in water-tight compartments. The voluntary hospitals should consider how they might fit into the wider scheme of things. Could cooperation be extended? Might there not be in time some central health authority with representatives of the voluntary hospitals upon it,

responsible for the general health policy of an area? In return for a certain subordination of their complete and absolute freedom to do what they liked, they might receive financial assistance.¹³ His speech revived fears of a state take-over and *The Times* published a leading article criticising his approach. Chamberlain replied that he was concerned with overlapping services and waste of money. Local areas should be examined as a whole, and closer coordination of the institutions in an area by a central body with general powers of guidance was needed. Would not the voluntary hospitals like to play their part? If they did not, such a body would undoubtedly be formed without them, a development he would view with grave anxiety.³³

The British Hospitals Association wrote to Chamberlain to ask how the voluntary hospitals might best cooperate with the public health services. Chamberlain considered that discussions might be more productive if there was a series of concrete proposals to be considered, rather than the somewhat abstract topic of 'cooperation'. He therefore suggested a number of issues which might be considered locally, including the allocation of some categories of illness to one or other type of hospital, the effect of such agreements on future hospital development, the deficiencies which existed and how they could be remedied, the possibility of a clearing house for admissions, so that patients could be admitted rapidly to one or another institution, and what pattern of joint staffing might be desirable.³³ Chamberlain was invited to address the association but declined because of the uncertainties surrounding the forthcoming Local Government Bill.

The British Hospitals Association consulted its branches and replied to the Minister's questions without being particularly constructive. Cooperation on building developments did not seem to them to be practicable. The voluntary hospitals already provided a full service, and where they did not they planned to do so, but it would help if their staff could use beds in public hospitals. Dawson, now in the House of Lords, used his influence within the British Medical Association to ensure that its response was more constructive. In 1927 Neville Chamberlain addressed the autumn meeting of the British Medical Association on cooperation between the voluntary system and the municipal hospitals,³⁴ and made further attempts to persuade the British Hospitals Association to look seriously at the need for it. In response the Association's officers told their members that it was imperative that the voluntary hospitals should cooperate with local authorities. The Local Government Bill would soon be law, and if

competition developed with the rate-supported hospitals, which had almost unlimited finance behind them, there could be only one outcome. Yet the very thought of cooperation alarmed many of the voluntary hospitals. Eason, the medical superintendent of Guy's, referred to the elephant who said he was a strong believer in cooperation as he sat on the pheasant's eggs in a praise-worthy attempt to assist in hatching them out. Some of those who worked for the voluntary hospitals feared that they would be squeezed out of existence by a beneficent public sector.³⁵

Informal contacts were established between the London voluntary hospitals and the county council's medical officer of health, Dr F N K Menzies, (later Sir Frederick Menzies) who began to play an increasing role in hospital affairs. He was described as a big man, mentally and physically, full of vigour and initiative, with a pleasing personality. He had a commanding presence, a persuasive tongue and personal friendships in high places. *The Lancet* regarded him as a man of affairs with great driving power, a facility for choosing the right assistants and a knack of getting his way in large scale problems of medical administration.^{36,37} Already an honorary member of the Westminster Hospital's staff, he met representatives of the voluntary hospitals and assured them that the London County Council was not seeking to take them over.

At a meeting with the King's Fund in 1928 Menzies said that the attitude of the county council was entirely friendly and a tradition of cooperation with voluntary hospitals had been established. However the hospitals should bear in mind that if satisfactory arrangements were not agreed, the Labour group would demand complete municipalisation and would be able to make out a good case. An assumption of arrogance on the part of the voluntary hospitals would only antagonise their friends and throw them into the hands of their enemies. The King's Fund became convinced that Menzies was a valuable ally, but recognised that if the voluntary hospitals showed an unwillingness to negotiate his patience might become exhausted.¹⁰

The British Hospitals Association organised two conferences of London hospitals, for those with and those without medical schools, to discuss the future with Menzies. The teaching hospitals expressed doubt about the ability of the council to manage the vast hospital resources to be transferred to it, and if it tried it might be difficult to avoid antagonism, competition and duplication between the two

systems. The voluntaries suggested that the county council could ask them to manage municipal hospitals on its behalf and at its expense. A variety of agency arrangements were possible and existing examples of cooperation were cited. St Mary's students went to the Paddington Infirmary, and the Infirmary used St Mary's laboratories. The chairman of the guardians was a member of the St Mary's board, and the benefits of the association were mutual. Dr Menzies could not agree that the council might consider surrendering its responsibilities, although Herbert Eason, the medical superintendent at Guy's, repeated the proposal that teaching hospitals could administer the municipal hospitals and deploy their staff in both at a meeting of the British Medical Association chaired by Menzies in 1927. 35, 39

Two doctors wrote to *The Times* suggesting an advisory council for hospital services in the metropolitan area, in which the representatives of the voluntary hospitals would be in the majority (because of their long experience) and in which the King's Fund would play a leading role.³⁹

There was little support for the idea in any quarter. Meanwhile the King's Fund established a special committee to consider the steps which should be taken whilst the Local Government Bill was passing through Parliament. The Minister, Neville Chamberlain, saw a deputation from the Fund in November 1928. He was asked if he would make it mandatory for local authorities to co-opt persons with voluntary hospital experience onto their public assistance committees. Chamberlain said that he was all for maintaining the voluntary system, and for coordination, but that he had not met with much response, being suspected of wishing to introduce municipalisation. The danger to the voluntary hospitals did not come from the Bill, but from the progressive improvement of the poor law infirmaries. Co-option would not of itself secure coordination, and would be resented by many local authorities. Furthermore, if it was made reciprocal, with the co-option of local authority representatives onto the boards of the voluntary hospitals, that also might meet with a hostile reception.^{10,38,40.}

A series of informal discussions took place between representatives of the King's Fund, the London County Council and the voluntary hospitals to explore the problems of working together. In March 1929 the King's Fund published a carefully drafted memorandum on the Relations between Voluntary and Municipal Hospitals.⁴¹ It proposed permanent consultative machinery to consider hospital provision,

equipment, staffing and training. It wished representatives of the voluntary hospitals to be appointed to local authority public assistance committees, proposed the coordination of the two hospital systems in nurse training, and the use of the facilities of the municipal hospitals for medical student education.

The Local Government Act, as passed in 1929, included a clause placing a duty on local authorities to consult a committee representative of the governing bodies and medical staff of the voluntary hospitals about the accommodation to be provided and the purposes for which it was to be used. 'It is imperative', said a Ministry circular, 'that the Local Authorities establish the most cordial relationships with, and should make full use of, the medical profession in regard to hospitals.'⁴² In March 1929, shortly the Bill became law, the London County Council wrote to the King's Fund asking for its views on the manner of cooperation. The Fund had been discussing the matter with the voluntary hospitals and produced a proposal for a group which Dr Menzies felt was too cumbersome to allow any business to be done. Nevertheless the London Voluntary Hospitals Committee was formed along complex lines, representative of the King's Fund, the Conference of Teaching Hospitals and the London Regional Committee of the British Hospitals Association.⁴⁰

The Local Government Act (1929)

The Act had three main effects on hospital services. It brought poor law infirmaries and fever hospitals into line with other municipal services, opening them to all in need without the stigma of the poor law. It placed them under elected and representative local authorities, instead of ad hoc bodies like boards of guardians. Finally, it decentralised the financing of these hospitals, consolidating the exchequer grants for the total range of local public services.

Speaking to the medical students of the Westminster Hospital, Dr Menzies explained how public opinion had rebelled against the way a sick person had to be regarded as a pauper if he was to be treated by the guardians. Twenty-five years of agitation had at last been successful and the London County Council would soon have 75,000 beds under its control for all types of disease, five times as many as in the voluntary hospitals of London. The principle had been established that sick people in need of treatment should receive it, and if they were unable to provide for it themselves it was the business of the health

authority to do so. Menzies recognised the fear of the voluntary hospitals that they would be adversely affected but he saw no reason for anxiety. For twenty years the policy of the London County Council had been cordial cooperation with the voluntary hospitals, and in its new task the council would need the sympathy and support of all who were interested in the care of the sick.⁴³ Sir George Newman, in his annual report at the Ministry, also welcomed the change. 'For the first time in the history of the public health services the medical officer of health has a direct and ample opportunity for closely and effectually coordinating in his area all the varied medical services of the State.' 'Only the best must be good enough for the patients in our Hospitals and in medical treatment expenditure is very often the best form of economy', wrote Lewis Silkin in a London municipal pamphlet produced by the Labour Party. The London County Council intended that the hospitals to be taken over from the guardians should be used primarily as general hospitals, 'equivalent to the voluntary general hospitals'. The council would not only possess the majority of beds in London but the biggest hospitals as well: Lambeth, St Giles' Camberwell and St Mary's Islington". The voluntary movement observed the behaviour of the council with apprehension. The council could have continued to administer the infirmaries under the Poor Law Acts but it chose to work under the Public Health Acts instead, which had the advantage for the council that 'appropriated hospitals' were removed from the detailed oversight of the Ministry of Health.⁴⁵

The council's inheritance

Developments in the infirmaries had been patchy although the use of some as military hospitals had led to an improvement of facilities. An increasing number were recognised by the General Nursing Council for nurse training and some had been opened to medical students from nearby teaching hospitals. The Paddington board of guardians had made an agreement with St Mary's in 1920, and King's College Hospital and the Camberwell Infirmary were in negotiation. Some infirmaries had developed considerable esprit de corps and opposed transfer to the London County Council as a threat to their individuality. The Lambeth guardians had purchased both radium and deep X-ray equipment, and had sent their senior physician on a tour of Europe to see what was being done in the world of radiotherapy.⁴⁶ However, few staff of the voluntary hospitals set foot in the infirmaries; some of those who did had had their views confirmed that they provided a second class service with second class staff.

The infirmaries were managed by 25 unions. Populations varied from 100,000 to 300,000, with exception of one very large union - Wandsworth. In total, they provided 16,250 beds staffed by 140 doctors. In 1928, Drs Meredith Richards and Manby surveyed the infirmaries for the Ministry of Health.⁴⁷ Some of the accommodation was found to be excellent, much was indifferent, but most was found to be sufficiently good to serve a purpose. Many infirmaries were on noisy sites, had insufficient isolation accommodation, and did not classify patients according to their needs. Occasionally wards were tightly packed and there might be no margin of beds for emergencies. The surveyors thought that if existing poor law boundaries were disregarded, the facilities could be used to greater advantage. Admission policies also varied. 'If they did not go out into the Highways and Hedges to compel patients to come in,' said the surveyors, some guardians 'were at least ready to welcome all who sought admission.' Others, acting strictly within their statutory authority, made careful enquiries about the needs and resources of those seeking relief. In some infirmaries the doctors were mainly occupied with surgery and the care of the acutely ill; in others most of the patients were suffering from chronic illnesses. Boards of guardians varied from a progressive attitude to almost complete inertia; these variations could not be justified.

In the view of the surveyors, larger areas of organisation were called for. They thought that the administrative County of London was too large a primary unit, just as the borough councils and unions were too small. Meredith Richards and Manby therefore suggested that the infirmaries should be managed in groups based upon borough boundaries, three groups north of the Thames, and two to the south. The special committee on changes in London local government, established by the London County Council, suggested that there should be five non-executive area committees for the purposes of hospital administration, and the council began to develop the administrative machinery necessary to take control.⁴⁸ Discussions with the guardians made a smooth hand-over possible, and few patients would have noticed the change. The London County Council proved a much less autocratic body than the doctors had feared; consultation with the hospital medical officers was frequent and promotion prospects were better.⁴⁶

London County Council management

The council asked its medical officer and architect to carry out a survey and report on hospital premises. The report on the infirmaries showed that the condition of most left much to be desired. Menzies commented ruefully that all the floors seemed to be breaking up and all needed rewiring. The best were, undoubtedly, Lewisham, Hammersmith, St James' and St Charles'. The worst were probably St Leonard's, St Pancras and St Stephen's.³⁶ The older infirmaries showed little evidence of ordered planning, but those built from 1880 onwards were usually of the H, E, U or V plan, with the administrative block occupying a central position and the wards lying on either side along a main corridor.

The London County Council distinguished between hospitals which in essence provided medical treatment and nursing, and institutions for long-term residential care. Menzies told his committee:

'Many of the deficiencies are attributable to the fact that just as each voluntary hospital is a law unto itself, so hitherto each board of guardians has suffered from a comprehensive legal obligation to provide treatment for all destitute sick persons. Now that the existing poor law boundaries are to be swept away and the area to be considered is the administrative County, a great opportunity is afforded of considering the best way of meeting the needs by rearrangement and regrouping of poor law infirmaries and institutions, so as to utilise them to the maximum degree of efficiency within their limitations.'

Menzies worked on much the same principles as Markham, sixty years before. He suggested the hospitals which might be appropriated by the council under the Public Health Acts, excluding those offering only custodial care. The council approved the list, as did the Ministry, and appropriation took effect on 1 April 1930. Menzies groundwork ensured that on the day a vast new hospital service swung smoothly into action. Hospitals were divided into six categories:

- For people who were or had been acutely ill
- For less serious acute or chronic illnesses;
- Sick children
- Maternity patients
- Mental patients
- Senile patients

This classification meant that some residents who were not really 'sick' occupied beds in acute hospitals, and it took time to transfer them to appropriate institutions. Indeed, it was not clear to the council whether it was best to separate the acute and chronic sick. The council decided that a hospital standard of care should be offered to all, including the chronic sick, the aged and the infirm.

The council's management of its hospital service

The nature of the hospitals which had passed to the council varied widely, as did the quality of the staff and their terms of service. The assimilation of 75 hospitals with 40,000 beds and a workforce of 26,000 into a single organisation was a task of the first magnitude which took several years to complete. The achievement was impressive by any standard.^{49 50} The nature of the services provided by the London County Council differed significantly from those of the voluntary hospitals which seldom retained chronic or long term cases. These were transferred to council hospitals as the local authority had a statutory obligation to provide care which the voluntaries did not bear. The council also faced the increasing problem of care for the elderly; in the thirty years from 1901 to 1931 the proportion of the population over 65 years had increased by 70 per cent, from 4.09 to 7.34 per cent.³⁶ At the same time an attempt was made to cope with the changing pattern of care; the proportion of acute cases admitted was rising, higher social classes took advantage of the service and as the equipment of the rate supported hospitals was improved more operations were carried out.

LCC and voluntary hospitals in London, 193

	LCC general hospitals	Voluntary hospitals
Operations/100 beds	52	917
Beds/operating theatre	615	62
Beds/nurse	3.7	2
% Surgical beds	18%	30 %
Average length of stay	35.4 days	17.21 days
Beds/resident medical officer	97	26

The council's approach to the provision of outpatient care also differed from that of the voluntary hospitals. The London County Council relied in the first instance on its district medical officers, believing that there

was no point in providing an outpatient department to do work that could be done equally well by its district medical and nursing services. The purpose of the hospital was to fill gaps in the district service, whose medical officers followed up cases discharged from hospital. None of the council's hospitals allowed patients direct access to the hospital services, as did the voluntary hospitals. The voluntaries justified the policy of 'an open door to the sick poor' by arguments which had little appeal for the council. These included distrust of the general practitioner as a sifting mechanism, the provision of clinical material for students, a facility for poor people who had no doctor or who did not wish to see the council's district medical officer; and the usefulness of the outpatient department as evidence of the popularity of the voluntaries when appeals for support were made.

The council's management style was centralist, based upon a belief in discipline, system and standardisation. The motive was laudable - a desire to see a rapid improvement in the state of the hospitals, and to enforce economy in the provision of services. However the council's passion for meticulous supervision soon brought it into conflict with the London boroughs and professional organisations. Local hospital committees had few powers and were run by junior staff from County Hall. Decisions involving money, however little, went to the Central Public Health Committee and its successor the Hospital and Medical Services Committee. Each hospital was seen as only a small part of a very large service and neither the local staff nor the hospital committee had a budget or could take decision on matters of policy. Meat was bought centrally at Smithfield, scalpels and syringes were purchased on a central contract, and the minutes of the County Hall committees reveal a mixture of major issues and a welter of trivia.

Two or three times a week the committee would deal with matters of moment such as the cost of meals of an individual relief nurse, the length of sick leave granted to a junior doctor, or the admission to the obstetric practice of St Mary Abbots, Kensington, of a couple of medical students. Doctors and nurses were responsible to County Hall through the local medical superintendent. The London County Council said that a proper balance had to be maintained between 'centralised control and devolution of responsibility to "local" centres'. The council thought it had the balance right but few others agreed.

Fully aware of the progress being made in all branches of medical science, the council wished this to be reflected in its hospitals. It

believed that a hospital which 'stood still' was in fact regressing and that money could be saved and efficiency would rise as a result of investment. From 1933 onwards the council's annual reports recorded the progress which had been made. Between 1934 and 1939 £4 million was spent on hospital improvements.

Hospital construction was examined to determine the best policies to follow in renovating buildings. A study of the relative costs of various types of hospital construction was in favour of semi-permanent buildings which would last up to sixty years, being cheaper and more adaptable to changes in medical practice. The Hospital Standards Committee considered the various types of equipment - artery forceps, waterproof sheeting, sanitary fittings, baths and washbasins - and recommended the type to be used. The way in which the departments of a typical 500 bed hospital might be arranged to facilitate effective working was also studied.⁵¹

Even hospital names were standardised. In some cases the names were out of date and the possibility was considered of using the names of saints, kings or persons with local associations instead. The officer concerned felt it 'desirable to adopt some uniform system of nomenclature', and as some of the transferred hospitals were already named after saints, he found saints' names for the others. Because saints were not to be duplicated within the administrative county, he sought associations with local parishes. So Plumstead and District Hospital became St Nicholas', and St Charles' and St Alfege's, among others, were given their names.

Nursing was a particular problem. The staff transferred from the guardians exceeded 9,000, employed in no fewer than 78 grades. A matron-in-chief was appointed, responsible to Dr Menzies (now Sir Frederick Menzies). He was of the opinion that the only way to create a permanent and efficient nursing staff with a sense of dignity and pride in its work was to make it responsible to a woman of the same status as the principal medical officers - a development which the officers did not view with unqualified approval. Some hospital matrons began to regard themselves as independent of the medical superintendent, and the senior doctor and nurse in a hospital might not be on speaking terms.

The London County Council's service had its strengths and weaknesses. In the face of its impressive achievement any criticism

seemed carping, not least because the qualities of Sir Frederick Menzies were a guarantee that matters would not go badly wrong. In 1934-5 Dr Carnwath, of the Ministry, carried out an exhaustive survey of the public health services provided by the council, describing the problems which the council had faced and the way they were being tackled.³⁶ An abbreviated version of his report appeared in the report of the Ministry of Health for 1934-5. The Minister congratulated the council on its enlightened policy and upon the highly efficient organisation built up by Sir Frederick Menzies for overall planning and control of the hospital and medical services. The council was so pleased that it had the appropriate section of the Ministry's report reprinted as a separate publication.

Voluntary hospital and county council cooperation

Under section 13 of the Local Government Act local authorities were instructed to consult a committee representative of the governing bodies and medical staff of voluntary hospitals 'as to the accommodation to be provided and the purpose for which it was to be used'. This clause, designed to foster cooperation, was an expression of Chamberlain's views, had the support of the voluntary hospitals, and was moved in the Upper House by Lord Dawson of Penn. The British Hospitals Association meeting at the Westminster Hospital in November 1928, viewed cooperation mainly as a means of allocating beds in the infirmaries to the staff of the voluntary hospitals, to make the transfer of chronic cases easier. Representatives of the teaching hospitals who met the following month at St Thomas's welcomed the centralisation of the public hospitals under the London County Council. They thought that their senior staff would be too busy to work regularly in municipal hospitals, but that it would be desirable for more junior staff to do so for a stipend, to avoid a permanent division between two systems of consultant staff. The voluntaries could also provide the council with resident house officers, and would wish to take advantage of the teaching facilities that the municipal hospitals could offer.⁵²

Members of the London County Council did not take kindly to the attitude of superiority sometimes adopted by the voluntary hospitals. Both sides became touchy and began to stand on their dignity. The King's Fund tried to act as peacemaker, and suggested that the representatives of the voluntary hospitals, when speaking in public, should censor their remarks to avoid unnecessary offence. Ten years later, in his reminiscences, Menzies regretted that the interests of the

voluntaries were not represented by the King's Fund, but by the specially formed London Voluntary Hospitals Committee. The King's Fund was well established, highly respected and backed by large resources. Had the King's Fund's council and the London County Council been able to work directly together, Menzies thought that relationships would have been much better. As it was joint discussions were a failure from the start. The London Voluntary Hospitals Committee was chaired by Lord Riddell, president of the Royal Free Hospital, who suggested at the first joint meeting with the London County Council that the best policy for the LCC would be to devote itself to the care of the chronic sick, the aged and the infirm, and to make appropriate financial grants to the voluntary hospitals so that they might deal with the acutely sick. Sir Frederick Menzies did not believe that this was the unanimous view of the London Voluntary Hospitals Committee, but its chairman was not a man inclined to encourage colleagues to speak. Similarly the voluntary hospitals did not wish the London County Council to make significant improvements to its hospitals without prior consultation with the voluntaries.⁵⁴

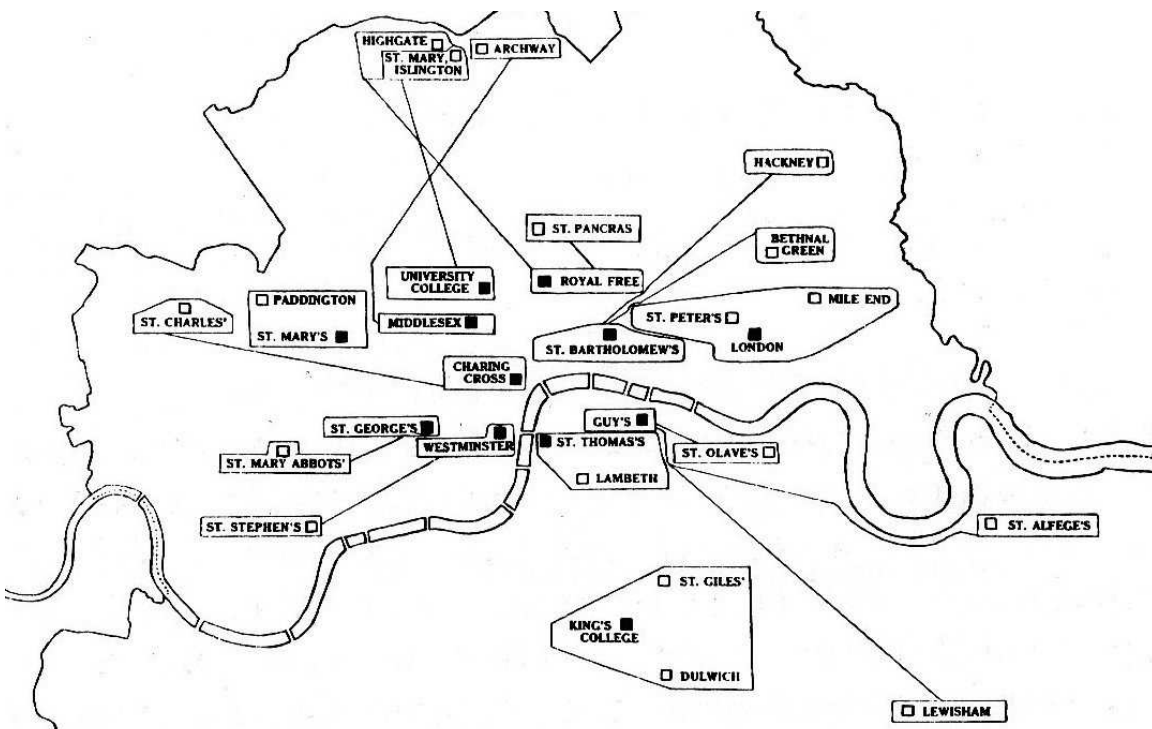
To make such propositions to the greatest municipal hospital authority in the world was a little tactless, and the attempt to dictate its hospital policy was greatly resented by some council members. It was made clear that while the council might feel disposed to notify the Voluntary Hospitals Committee of proposals involving a substantial increase in accommodation, it would make its own decisions. Lord Riddell thought this was unsatisfactory, and that the council intended to go its own way and develop its service irrespective of the voluntaries. Nevertheless a two-way exchange of information was maintained. The council informed the voluntary hospitals of its proposals. The voluntary hospitals commented upon them, supplying in return details of their own plans.⁵⁵

The London County Council was proud of its achievements in education and housing and intended to make a similar success of its hospital service. Believing that cooperation with the Voluntary Hospitals Committee would be difficult, it worked with individual hospitals, especially those with medical schools. The medical schools were particularly short of obstetric experience, and the facilities of council units were made available. Sir Frederick Menzies also devised a scheme which linked county council infirmaries to the teaching hospitals. After discussions with the London Voluntary Hospitals Committee the London County Council agreed that 'facilities should be

afforded at its special and general hospitals for demonstrations to medical undergraduate and postgraduate students, on the understanding that the council bore no expense and that the work of the hospitals was not impeded'. In January 1933 Sir Frederick Menzies reviewed the arrangements which already existed with KCH, UCH, St Mary's and the Royal Free, and held discussions with the twelve London deans about the facilities they might require. The scheme he developed was approved by the council, permitting 12-15 students to attend for demonstrations several times a week.⁵⁶ Sir Frederick's scheme was based upon geographical relationships, and was illustrated in the report of the Voluntary Hospitals Committee by a sketch map. It is not surprising that some of the associations which were established in the 1930s persist to this day. The London County Council was worried initially that an arrangement with a teaching hospital might mean that it would have to look to the hospital for consultant staff. The deans thought that this would be desirable but not essential. Nevertheless they were worried about the quality of teaching students would receive, and students were therefore often taught by a visiting consultant rather than by one of the council's own medical staff. Rules were laid down and the teacher had to select his cases from a list provided by the medical superintendent, and no impression was to be given at the bedside 'which might convey a wrong impression to the patient as to his diagnosis or treatment'. The arrangements proved satisfactory and all schools save The London (where adequate facilities already existed) took advantage of the scheme. The senate of the University of London 'expressed their deep appreciation of the action of the Council in making such important additional facilities available'.⁵

Medical school linkages with LCC hospitals

Charing Cross	St Charles'
Guy's*	St Alfege's (now Greenwich DGH)
King's College	St Giles and Dulwich
The London	St Peter's Stepney and Mile End
The Middlesex	Archway
The Royal Free	St Mary's and Highgate and St Pancras
St Bartholomew's	Bethnal Green, St Leonard's & Hackney
St George's	St Mary Abbots'
St Mary's	Paddington (St Mary's Harrow Road)
St Thomas's	Lambeth
UCH	St Mary's Islington
Westminster	St Stephen's



*later St Olave's and Lewisham in addition

Source: PRO/MH/66/155

The London County Council and the Voluntary Hospitals Committee agreed that the council should make no general grants of capital or revenue to individual hospitals without first approaching the committee, but the council might make specific arrangements with individual hospitals for services rendered. A joint survey of hospital provision in London was undertaken. Published in two parts, one for the voluntaries and one for the municipals, the survey's maps and geographical analysis of patient flows brought the hospital provision for London into focus and enabled the voluntaries to point out that 37% of their patients came from outside the administrative county.

National relationships of the hospital systems

Local authorities resented the fact that whilst they were obliged to consult the voluntaries under the 1929 Act, there was no reciprocal obligation. In London a mechanism had been created which brought

the two sides together, at least in a formal sense. Sir George Newman, chief medical officer of the Ministry of Health, took cooperation as his theme when he addressed the conference of the voluntary hospitals in 1934. Sir George favoured a cooperative hospital system of 'unity rather than uniformity ... a practical compromise between collectivism and individualism', rather than placing all hospitals, both voluntary and municipal, on the basis of rates and taxes. Lord Riddell agreed that there must be no jealousy between the two services and admitted that the voluntaries had taken a long time to appreciate the enormous changes brought about by the Local Government Act. Sir Ernest Morris of The London Hospital said that the voluntary hospitals were worried as they had known for a long time that the unsystematic voluntary hospital system could not possibly provide all that was now required of a health service. It would be unable to meet the recommendations either of the Labour Party or Lord Dawson's consultative council, which said that services ought to be available to everyone. That fear must be mastered - there had been problems enough in the past and they had been overcome.^{59, 60}

Joint survey of medical and surgical services in the administrative county of London, 31 December 1931

Voluntary hospitals

Teaching hospitals	5,881
Other general hospitals of 100 beds or more	2,524
General hospitals under 100 beds	442
Special hospitals	5,986
Total	14,833

London County Council Hospitals

General hospitals	16,920
General convalescent hospitals	820
Public health and public assistance institutions with beds for the chronic sick	6,773
Special hospitals	
Fever and smallpox	8,803
Tuberculosis	2,062
Childrens'	2,618
Epileptic	817
Others	132
Total	38,945

Source Joint survey of medical and surgical services in the administrative county of London, prepared by the Voluntary Hospitals Committee and the London County Council, two volumes. London, P S King and Son, 1933. The survey excluded services for the mentally ill and handicapped.

The local authorities, however, now had a unified and effective hospital administration, and could confer the power to negotiate upon their representatives. But with whom could they talk? The voluntary hospitals seldom authorised anybody to speak on their behalf, and the *Hospitals Year Book* of 1932 urged them to strengthen their machinery for consultation so that they could provide a considered and collective view. The days of 'more or less undisturbed tranquility' were over and a hospital which made an error in its planning delivered a blow to the voluntary system as a whole.⁶¹ Hospitals should now act as members of a system with a common policy.

In its financial review of 1935 the *Hospitals Year Book* pointed out that the income of the voluntary hospitals was relatively inelastic, while the enthusiasm of 'spenders of other peoples' money' was setting a standard in the municipal hospitals which it would be hard to match.

The London Voluntary Hospitals Committee

It was generally known that the London County Council would have preferred to have dealt with the King's Fund directly, instead of with the Voluntary Hospitals Committee. The LCC treated the committee rather as it treated deputations, in a manner which lacked the open trust of those working together for a common purpose. Relations improved in 1935 when the committee was reconstituted under a new chairman with new officers, but it was too late. It never became a potent influence or rallying point, devoid as it was of financial resources to persuade or coerce the London hospitals into a common policy. The reconstituted committee was elected by individual hospitals and brought together the London Regional Committee of the British Hospitals Association and the statutory committee with which the London County Council had been dealing, so avoiding the problems of communication between various bodies claiming to represent the London voluntary hospitals. The understandings between the LCC and the committee were codified, and the Ministry of Health accepted the Voluntary Hospitals Committee as the body with which matters of

importance to London voluntary hospitals were discussed. In giving evidence to the Sankey Commission, the committee expressed the hope that in the course of time it would formulate the principles of hospital policy in London, and, backed by the King's Fund, would get the principles translated into action. The secretary of the British Hospitals Association believed that this was sensible, but saw that the only power available was the power of the purse, which the King's Fund alone possessed.

The approved procedure was for the voluntary hospitals to provide early information to the Voluntary Hospitals Committee about substantial schemes, before the press was told. They then had to submit fuller details of proposals which involved substantial capital expenditure, or which produced 'an important change in the amount, nature, cost or site of the work done'. The committee's object was to ensure that all schemes on which subscribers' money might be spent were clearly justified by the demand for care, but to avoid detailed enquiries into the need for particular forms of therapy or the precise nature of the accommodation to be provided. It did not wish to trench upon the 'freedom and initiative that distinguished the voluntary from the municipal hospitals'.

The King's Fund instructed the voluntaries to give it prior knowledge of proposed developments, and to seek the views of Lord Riddell and the Voluntary Hospitals Committee before seeking a grant. Mr Ives, who became secretary to both the Fund and the committee, was circumspect in his dealings with the county council. He said that he 'was not sure how far it was desirable to submit to the London County Council statements setting out in detail the inadequacies of individual voluntary hospitals'. When the Royal Free Hospital sought permission to expand by a hundred beds because of its long waiting lists and the many acutely ill patients that had to be turned away, these details were not passed on to the council.⁶³

Postgraduate education and the British Postgraduate Medical School

The establishment in London between the wars of a postgraduate medical education centre was a unique innovation. Two ideas were brought together, the need for a national and imperial centre for postgraduate education, as Sir George Newman had advocated, ²³ and the desirability of providing a firm scientific basis for medical

development.

In December 1919 Sir Bertrand Dawson, at the request of his Consultative Council, had impressed upon Dr Addison, Minister of Health, the need for improved facilities for postgraduate education. In October 1920 the chairman of the University Grants Committee (UGC) asked the Minister to form a small committee on postgraduate education in London. There was pressure on the UGC to fund postgraduate education and a number of schemes were under discussion.⁶⁴ The Minister agreed and appointed a committee chaired by the Earl of Athlone, the chairman of the Middlesex Hospital.

The committee was asked to 'investigate the needs of medical practitioners and other graduates for further education in medicine in London and to submit proposals for a practicable scheme for meeting them'. The Athlone Committee worked fast and considered a wide range of evidence. It held 26 meetings and reported in May 1921 that a school attached to a hospital of at least 300 beds, centrally situated in London, should be devoted solely to postgraduate education. The 'great special hospitals' should be closely associated with the school, but it was held that undergraduate and postgraduate education could not easily coexist in the same institution. ⁶⁵

Little more was done at the time because of the financial problems of the early twenties, but in 1925 the Minister of Health, Mr Neville Chamberlain, appointed a committee of medical men to devise a practicable scheme. Chamberlain chaired the committee himself, and it included his chief medical officer, Sir George Newman, the Presidents of the Royal Colleges of Physicians and Surgeons, Lord Dawson, and Herbert Eason of Guy's.⁶⁶ This committee established a sub-group to visit a number of London hospitals. It rapidly eliminated the Westminster and Charing Cross, because of the limitations of their buildings, and the Royal Northern as it was too far from the centre of town. St George's would have nothing to do with the idea. The Middlesex and St Mary's appeared more suitable, but the committee decided that all the other teaching hospitals should be asked whether they wished to be considered. Sir George Newman thought it safe to say that there were more undergraduate schools in London than would be required to meet future needs; that the tendency would be to concentrate education into a smaller number of schools; and that there would be no difficulty in sparing one for postgraduate education.

On 17 June 1926 letters went to all the teaching hospitals. Within a few weeks, and sometimes within a few days, the proposal had been turned down by University College Hospital, King's College Hospital, The London, Guy's and St Bartholomew's. St Thomas's and the Middlesex took a little longer to refuse. In almost all cases the idea was rejected because the future postgraduate hospital would be required to give up undergraduate education. St Mary's was the only hospital willing to consider the proposition, but asked for further details. In the meanwhile, however, the West London Hospital volunteered and an inspection showed it to be a possibility.

After consideration, the Minister's committee concluded that the West London was the only hospital appropriate for conversion and expansion into a postgraduate centre. Further discussions with its board, however, showed that it had little idea of the scope of the scheme and considerable misgivings about its ability to raise the money to support the beds which would be required. The hospital looked to the Ministry to solve these problems. 'This is not a Board', commented Sir George Newman, 'with whom we can go out tiger hunting'. Sir Berkeley Moynihan, the President of the Royal College of Surgeons, shared his concern and suggested that the passing of the Local Government Bill should be awaited. Then, the best poor law hospital in London should be selected and the college built nearby. This would demonstrate that a first class medical school could be attached to a municipal hospital and that the association of a medical school with a state hospital was constructive and advantageous, rather than restrictive and bureaucratic. There would be no need to beg for voluntary subscriptions. Nevertheless talks continued with the West London, the enthusiasm of its board increasing from cool to lukewarm.

Although work on the Local Government Bill was taking up a great deal of time, Neville Chamberlain reassembled his committee in November 1928 to consider the next steps. The imminent municipalisation of the infirmaries led the doctors on the committee to repeat the proposal that an infirmary should be used instead of the West London. Sir Berkeley Moynihan saw Neville Chamberlain in private the day before a meeting of the postgraduate committee on 20 February 1929. During the meeting the President of the Royal College of Physicians, Sir Humphrey Rolleston, said that the objection to the West London scheme was that the committee would not be aiming at

the best within its reach. The West London was not central, the problem of its existing staff (and its quality) had not been solved, and the scheme might cost as much as an entirely new institution. Sir Berkeley Moynihan said that the West London was not large enough to accommodate all the special departments required, that the medical staff was not of such standing as to be easily assimilated into the new centre, and that alternatives should be explored. Mr Chamberlain read out a letter from Lord Dawson which asked for exploratory talks with the London County Council. The committee discussed the possible use of the infirmaries at Camberwell, Lambeth, Lewisham and Wandsworth and none of the members opposed the idea. Mr Chamberlain agreed at the committee's request to approach suitable members of the London County Council. In the meanwhile, he would see the chairman of the West London Hospital to inform him of the reservations of the committee about proceeding further.⁶⁷

The London County Council proved to be willing. A report proposing the association of the new school with the Hammersmith Hospital went to the Cabinet and was presented to Parliament in April 1930. The postgraduate school was to be established at the Hammersmith with the assistance of a government grant.^{68,69} Although the idea of using a municipal hospital had been generally supported by the eminent doctors who were members of the postgraduate education committee, it was not to the liking of the London Voluntary Hospitals Committee. While unable to suggest any alternative, it pointed out that the voluntary hospitals were the traditional basis for medical education and argued that expansion into postgraduate teaching would be better conducted in a voluntary than in a municipal hospital. It maintained that doctors with large private practices had the widest clinical experience and best knew the needs of general practitioners. The stimulus of postgraduate education, and the Treasury grant which went with it, should be kept within the voluntary system. If a London County Council hospital became the new centre, its whole-time staff would become university teachers, suggesting that the centre of gravity of even undergraduate teaching might gradually shift to the municipal hospitals, an occurrence which would greatly undermine the voluntary system as the teaching of medicine was one of its main sources of strength and vitality. A further objection was that to place the *centre* of postgraduate education on the *outskirts* of London was a fundamental mistake.⁷⁰

During subsequent discussions with the LCC it was agreed that while the Hammersmith should be well equipped as a hospital, unrealistic standards of provision were not necessary. The quality of the teaching would depend on the quality of the teachers. The economic problems of 1932 led to a reduction in the government grant from £250,000 to £100,000. The scheme came to a halt and the appointment of the dean was delayed. For a time it was feared that the whole project would have to be cancelled, but in November 1932 the chancellor agreed that it could go ahead and the London County Council was informed.⁷¹ The council facilitated the conversion of the Hammersmith Hospital into a centre for postgraduate education, matching the government's grant by one of its own. The British Postgraduate Medical School, as it was called, agreed to meet a proportion of the extra cost which arose from its establishment in relation to the hospital, the LCC and the school sharing the cost of equipment for joint use.

The school was opened in 1935, Professor Francis Fraser moving from St Bartholomew's Hospital to become its first professor of medicine. Some of the intentions of the founders were expressed by King George V at the opening. The school was to be 'rooted in the ward and the laboratory' and was to 'renew knowledge and disseminate it for the benefit of mankind'. Stress was laid upon the contribution to be made to the Commonwealth, and the overseas relationship was underlined by the composition of the governing body. Professor Fraser was later to play a key role in the hospital service of London during the years of war, and in the emergence of the pattern of the National Health Service in the capital. He was able to establish new traditions at the Hammersmith and to ensure that from the beginning the hospital and school were staffed at consultant level mainly by whole-time academics.

The voluntary hospital system's prospects

The voluntary hospital system was now on the defensive. During the financial crisis of 1921 its efficiency had been called into question. With the advent of the municipal hospitals in 1929 its very existence was at stake. Between 1928 and 1932 the London voluntary hospitals had increased their beds from 15,900 to 17,100, and treated 16 per

cent more inpatients. However the cost per bed was rising and voluntary donations were falling, although the shortfall was made good by increasing payments by patients. In 1932, 85 hospitals succeeded in balancing their books; 60 did not. 72

In 1930 Mr Inman, then house governor at Charing Cross Hospital, wrote two articles for the *News Chronicle* and the *Star*.⁷³ He said that what was vitally necessary was not a patched up policy but a permanent panacea. Hospitals could not rely on sweepstakes and competitions for their survival. He saw three possibilities: that the depression would end and the financial state of the hospitals would improve; that the state might offer assistance without there being state control; or that the hospitals would be nationalised. He forecast that in ten years every hospital would be state supported and state controlled. That such a statement should be made in the press by the house governor of a teaching hospital alarmed the King's Fund. The Fund's council members were sent a copy of the offending articles and their chairman asked the chairman of Charing Cross, Mr Verity, to come to see him. Verity was completely loyal to his house governor, and said that he shared Inman's detestation of the undignified methods of fund-raising which were in vogue. Inman himself wrote to the Fund expressing his strong support for the voluntary system.⁷⁴

The seriousness of the hospitals' financial position led the British Hospitals Association to pass a resolution in 1935 to establish a commission, chaired by Lord Sankey, to examine the administration, management and finance of the voluntary hospitals. The main organisations with an interest in hospitals gave evidence, while the commission considered how the hospitals' interests could be promoted, their policy developed and their future safeguarded.⁷⁵ Although the King's Fund was sympathetic it declined to give evidence, while prepared to answer any 'definite questions' which were addressed to it. The commission's report, published in 1937, stated that future prospects were not favourable, and made thirty seven recommendations involving major changes which were considered essential if the voluntary system was to continue.

A key proposal was the formation of regional councils to express 'considered views' on hospital systematisation. Loyal acceptance of their decisions was expected, even if they were painful.⁷⁶ Similar proposals had been made sixteen years earlier by the Cave committee.¹² The more accommodating spirit now in evidence was

inspired both by fear and hope; fear of being driven out of business by the municipal hospitals, and hope of receiving assistance from local authorities or the state.

No member of the Sankey commission worked in a special hospital and its report reflected evidence given by the Royal College of Surgeons that special hospitals should be brought into close cooperation with general hospitals, or run as one of their departments. 62 This exercise in force majeure did not appeal to the special hospitals, one of whose secretaries protested to the British Hospitals Association. Political and Economic Planning (PEP), a group of individuals interested in the planning of the country's services, also regarded the case against the special hospitals as 'not proven.' 77

The work of the King's Fund

Although it seldom displayed its power in public, the influence of the King's Fund was considerable. In 1924 it investigated the problems of the uncoordinated ambulance services in London and the difficulties of obtaining an emergency admission, both of which were complicated by the large number of independent hospital boards and poor law infirmaries then governed by guardians whose rules and regulations varied.

A hospital economy committee was formed in 1924, during the period of financial crisis, to examine comparative costs, draw the attention of hospitals to excessive expenditure, and consider the explanations offered by the hospitals. This committee also examined the reason why hospital beds might be under occupied, and the way better use might be made of existing facilities. 78

The management of voluntary hospital outpatient departments was the concern of a special committee chaired by Lord Onslow in 1931. The voluntary hospitals' open door policy continued to attract criticism. The Charity Organisation Society and the British Medical Association gave evidence, as did many of the hospitals. The BMA's view that outpatient departments should be purely consultative, seeing only those patients referred by general practitioners, was considered impracticable. The introduction of appointment systems was also thought to present too many practical problems, although ways of reducing the time spent waiting for the doctor were suggested. 78

In 1936 the Fund explored a suggestion of Mr Gardham, a surgeon at University College Hospital, that a centralised admissions service should be established for the voluntary hospitals. Faced with competition from the London County Council hospitals, the voluntaries needed such a service to ensure that they continued to receive a flow of emergency work, so necessary for medical education. The service would also supply a public need and remove a possible cause for criticism. And so the Emergency Bed Service was born which for some 40 years helped the ambulance service to find beds in crowded London hospitals.⁷⁸

The King's Fund also continued its work of considering building plans, sanctioning improvements and advising hospitals on new developments. Hospitals could not always be persuaded to make the most sensible decisions, but the wilder ideas were usually extinguished. A hospital which went its own way had little chance of a successful appeal to the Fund if things went wrong.⁷⁹

Despite financial problems, two major teaching hospitals were largely rebuilt the Middlesex under the chairmanship of Prince Arthur of Connaught, and the Westminster under Sir Bernard Docker. In 1923 a large fall of plaster revealed unexpected defects at the Middlesex. The surveyor's report showed that the east and west wings were in a dangerous condition. Their foundations were virtually non-existent and wards would have to be closed. The King's Fund was worried at the prospect of a major appeal at a time of economic crisis and a second survey was carried out at its request to see if remedial works would be possible. The findings were confirmed; the Middlesex really was falling down. The hospital favoured total reconstruction and an appeal was launched to which the King's Fund made substantial grants. One wing at a time was demolished and rebuilt, and the new building was opened in 1935 by the Duke of York.⁸⁰ Significant additions were made to many other hospitals. St Bartholomew's rebuilt its surgical block with the help of the King's Fund, and launched a much larger appeal for a million pounds in 1929, but without telling the King's Fund in advance. The hospital expressed its regrets and the Fund accepted the new proposal with good grace. However because of the economic situation the response was poor and the appeal had to be abandoned.⁸¹ University College Hospital built a new obstetric hospital which was opened with the customary panache. The secretary wrote to his

chairman:

*'I think we might have a big marquee with a platform and accommodation for one or two thousand people. We should also have a band and when the Prince has opened the new buildings the company might re-adjoin to the College grounds for tea and refreshments.'*⁸²

Special hospitals were also developing their facilities. Queen Charlotte's was rebuilt to the west in Goldhawk Road, a major block was added to the National Hospital for Nervous Diseases, and there was rebuilding at the Gordon, St Mark's and at the Royal Westminster Ophthalmic Hospital. The medical staff at Great Ormond Street were asked to report on the condition of their hospital, and their highly critical comments led to the construction of the Southwood wing.

New architectural principles were applied to the design of the new buildings. Aerial spread of infection was largely discredited and the pavilion plan was abandoned. Instead, compact multi-storey blocks were erected, in part because of the cost of city-centre land. Ward units were smaller and more space was devoted to service departments. An attempt was made to deal with ward infection by partitions and screens, balconies were increasingly introduced, and attention was paid to the problem of noise. It was appreciated that building vertically rather than horizontally would make it more difficult to adapt hospitals to changing requirements, as proved to be the case.⁸³

Facilities were improved to keep pace with medical science. The King's Fund established a radium fund and supervised the distribution. Professorial clinical units were introduced. But these developments did not alter the historic concentration of hospitals in central London which was hardly, in the opinion of Political and Economic Planning, the best arrangement under modern conditions.⁷⁷

The Westminster, St George's and Charing Cross Hospitals

Many hospitals were re-planning their services and the King's Fund was at the centre of all proposals for redevelopment. In 1913 the Westminster had purchased a site on the north side of Clapham Common, the Fund agreeing to make an annual grant towards the payment of interest on the mortgage. Once the war ended the scheme

was revived and in July 1919 plans were drawn up for a new hospital. However, the Westminster's medical staff now preferred an alternative - amalgamation with King's College Hospital at Denmark Hill. They feared that the money available would not be enough to build and maintain a new Westminster Hospital large enough to contain a full range of clinical facilities and achieve recognition as a clinical medical school.

The King's Fund discussed the facilities which might be made available to the Westminster Hospital at Denmark Hill with Lord Hambledon, chairman of King's College Hospital. Although only 360 of the 600 beds originally planned had been built, Lord Hambledon said that half of them could go to the Westminster. Some expansion would be comparatively easy and the name 'The King's Westminster Hospital' would be quite acceptable. Having considered the options open to the Westminster, the King's Fund continued to prefer Clapham and suggested that the Westminster might consider amalgamation with another hospital on that site. But as the cost of the Clapham scheme was high the Fund agreed that if it became too expensive and the need to move was pressing, Denmark Hill might be reconsidered. 84

Neither proposal proved practicable and the Westminster's Broad Sanctuary building had to be upgraded, to the distress of Lord Knutsford who thought it a 'ghastly waste of money' and the loss of a great opportunity to achieve either the removal of the Westminster or its amalgamation with another hospital. The matter rested until 1933 when the Westminster was offered the Horseferry Road site. A scheme for amalgamation with St George's was then considered, but St George's felt that the Westminster was paying too much for the land and did not like its position. The Westminster had to go it alone. The King's Fund was kept fully informed throughout the complex negotiations and the land was not purchased until its approval had been obtained. The Westminster Hospital's appeal brochure was edited by the Fund before it was issued. 85

Charing Cross was another potential partner for the Westminster. It had long been accepted that the Charing Cross site was inadequate, without room for expansion. The Fund used its influence in 1936 to prevent Charing Cross rebuilding at the Adelphi because of the high cost of the site, and pointed to the existence of enough ground in Horseferry Road to build a 400 bed hospital next to the Westminster,

but Charing Cross would not agree to abandon its separate existence. The Westminster's new buildings were opened in April 1939, and were hailed as a new departure in hospital planning. Outpatient and inpatient departments were related to each other on each floor, to make progressive patient care easier.

The King's Fund later agreed to an alternative scheme for Charing Cross Hospital which was proposed in 1938. It would have provided 320 ordinary and 80 private beds at the north end of Shaftesbury Avenue, to which neither University College Hospital nor the Middlesex made any objection.⁸⁶ St George's was also slow in coming to any firm conclusion. For thirty years it had vacillated over rebuilding at Hyde Park Corner or attempting to sell the site - difficult because of divided ownership - to finance removal. In January 1935 it was agreed that the hospital should be rebuilt where it was. The council of the King's Fund viewed the proposal with disquiet, but acquiesced after the views of all its members had been canvassed. The Fund's approval was given in February 1935 and an appeal was launched. HRH the Duke of Kent contributed the money collected for his wedding gift, and signed the appeal brochure which was issued the following year.⁸⁷ Dr Hugh Gainsborough, speaking at the hospital's annual dinner in 1937, deplored hurry. Hospitals had to be carefully planned; 'plan slowly and build quickly' was his message. The architect published his plans for a twelve storey building in March 1939, but the planning had been too slow. The new hospital could not be constructed because of the outbreak of war.⁸⁸ The architect, however, was subsequently involved in the post-war redevelopment of Guy's.

The King's College Hospital crisis

In 1930 King's College Hospital, in dire straits, had approached the London County Council for assistance. The London Voluntary Hospitals Committee asked King's not to make its request for financial help public. The county council refused a general grant-in-aid. Again in 1938 the hospital's financial position began to deteriorate. This time the King's Fund agreed to make an emergency grant of a pound for every pound the hospital could raise above its average receipts in previous years, with an upper limit of £5,000. In due course this sum was provided. The hospital also asked the county council that year to receive a deputation.⁸⁹

It was made clear to the council that the hospital did not wish the Voluntary Hospitals Committee to act as an intermediary. The deputation, led by Lord Hambledon, presented a memorandum outlining the origin of the Denmark Hill development. Only two thirds of the beds originally planned had been built, the council was already using one ward as an adjunct to the Maudsley and King's was prepared to make a further ward available to the council should it wish to expand its acute services in south London. King's also suggested a joint approach to the provision of acute hospital services by the council and the hospital and pointed to the availability of adjacent land for new building. Questioning made it clear that Lord Hambledon was afraid that if matters did not improve, more wards would have to be shut. The hospital was, therefore, seeking council assistance to open and run wards which it could not itself finance, a course of action which would be contrary to the agreement which obliged the council to pay only for services rendered. The problem was referred to the London Voluntary Hospitals Committee.

Conferences and delegations

After King's had been to see the LCC, Sir Frederick Menzies wrote in confidence to the Minister of Health, drawing attention to the serious revenue problems of some of the teaching hospitals. He believed that St Thomas's and the Middlesex might be on the rocks within 12-18 months. Other hospitals were in need of capital for modernisation schemes, like The London, St George's, Charing Cross and Guy's. The forthcoming pay recommendations of the Inter-Departmental Committee on Nursing Services were likely to increase costs and the voluntary hospitals would be hard hit, and quite a lot of them would be seriously damaged.

Menzies felt that it would be disastrous if the great hospitals had to close beds, or fell behind in medical science - their medical schools and their national role as teaching centres were of inestimable value. He therefore suggested a royal commission to explore the problems urgently and report rapidly. The chief medical officer consulted the King's Fund and the principal of the University of London, Herbert Eason of Guy's. Both believed that help was necessary and supported

the proposal for a commission. However, they thought the problem a national one, and that the solution would be a hospitals board to provide grants to all teaching hospitals, just as the University Grants Committee funded the medical schools. For the time being they thought that the most likely source of money for London hospitals was the LCC, in view of the sympathy Menzies was showing, and in spite of the apprehension of the hospitals about undue local authority control.^{90, 91} In Menzies' view the problem was mainly a London one. He said that there was no territorial pride in the County of London 'and the Londoner, as a Londoner, did not care twopence about the future of the voluntary hospitals'. He said that the London County Council, led by Herbert Morrison, would be in favour of keeping the teaching hospitals on a voluntary basis, although 'the more extreme members on the Labour side might like the idea of a London County Council teaching hospital'.

There was to be no royal commission but in June 1938 the King's Fund convened a private conference of the twelve teaching hospitals to consider their high costs. Over the years their costs had risen considerably and in 1938 they were 200 per cent higher than in 1913. The proportion defrayed by the King's Fund had fallen from around 15 per cent to 3 per cent, but the King's Fund figures for the period 1933-37 showed that, taken as a whole, the voluntary movement in London was not in too bad shape. The Hospitals Year Book, however, had drawn attention to the marked differences in maintenance costs of the London hospitals and those in the provinces. In 1935 the annual expenditure per bed in the London hospitals was £236.1 whereas in provincial hospitals it was only £137.9. Costs were slowly rising, but the differences remained each year.

The Fund's conference agreed that the high costs of the teaching hospitals were due to:

- the time spent on teaching which meant that more junior medical staff and nurses were needed;
- the expense of the investigation of patients
- the larger premises needed for teaching;
- the greater number of specialist departments required in a teaching hospital.

Supported by the Fund, the representatives of the teaching hospitals

submitted a memorandum to the Minister of Health, Mr Walter Elliot, on the case for a state grant to the London undergraduate teaching hospitals. While paying tribute to the help received by the medical schools from the government, the memorandum pointed out that the provision of clinical facilities included much more than teaching and teaching equipment. Heavy expenditure fell upon the hospitals. The Minister received a deputation in November 1938 but was non-committal.

In July 1938 representatives of the voluntary hospitals suggested another conference with a wider attendance. It would consider three main proposals to place the hospitals on a sounder financial basis: first, a regional grouping of hospitals, pooling their resources; the second, subsidy by the state or the local authority; third, an extension of the contributory and hospital savings schemes which had brought much relief to the hospitals already. During informal discussions a central advisory board for London was proposed, chaired perhaps by Lord Dawson, with a membership from the Ministry of Health, the London County Council and the King's Fund. As the financial crisis worsened the voluntary movement pressed for a conference. The London County Council saw no grounds for holding one but was prepared to attend without commitment. It finally took place in January 1939 as a confidential discussion between the Ministry, the King's Fund and the council, and was held at the Ministry of Health. 92

Everyone agreed on the virtue of cooperation and that it had been more successful in other large cities than in London. Lord Dawson thought that it would be folly to displace either of the two systems, voluntary or municipal, but an effective service for the County of London needed planning. He therefore advocated an advisory board to classify hospitals, identify places where the services needed strengthening, and prevent overlap. The LCC and the King's Fund could look to such a board for advice in making their allocations. Lord Dawson hoped for additional money from the state, but said privately that the voluntary hospitals should pool their resources and help each other. The King's Fund pointed out that the London voluntary hospitals were 146 separate units and a hospital in distress could not draw upon the assets of a more fortunate institution. The Fund's ability to adjust inequalities depended on its income, then £300,000 a year; salvation could only come from the state or the LCC. Herbert Eason, speaking for the university, paid tribute to the high quality of care and organisation in the London County Council system. He said he would

prefer council money and supervision to that of the state. The voluntary hospital representatives as a whole wondered whether the time had not come to review the question of capital and maintenance contributions from the council.

Speaking for the council, Herbert Morrison said that it could spend with advantage far more money on its own hospitals than it was doing. But the rate-payers might rebel and it was his business to win elections, not to lose them. The voluntary hospitals already received some £160,000 a year for contracted services. Although he conceded that some extension of this principle was possible, he did not think that the council would embrace the idea of block grants that the voluntary hospitals were now suggesting. Substantial public finance for the voluntary hospitals would reduce the subscriptions they received. Neither did he personally favour a joint advisory board if the voluntaries were to retain a proper sense of their financial responsibilities. Were all 146 voluntary hospitals justified? If some of those which could not be run effectively and efficiently were eliminated, the King's Fund could restrict its contributions to the best. The LCC was sympathetic and wished to be helpful, but difficult problems were involved.

Other council members pointed out that the teaching hospitals, which were in the deepest trouble, were national institutions and a problem largely for the state rather than London. Speaking on behalf of the council's finance committee, a member pointed out that the council bore the burden of all the mental hospitals and the care of the chronic sick, problems with which the voluntary hospitals were not concerned. If teaching hospitals cost more than other voluntary hospitals, was it not for the state to meet the difference? Sir Frederick Menzies returned to the theme of hospital planning; an appeal was to be launched to rebuild St George's on site and Charing Cross was considering removal. The rebuilding of hospitals and medical schools was a question of major importance, to which careful thought must be given. The King's Fund pointed out that it was the smaller hospitals which were solvent, and to eliminate them would be difficult. Herbert Morrison, sensing that there was increasing pressure for a financial commitment he was unable to give, said that the problem could be taken no further for the time being.⁹²

The Minister, when questioned in Parliament subsequently, could give no more than a non-committal reply about the outcome of the

conference. The attempt to create an advisory board, and to persuade the Council to contribute more money, had failed. A county council spokesman was quoted in the press as saying that the addition of the costs of the voluntary hospitals to its own budget would add 1s 5d to the rates.⁹³

Both the London County Council and the voluntary hospitals were willing to see the state make grants. But at least one Ministry officer thought that if state grants perpetuated the existing pattern of medical education that would probably be a mistake. He felt that the organisation was far from ideal, for there were many medical schools and some of the hospitals with which they were associated were ridiculously small.

Emergency planning

But other matters were now on people's minds. The risk of war with Germany was rapidly increasing and the Ministry, the LCC and the Voluntary Hospitals Committee had to concentrate on emergency planning. The first task was to determine how many beds the hospitals could hold in time of war. In December 1937 Sir Frederick Menzies and Professor Dudgeon of St Thomas's, representing the voluntary hospitals, were called to the Ministry and told that there was to be a national survey of 'anything called a hospital or a Poor Law institution'.

Shortly afterwards, with their assistance, questionnaires were sent out to the hospitals, which were subsequently visited by a Ministry inspector. Preliminary results were available a month later and the final draft was circulated in May 1938

Summary of available beds in London hospitals

	Administrative county	Greater London
Population	4,141,000	7,993,000
Beds available	23,504	45,951
with crowding	48,347	96,249
with use of adjoining buildings	62,929	131,718

Menzies and his colleagues agreed that, all things being equal, the

extra beds which would be needed should be placed on the periphery of London, on ground adjacent to the main roads out of town. A policy of dispersal was safer because 'there was the certainty that several of the London hospitals would be put out of action'. Menzies envisaged the division of London into sectors, three north and three south of the Thames.⁹⁴

In May 1938 attention was turned to the problems of dealing with mass casualties from intensive bombing, casualty evacuation, and the transport of those patients who could be moved from beds in central hospitals. A committee was established under the chairmanship of Sir Charles Wilson (afterwards Lord Moran), which reported two months later. The number of casualties predicted was high - an estimate of 30,000 per day for several weeks. It was therefore agreed that some 50,000 beds would be needed in the inner zone, and that rapid evacuation of casualties would be necessary. It was suggested that the whole of the region should be divided into five segments radiating from the centre, with the general idea that the hospitals in the inner part of each segment would clear their casualties to the outer part.⁹⁵ A further group was established to examine the way in which a series of temporary hutted hospitals could be created to increase the number of beds available. Driven by Dr John Hebb, a rough diamond transferred from the staff of the Ministry of Pensions, plans were well in hand by July 1939 to provide a ring of hutted hospitals on the periphery of London.⁹⁶ Equipping them proved difficult in the face of the demands from the armed services. The Ministry turned to Eric Salmon, Clerk to the London County Council, who asked how much might be spent. 'Whatever it costs' was Evelyn Sharpe's answer and the highly efficient supplies department of the council did the rest. With the establishment of the Emergency Medical Service, Sir Frederick Menzies took early retirement.

Other committees considered transportation, the conversion of buses into ambulances, and the way ambulance trains might be stabled and routed. Labels were printed to attach to patients, indicating the hospital to which they were being evacuated. Teaching hospitals examined the way in which clinical information might be passed to receiving hospitals without risking the permanent loss of case notes. On 31 August 1939 the Ministry of Health gave the order to the railway companies to proceed with the assembly and preparation of thirty-four casualty evacuation trains. A fleet of Green Line buses was requisitioned. They were in position on 4 September. Hospitals divided

their patients into those fit to go home, those fit to move and those who had to stay where they were. The evacuation of patients then began. 97, 98

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Chapter 9 Regions and Districts

We now break the continuity of the narrative, which is essentially chronological, to consider the development of two concepts which increasingly influenced the development of hospital systems in this country. These are hospital *districts* and *regionalisation*. Both can be traced back for many years and neither is specific to London. The ideas can be found in hospital and medical literature from the end of the nineteenth century, in the report of the Select Committee of the House of Lords on Metropolitan Hospitals ¹, and in the writings of the Fabian socialists. ²

By the outbreak of war in 1939 such organisational concepts were being widely discussed, as was the role of county councils in the provision of health care. However, while the leaders of the voluntary hospital movement frequently urged hospitals to think about matters outside their walls, and to take a national view, they generally saw little need to do so. As a national hospital service became increasingly likely, the necessity became more pressing. Independence of management and local traditions were not going to persist for ever, and hospitals needed to present a united front on many issues. Districts and regionalisation were amongst the matters on which a voluntary hospital view was called for. The London services might have longstanding traditions, but the problems of the capital's hospitals, although complex, had to be solved within a framework of wider policies.

The district

Institutional care had been provided by geographically based organisations for many years. The role of parishes in the care of the poor had been accepted since the statute of 1601, the '43rd Elizabeth'. There was therefore nothing new in the idea of institutions within the poor law having a district responsibility. The municipal hospitals later worked on the same basis. However, the voluntary hospitals and medical charities seldom set a boundary to their responsibilities. They might have been established to meet a pressing local need, but a residential test was not applied before deserving cases were admitted. The idea of a district hospital, providing a higher level of care than customary under the poor law, to which incurable cases of cancer, dropsy and consumption might be sent, was raised by Louisa Twining in her evidence to the Select Committee on Poor Relief in 1861.³ A

parallel was drawn with the newly established district schools. At the hospital conference of 1881 Henry Burdett suggested that each large hospital should be the centre of a district, an idea later echoed by Mouat. 4,5. Most plans for hospital systems produced after the conference suggested the organisation of services on a district basis.

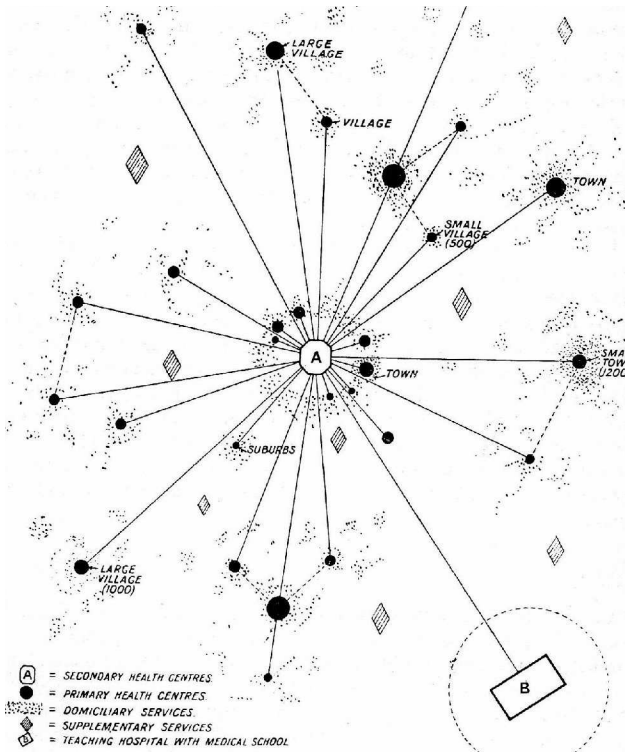
The affiliation of voluntary and rate-supported hospitals and the provident dispensaries to provide a united district service was proposed by witnesses to the select committee of the House of Lords in 1890, including the Charity Organisation Society. This was too radical an idea at the time for there was no general acceptance of the view that all institutions in a locality should cooperate in the provision of services. Neither was there any desire on the part of the voluntary hospitals to determine the areas for which services might be planned. A memorandum prepared in 1918 by the Labour Party's advisory committee on public health described in some detail how a hospital service might be organised, and is remarkably modern in its approach. 2 However, Sir Bertrand Dawson KCVO, physician at The London Hospital, is generally credited with the first definitive statement of the principles of organisation of a complete hospital system.6

The Dawson report

Bertrand Dawson developed his ideas on system in health services while in the Royal Army Medical Corps, where organisation and planning saved lives. As a physician to the Royal Family with an extensive private practice, he was well known and respected in political circles and involved in discussions on the future Ministry of Health. His views on the need to centralise certain specialised activities were outlined in his Cavendish Lectures to the West London Medico-Chirurgical Society on "The Nation's Welfare and the Future of the Medical Profession" of 1918 6, on which *The Lancet* commented favourably.7 Dawson urged the medical profession to take a lead. Dr Christopher Addison, the first Minister of Health and former dean of the Charing Cross Hospital Medical School, was therefore well aware of his thinking when, in October 1919, he asked Dawson to chair a consultative council to advise on 'schemes for the systematised provision of medical and allied services, as should be available, for the inhabitants of a given area.'8 Before the report was published Dawson was elevated to the peerage as Lord Dawson of Penn. Lloyd George felt there was an advantage in having in the House of Lords some real authority on public health.

Implicit in the report, much of which was based on ideas Dawson himself put forward, were the concepts of district and regionally based services. The Medical Officer of Health for Gloucestershire, Dr J Middleton Martin, had been thinking along similar lines, and had made co-operation a reality in his locality. He wrote to Dawson after his Cavendish lectures about this practical example. The council suggested a hierarchical system which proceeded from the simple to the complex. Domiciliary services would be supported by primary health centres staffed by general practitioners with the help of laboratories, radiography and inpatient accommodation. In nearby towns, secondary health centres would provide a full range of general and specialised medical services, with medicine, surgery, gynaecology, ophthalmology and ENT as a minimum. These hospitals would relate in turn to university hospitals where the rarest and most difficult cases might be managed. The scheme would require a new pattern of medical administration, to ensure 'unity of purpose at all levels'. It was proposed that there should be a single health authority to unify and control all health services, curative and preventive, much stress being laid upon the latter. As to the constitution of the Health Authority the members of the Council were not in agreement; some preferred a statutory committee of an existing local authority - presumably the county council or county borough council - others an independent body for the purpose of administering health services alone. This issue was not resolved until Bevan decided to by-pass local authorities. The medical profession would be represented on the authority, which would have administrative medical officers on its staff; a medical advisory council would assist the authority in its work. There were no recommendations about funding but most members of the council favoured part payment by patients. The report indicated how the scheme might be applied to Gloucestershire, and suggested that a hospital survey of the whole country might be undertaken. A survey would show where new centres would be necessary to supplement the existing voluntary hospitals and the more modern of the poor law infirmaries.

When the report appeared the *British Medical Journal* commented that its implementation would have a profound effect on the future of medicine in England.⁹ *The Hospital* said it was of transcendent importance but that its proposals would be costly and its implementation would inevitably entail the disappearance of the voluntary hospital system, as then known.¹⁰ The report was



Source Great Britain, Ministry of Health, Interim report of the Consultative Council on Medical and Allied Services, 1920

inherently controversial for district organisation would only be possible if hospitals sacrificed some of their autonomy. The organisation of services to cover wide areas was a challenge to the concept of local government and its boundaries. In the event the reaction was muted, for many of the ideas had been advocated previously in one form or another, and their implementation seemed too distant to be a real threat.

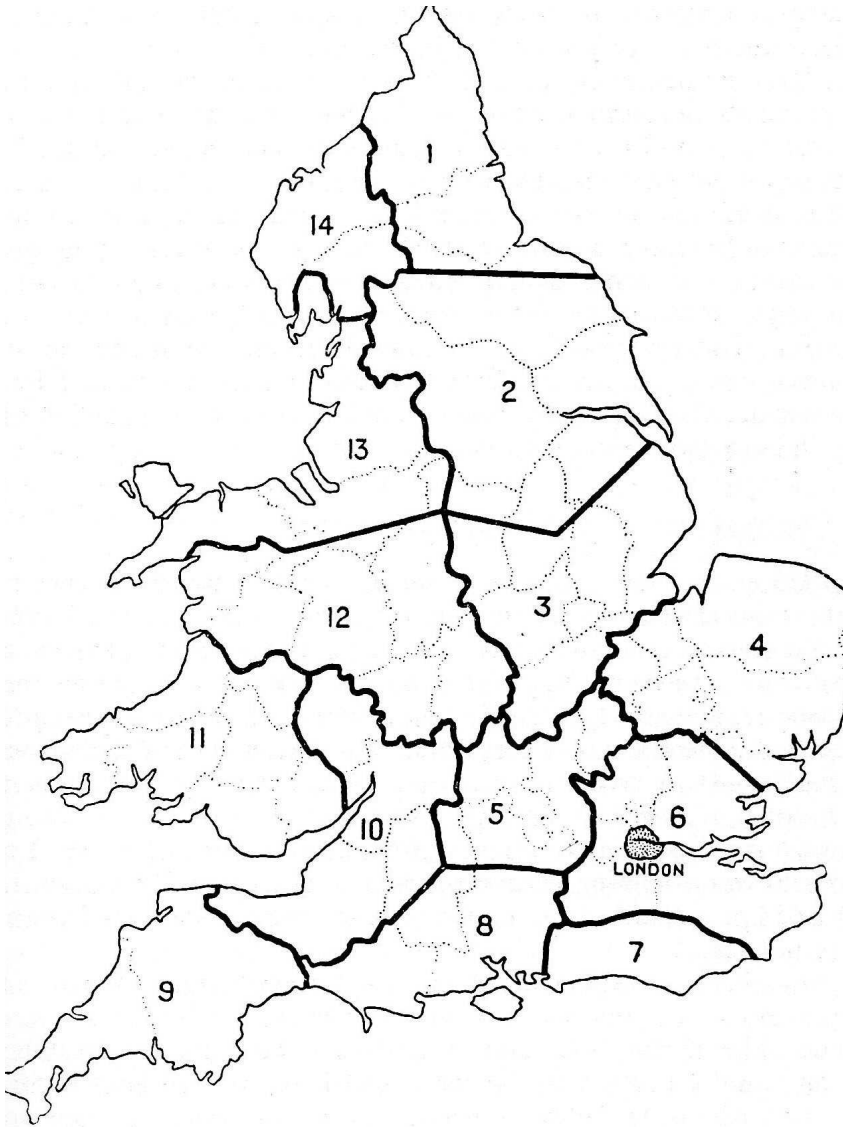
There had been disagreements in the consultative council about financial matters, and whether health authorities should be statutory committees of existing local authorities, or ad hoc bodies established purely to manage health services. A final report never appeared. The model scheme quickly came to pieces, and the potential cost of

building and maintaining the services likely to be required was an embarrassment to the government.¹¹ The financial crisis which developed just as the report was published delivered the coup de grace, and a document which now appears a crucial if idealistic statement of the shape a health service system should take was discounted at the time. The council ceased to meet shortly after the publication of its interim and only report.

Regions

Organising hospital services on a district basis stems naturally from the needs of a population for day-to-day care. The rarer complex cases requiring more specialised care demand larger catchment populations. A regional hospital system providing specialist services had few precedents and the idea suffered from close identification with the interests of the larger voluntary hospitals, which were the main providers of specialist care. Dawson's writings had expounded the principles of the organisation of services for large areas, and the reference of patients to distant specialist centres was slowly becoming established practice. The *organisation of a hospital system* to facilitate this was a new idea. The voluntary hospitals felt the need to combine in defence of their own interests, and regionalisation was an obvious and convenient method of dealing with practical problems on a geographic basis - even though it did not find many parallels in local government.¹²

In 1935 the British Hospitals Association, realising the seriousness of the hospitals' financial position, established a commission under the chairmanship of Lord Sankey to consider collaboration within the voluntary movement. Its report, published in 1937, recommended the formation of regional hospital councils. While noting the 'freedom of spirit and of action of the voluntary hospital movement', the commission pointed out that competition between voluntary hospitals and with the growing municipal hospital service was wasteful. The regional hospital councils would be based on the organisation of the British Hospitals Association, coordinated by a central council. Thirteen Regional councils would have offices and staff, would coordinate hospital work, and might in time administer a regional fund so that a hospital with a surplus could help one with a deficit. The regional councils would define the functions of hospitals in their areas, 'grade' them, keep bed states and patient records, organise an ambulance and blood transfusion service, keep statistics, arrange the



joint purchase of supplies, and publish regular reports. Lord Sankey thought that two things were necessary if his report was to be implemented: the constant thought and attention of public spirited men and women, and money. His report was widely welcomed but largely for reasons of finance the British Hospitals Association took no active steps to implement the recommendations. The scheme remained in abeyance.

Political and Economic Planning (PEP), in its broadsheet and its *Report on the British Health Services*, supported regionalisation and quoted with approval the recommendation of a royal commission on local government in Tyneside, that for efficiency and economy medical services and hospitals should be administered by a single regional authority covering a wide area.^{15,16} The 1939 edition of Burdett's year book, now issued by the British Hospitals Association, also dealt with regionalisation. The Association's secretary, Mr Orde, believed that it was necessary for the voluntary hospitals to improve access to care, improve facilities and make the best possible service available at the least possible cost. He felt that state financial aid would be required sooner or later and the only way to attack the problem was on a regional basis. Orde felt that a preliminary survey of existing hospitals and patient flow was called for, but he believed that the boundaries of 'natural hospital regions' would be unlikely to coincide with existing local authority boundaries. He wished to see regions based upon the 'great teaching hospitals' and provided a map of England and Wales showing fourteen divisions on which there was provisional agreement within the British Hospitals Association. Each region should be able to provide its patients with all the services they needed. Region six included London, Kent, Sussex, Surrey, Middlesex, Hertfordshire and most of Essex. ¹⁷

The danger of war in 1938 led to a further exercise in regionalisation. The Ministry of Health, after discussion with the local authorities and the voluntary hospitals, began to survey hospitals and infirmaries and to classify them according to the facilities they provided, linking those in vulnerable areas with others in more distant places. For the purposes of the survey the Ministry, in discussion with Mr Orde, adopted the British Hospitals Association regions.¹⁸ Medical officers were appointed to work out the details of an emergency organisation for different parts of the country, and in the south-east three hospital officers, based at the Ministry itself, were responsible for region six. When war broke out in 1939 the Emergency Medical Service came

into being and a regional form of organisation was established overnight. There was a suggestion that the Government should go the whole hog and establish a centralised state hospital service from the first months of the war. Less radical counsels prevailed, but Sir Edward Forber, a retired civil servant who was considering postwar hospital policy at the Ministry of Health, suggested in November 1939 that an investigation into possible health region boundaries should be started.¹⁹

The Nuffield Provincial Hospitals Trust

In 1935 an informal grouping of voluntary and municipal hospitals in Oxford was established with the support of Lord Nuffield (1877-1963). This successful collaboration between hospital systems which elsewhere were often rivals was followed by the establishment of the Nuffield Provincial Hospitals Trust. In October 1939 Lord Nuffield wrote to the Minister of Health, Mr Walter Elliot, introducing the deputy chairman of Barclay's Bank, Mr William Goodenough, who had a long experience of hospital affairs at the Radcliffe Infirmary in Oxford. Goodenough brought a proposal for the establishment of a trust, to which Lord Nuffield was proposing to give a million shares in Morris Motors Ltd valued at £1,250,000. Here was the money for which Lord Sankey had been hoping.

On the face of it a parallel existed with King Edward's Hospital Fund for London but it was clear from the start that the Fund and the Trust would differ in their emphasis. The Fund contributed significantly to the revenue of London's voluntary hospitals but even as large a gift as was in prospect could have little effect on the finances of the provincial hospitals. The prime object of the new trust would be to encourage regionalisation, coordinating municipal and voluntary hospitals, and ancillary services.

The Minister considered his position in relation to the new trust carefully. There had to be visible support for the voluntary principle and regionalisation was the most hopeful approach apparent, but he could not become committed to details in advance of a general government statement on hospital policy. Competition with the King's Fund also had to be avoided, but the gift was welcomed in the House and widely publicised in the press on 6 November 1939.²⁰ The basis of the plan developed by the Trust in the next few months was the demarcation of the country into a series of hospital regions, each

having as the focus of hospital and health services a university medical school and a 'key' hospital. The regions were divided into hospital divisions, each with a main hospital at the core to which the smaller hospitals and clinics of the division were linked. In turn the divisional hospitals were linked to the regional key hospital. The Trust was able to build upon a number of schemes which were already being developed,¹² and four regional and eleven divisional councils had been formed by the time of the announcement of the government's post-war hospital policy in 1941. The search for coordination was always pursued as a means of ensuring that the patient might find a good and complete service in his own area, never in the interests of administrative convenience.²¹

The speed of the Nuffield Trust's progress began to worry the local authorities, including the London County Council, who felt that the Trust was forcing the pace. They were not reassured by occasional remarks by leading members of the Trust about the importance of maintaining voluntarism and avoiding state shackles. It soon became apparent to the Nuffield Provincial Hospitals Trust that the natural units of hospital organisation were related to catchment patterns, and not to home defence regions or county boundaries. The Trust sought ministerial endorsement of its aims, first from Mr Malcolm Macdonald and then from Mr Ernest Brown when he took over the Ministry. Endorsement was given in guarded terms. Ministry officers were encouraged to attend regional council meetings, but only as observers who were unable to commit themselves until there had been a government announcement about post-war hospital policy.

It was inevitable that the local authorities should see regionalisation as a threat not only to their own services, but to the whole concept of local government. They naturally favoured local authority control, and disliked the prospect of a regional council advising on provision over a territory wider than their own areas. In general the medical profession and the reports produced by bodies like the British Medical Association favoured the regional concept.²²

The Ministry of Health was caught between the two forces. The Minister, Mr Malcolm Macdonald, wrote to the Trust in January 1941 supporting their efforts in preparing the ground for future action; he believed that the ultimate hospital service should be built upon the foundation of existing organisations and was 'convinced that the problem was one which must be examined on a basis wider than that

of existing local government areas, and that some form of regional unit will be necessary in designing a system which will make the best use of our existing hospital accommodation and will avoid duplication and waste in making good any deficiencies'. There is, however, a distinction between 'designing' and 'operating'.²³

Anxieties that the Nuffield Trust was likely to establish a pattern for the future before others had developed their own ideas were communicated to the Ministry. On 9 October, the day before the Trust was due to consider a memorandum on 'A National Hospital Service', there was a somewhat precipitate announcement of the government's post-war hospital policy in the House.

The memorandum on '*A National Hospital Service*' brought together the Trust's proposals.²¹ Stating that there was increasing recognition of the need for coordination, it was maintained that a scheme to coordinate the hospitals would produce the most effective use of resources. Were the voluntary system to be abolished, however, the substitution of state hospitals would place a considerable load on exchequer funds - the type of remark which had led the local authorities to suspect the Trust of being primarily concerned with the defence of the voluntary movement. The British Hospitals Association, which had been advocating regionalisation before the Nuffield Trust was founded, rapidly produced its own memorandum. Stressing its commitment to regionalisation since the appearance of the Sankey report, the Association said that the area of coordination 'when circumscribed is not to be regarded as surrounded by Chinese walls or unbreakable barriers. The area is simply a unit formed after consideration of a number of factors such as the nature of the hospital services generally available, the present natural flow of patients, the nature and spheres of influence of the local authorities concerned, questions of transport and questions of geography'.²² After the Minister's announcement of post-war hospital policy in the House on 9 October 1941, William Goodenough was asked to 'go slow' on the formation of regional councils.²⁴ He had demonstrated his grasp of hospital matters and there were other jobs in store for him. The Ministry was concerned about the organisation and financing of medical education.

Regionalisation had become a battle-ground of conflicting forces. Groups such as the one chaired by Sir Wilson Jameson at the London School of Hygiene and Tropical Medicine, before he became the

Ministry's chief medical officer, and the Medical Planning Commission (1942) 25, developed the Dawson concept of a hierarchical service. The population needed for such a structure was of the order of two million. It was a *professional* concept, meeting the needs of specialist medicine and consistent with the desire to associate a university and its medical school with the health authority. Indeed the proponents of regionalisation could not visualise a region without a medical school at its centre. While the administrative county of London was itself equal in size to any of the regions being discussed, the London County Council was particularly hostile to any suggestion of regionalisation. Its vision of a region was the London County Council dominating the hospital services. In the provinces, regional councils were being set up in collaboration with local authorities, but in London the LCC was unwilling to play.²⁶

The idea of regional groupings had been in the air since the Sankey report (1937). The Nuffield Trust, backed by its money, had begun to bring it - or something like it - to earth. ²⁷ The idea of the two systems working together was unimpeachable, but whether it was practicable was another matter. As advisory bodies without executive powers, Sir Frederick Menzies doubted whether regional councils could ever be effective. He thought that 'a paper scheme in which in which the municipal hospitals and the voluntary hospitals are to merge themselves into a Regional Council for a given area by a series of resolutions, based on mutual sacrifice of their rights and responsibilities would never work in actual practice'. He felt it was too much to expect of them. Neither hospital organisation was constituted in that way in London, even if they were in the shires. The scheme savoured of the armchair and the calm of the academic cloister. Nevertheless he believed that the King's Fund and the London Voluntary Hospitals Committee should discuss the proposition, and he wrote to the Minister of Health, after his retirement, suggesting that if regional councils were formed, the Minister should nominate representatives to help overcome the mutual suspicion and distrust. Menzies had a practical touch; the altruistic cooperation of reasonable men was an inadequate foundation for regionalisation.²⁸ When regions came, they were more solidly based. Indeed, the entire structure of the health service was established upon a regional basis, with a lower tier providing services for health districts.

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Chapter 10 Emergency Medical Services - and planning during the war

'A few years ago when a very distinguished personage, as president of a great teaching hospital, was inaugurating the first instalment of a rebuilding scheme, he pressed a button and started a light revolving on the top of the tower. Taken a little aback, he turned to the Dean who was standing by him and murmured: "Good Lord, what have I done now?"

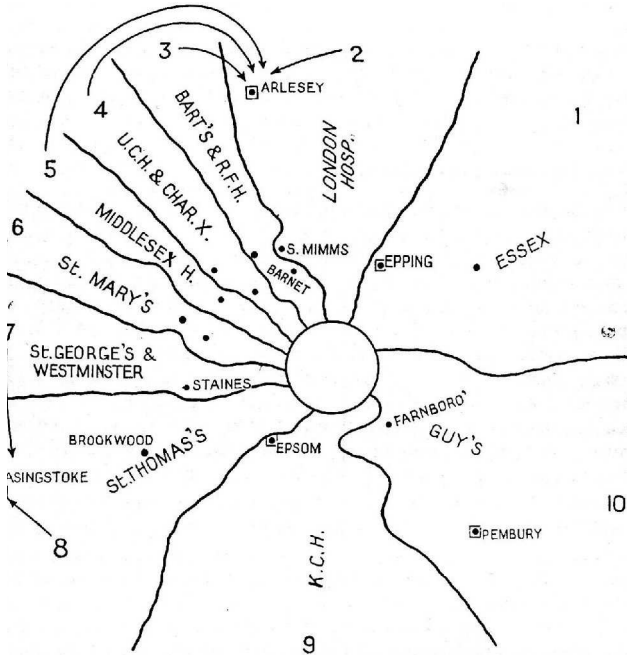
We can imagine the Minister of Health making some such ejaculation when he first realised the inexorable upshot of his Emergency Hospital Scheme. Designed to serve the purpose of a moment it has set going wheels which will turn and turn until the whole aspect of hospital and consulting practice, as we knew them as lately as the end of last August, has changed beyond recognition.'

The Lancet 1

After Sir Charles Wilson's committee had reported on how London's hospital service might be organised to meet the threat of bombing, the London County Council seconded staff to the Ministry to assist the subsequent planning of medical and ambulance services. In October 1938 negotiations started with the voluntary hospitals to establish a segmental scheme but progress was slow. Sir Frederick Menzies contrasted the efficiency with which the municipal hospitals could be organised with the difficulties experienced 'in bringing about a willing cooperation on the part of the voluntary hospitals'. The Minister of Health, Mr Walter Elliot, was told by his officials that Sir Frederick rather exaggerated the contrast between the rectitude of the LCC and the depravity of the voluntary hospitals, although some of the hospital representatives had not been so helpful as they might have been.² One of the sticking points was who would command the sectors.

The creation of the emergency medical service

It was thus the threat of the Luftwaffe which compelled Britain - and London - to reorganise the hospital services. Many detailed and practical problems had to be sorted out and the London Voluntary Hospitals Committee became increasingly anxious that while the Ministry's scheme was all right as far as it went, few staff had been allocated to the task; they had inadequate authority and virtually no money. On 1 February 1939 the Ministry wrote to the committee suggesting that as soon as the boundaries of the sectors had been



• The black circles show the position of advance-base hospitals; the circles in squares are the base hospitals.

Source: *The Lancet*, 1939, i, p 723

The arrangement of the sectors in the home counties

announced, the voluntary hospitals should agree amongst themselves to nominate a doctor to work out the details of the scheme. The Ministry would approve the nomination formally and pay this group officer £100 per year for his services. The committee thought that this went nowhere far enough and on 7 February wrote to the Permanent Secretary pointing out that a detailed and intricate organisation would be necessary, with group officers who would have to be capable men, able to take command in time of war.

The committee made a series of proposals which it wished to see laid before the Minister and, if necessary, the Cabinet. Adverse comments appeared in the press which Sir Charles Wilson disavowed. The Minister took a month to reply, and rejected the suggestion of failure to

take the situation seriously. Nevertheless, senior members of the teaching hospitals' staff were soon appointed as the first medical sector officers, and in June 1939 house governors and matrons were nominated as lay sector officers and matrons. Financial arrangements were also made for the establishment of first-aid posts and the sandbagging of the hospitals.³

The Metropolitan Police District and the area within about forty miles of it was divided into ten sectors. The general aim was to establish first-aid and casualty sorting centres in the danger areas, providing enough treatment to fit casualties for a journey by ambulance to advance base hospitals. These were in presumably safer areas, with enough staff and equipment for operative treatment of the injured. Base hospitals to which patients could be moved for after-care were still further from the centre. Finally there was a group of less well equipped hospitals for convalescent and chronic cases. The sector officers began the task of surveying the strange assortment of mental asylums, public assistance institutions and other hospitals which were at their disposal. They considered plans for the evacuation of staff and students.⁴ Contact was established with Sir Frederick Menzies and other medical officers of health, and a map was published in *The Lancet* showing the arrangement of the sectors and the position of the advance base hospitals.⁵

Nine sectors radiated from an apex in the centre of London into the home counties, and were based on one or more of the teaching hospitals; the Essex sector was based upon hospitals in Stratford, Ilford and Romford. At their extremities the sectors included parts of Essex, Hertfordshire, Buckinghamshire, Kent, Surrey and Berkshire which strictly belonged to other home defense regions — the regional organisational pattern established for military purposes.

The London sectors

Sectors I & II The London and Essex hospitals

Sector III St Bartholomew's Hospital and the Royal Free

Sector IV University College Hospital and Charing Cross Hospital

Sector V The Middlesex Hospital

Sector VI St Mary's Hospital

Sector VII St George's Hospital and the Westminster Hospital

Sector VIII St Thomas's Hospital

Sector IX King's College Hospital

Sector X Guy's Hospital

The Emergency Medical Service was introduced as soon as war broke out, and gave central government a right of direction over both voluntary and municipal hospitals which it had never before possessed. Patients were discharged or evacuated from the hospitals in central London in preparation for a wave of air-raid casualties which did not materialise. The staff who had been evacuated had little to do. Some occupied themselves treating local patients, many of whom had never previously had the benefit of specialist attention. Meanwhile, hospital beds stood empty in central London until, at length, limited services were resumed. In spite of the casualties which followed the evacuation from Dunkirk and the London blitz of 1940-1941 the Emergency Medical Service was never placed under the stress which had been predicted and for which it had been designed, serious though the damage from bombing proved to be.

However the Emergency Medical Service, more than any other single factor, can be held responsible for the form and pattern of hospital organisation which emerged in London. A certain amount of friction existed between the two parts of the system, based on traditional insularities of outlook, but not so much as to prevent a synthesis of the two groups of hospitals. Doctors and nurses for the first time moved freely between the voluntary and the municipal hospitals, seeing the problems each faced. The experiences of teaching hospital staff and students who were drafted to municipal hospitals, where standards of clinical care often left much to be desired, helped later in the acceptance of the National Health Service.

The senior officer in each sector had direct access to the Permanent Secretary at the Ministry of Health, and through municipal medical officers at sector headquarters, to municipal hospitals. His main power was the distribution of medical staff to hospitals according to their specialties and skills. The municipal and mental hospitals to be upgraded for casualty purposes had been chosen by the Ministry, largely without the advice of the sector officer.

Many hoped that the cooperation which had been enforced through war could be preserved in peacetime. 'The outstanding merit of the Emergency Medical Service' said *Political and Economic Planning*, 'is that it has begun a process which total war makes absolutely imperative - a pooling and reasonable distribution of medical resources and scientific skill.' Regrettably, the publication continued, the sectors

worked too much as independent units, a situation encouraged by the appointment of distinguished teaching hospital consultants as group officers.⁶ The group officers, and their administrative counterparts, saw less need than *Political and Economic Planning* for cross-sector coordination, as most problems could be resolved within the boundaries of their own areas. Within these sectors, links between hospitals were established which persist to this day.

The effects of evacuation, fire and bombing are described in hospital histories such as Cameron's account of Guy's and Clark-Kennedy's of The London.⁴ Not one of the London County Council's hospitals escaped damage. The Poet Laureate, John Masefield, considered writing a history of London's hospitals under fire, and he obtained a special allocation of petrol coupons to enable him to visit them. Sadly, the project was abandoned.

The medical schools, like the hospitals, faced many problems as a result of inadequate accommodation and makeshift laboratories, but in one way or another they were overcome.⁷ The experience of coping with dispersed students and staff, and trying to teach under such conditions, convinced most deans that decentralised schools were to be avoided. When, after the war, the medical schools were expanded, this conviction led to the demand for large university hospitals.

Planning a future hospital service

The twists of the negotiations and the complex issues which had to be decided before the introduction of the National Health Service by Bevan in 1948 form a story which has been told elsewhere.⁸ Lord Dawson's interim report of 1920 had indicated the hierarchical structure a health service might take. It was followed in the thirties by proposals and reports from several organisations, including the British Medical Association.⁹ The Nuffield Provincial Hospitals Trust was pressing ahead with the concept of regionalisation, while Wilson Jameson, dean of the London School of Hygiene and Tropical Medicine, organised a Saturday morning group with brought together doctors from many different fields. Known as the 'Gasbag Committee', it examined a number of problems including the financial plight of the teaching hospitals.⁹ There were ten to twelve members of the Gasbag Committee, including Wilson Jameson, until he moved to the Ministry as chief medical officer: W W C Topley a noted bacteriologist, Allen Daley (MOH LCC), H M C Macaulay (MOH Middlesex), George

Picketing (St Mary's), Ernest Rock-Carling (MRC & Westminster), Landsborough Thomson (MRC) and Harold Himsworth (MRC). There was a free exchange of views and notes were not kept as a matter of policy. An attempt was made to gain consensus on major matters of policy and the group met regularly from September 1939 until the Saturday before Dunkirk, August 1940. Inevitably as CMO Wilson Jameson had benefitted from the discussions.

Only the state could provide the large sums necessary but how, asked the group, could the teaching hospitals preserve their much valued independence in such a situation?

Since February 1938 the Ministry had been exploring various options and in October 1939 Sir Edward Forber, who had recently retired from the Board of the Inland Revenue but had been a Deputy Secretary at the Ministry of Health, was invited to enquire into wartime/postwar hospital problems. At the same time *The Lancet* published a 'Plan for British Hospitals' which advocated regionalisation and centralisation, and made biting comments about the London hospitals. The author was Stephen Taylor, later Lord Taylor, and a lengthy and emotive correspondence followed which was summarised in the journal in a statesmanlike fashion by Lord Horder. *Picture Post* also discussed hospital planning in a special issue on Britain in the future. The authors advocated a salaried state health service which placed an emphasis on preventive rather than curative medicine.

By 1941 several factors were making it increasingly urgent to establish a postwar hospital policy. The Emergency Medical Service had created the opportunity; a long-term policy was required to decide which hospitals in an area should be preserved and developed; and new and lively bodies like the Nuffield Trust were emerging in the policy-making field. From January to September 1941 a Ministry committee on postwar hospital policy was at work, which had a preliminary paper laid before it containing proposals remarkably like those which ultimately formed the basis of the NHS Act (1946).

The committee soon accepted that some form of regionalisation was necessary, because modern health services could not be provided within small local authority areas. Regional authorities could plan services which might then be funded from exchequer funds, insurance contributions and a precept on local authorities. It was recognised that a centrally directed regional organisation would be opposed by local

government, and a key question would be the relationship between Whitehall and local authorities. Possibly each area might have a body consisting of local authority., voluntary hospital and medical representatives, the ownership of the hospitals remaining unchanged. It was soon clear that the arrangements which might suit the rest of the country would be inappropriate in London, and that the financial framework would be of crucial importance, particularly to the teaching hospitals. The Office Committee on Postwar Hospital Policy thought that it might be possible to treat the teaching hospitals separately, leaving them a much higher degree of independence. Related to this, in London, was the necessity of maintaining as many as twelve teaching hospitals. The government had been asked to assist the teaching hospitals but Sir Edward Forber, whilst recognising that this was a controversial matter, questioned the need for twelve as some were really too small.¹¹

A paper prepared by John Pater for the committee drew attention to the fact that London contained not only the largest municipal hospital service in the world but 'a quite disproportionate number of the large voluntary teaching hospitals' crowded into the centre of the metropolitan area. He suggested two 'desirable developments':

- i. The grouping of hospitals to serve not only the Metropolitan area but also a large part of the home counties. He suggested wedge-shaped areas with their apex in the centre like the Emergency Hospital Scheme sectors.
- ii. The decentralisation of teaching work. If regional organisation was to be complete, provincial hospitals would have to be developed. The destruction of teaching hospitals by the blitz had created an opportunity for development on rational lines which would be lost if hospitals compelled to leave by bombing were allowed to return and rebuild in the centre of the city.

Future plans and the London County Council

Whilst this preliminary work was proceeding within the Ministry, and confidential discussions were taking place, the issue of the future hospital service and how it might be organised was raised in a most abrasive fashion by the Leader of the Labour controlled London County Council. It was known that the Nuffield Provincial Hospitals Trust was about to publish a memorandum on regionalisation, and writing in the Star on 12 August 1941, Alderman Latham said:

'The fifth-columnists against democracy are preparing to steal the people's municipal hospitals..., the beavers of reaction are ceaselessly gnawing at the foundations of popularly elected local government.'

Latham feared that although three-quarters of London's hospital beds were provided by the council, to 'save' the voluntary hospitals all would be taken over and handed to non-elected regional bodies, which would preserve the features of the voluntary system but sacrifice public accountability. Instead, he wished to see a comprehensive service administered by the local authorities into which the voluntary hospitals would have to come if they wished to play their part. He warned his readers to be on their guard - 'sappers against democracy would get them if they did not watch out'.

Public disagreements of this nature, in advance of a government statement, were unhelpful. The Ministry suggested a confidential discussion with LCC officers on post-war hospital policy, and the possibility of forming a London regional council. Latham was briefed by the Clerk and Allen Daley, who had succeeded Sir Frederick Menzies as medical officer of health. Daley had taken over in 1939 and was a different type of man. He was a superb administrator with demoniac energy, but he had a smoothness of manner which made him easy to work with. One administrator who knew him said that, had he not been medical officer of health, he might easily have been the clerk to the council. The county council's officers thought that a regional council involving over sixty local authorities was a daunting prospect, and the Clerk thought that much time would be wasted in debate. As a regional council would need supporting staff, would it not be better to have the staff without the council? Officers could outline principles and draw up a plan to guide decisions when the voluntary or municipal hospitals were seeking money. The council's officers thought that an officer group would inevitably have to work closely with the LCC, and would absorb LCC thinking. Lord Latham would have preferred a simple LCC take-over of those voluntary hospitals which were needed, but his officers pointed to the strength of the opposition to be faced. The council therefore decided to develop a London County Council view of a 'regional scheme', and also to continue to plan a comprehensive service for the administrative county including cooperation with the larger voluntary hospitals. The Ministry was told that the London County Council thought that a regional council would be a waste of time. Instead the Ministry might second an officer to conduct a hospital

survey. This course of action would be acceptable to all and would bind no one. Planning could be based upon such a survey, and the London County Council might be willing to aid voluntary hospitals which were part of such a plan, if the council had representation on their management committees.

Post-war hospital policy

On 9 October 1941 the Government made an announcement in the House of its postwar hospital policy, and the decision to institute a hospital survey for London to provide a firm basis for planning.¹³ The Minister's statement proposed a service organised by local authorities, in which the voluntary and municipal hospitals would cooperate. There had been careful drafting and an attempt had been made to avoid antagonizing any group more than was inevitable. A sentence was inserted at the last moment which said that special arrangements were contemplated for teaching hospitals, in the way of increased educational grants. The word 'regionalisation' was studiously avoided, but the Minister indicated that the service would have to be designed with reference to areas considerably larger than those of individual local authorities. There was advance consultation with the local authority associations, which welcomed the announcement. Afterwards the Ministry of Health held separate meetings with the local authorities, the medical profession and the voluntary hospital movement. The latter disliked the idea of a service under local authority control and the proposed financial arrangements; they began to mobilise their opposition.

In January 1942 Dr Allen Daley met the surveyors the Minister had appointed for an exchange of views.¹⁴ He explained the position of both parties on the London County Council. They favoured a county hospital service standing on its own feet, and not in any position of inferiority to the voluntary hospitals. The majority party was opposed to any organisation of hospital services on the basis of charity, believing that hospital services should be given to every ratepayer as a right. They were however softening their line on grants to the voluntaries, and might be disposed to accept a plan on something like the following lines:

1. The survey of the hospitals which was to be carried out would show the number of patients from the area of the London County Council which were treated at the voluntary hospitals, and the proportion of their beds which might be regarded as 'London beds'. These beds

could be included in the county council's service, as long as they were in hospitals which the survey had recognised as efficient units.

2. The London County Council would make a contribution towards the cost of these beds, perhaps on a patient/week basis, at a level set below the average cost in the council's own acute hospitals. Voluntary hospitals participating in such a scheme would have to agree on the rates of pay of their staff, a roughly uniform basis for the levying of patient charges, and to accept London County Council representatives on their committee of management.

3. The council's payments would have to be made to the individual hospital, and not to a central body like the King's Fund or the Voluntary Hospitals Committee.

The London County Council was in favour of the disappearance of many of the special hospitals as independent units, on the ground that they were too small to provide proper facilities or employ satisfactory staff. Perhaps they might amalgamate with large neighbouring general hospitals, whilst the big special hospitals could remain independent, although linked for postgraduate teaching to the postgraduate school. The LCC also wished to play a larger part in undergraduate teaching, linking hospitals to provide clinical material. A degree of centralisation of services was also called for; certain forms of treatment like neurosurgery or deep X-ray therapy should not be provided at every existing teaching hospital.^{12,14}

Planning initiatives

The Minister's statement to the House in October 1941¹³ stimulated a number of groups to begin work to ensure that their interests were not overlooked. The Leader of the London County Council instructed his officers to produce proposals for the administrative county. The voluntary movement began to take stock of its position; and the Ministry survey of the home counties was set in motion. Shortly afterwards at the government's request Sir William Goodenough began to examine the problems of medical education in a national context.

Even before the Minister's statement, the British Medical Association, the three Royal Colleges and the Society of Medical Officers of Health had been considering the establishment of planning committees. The British Medical Association was early off the mark and invited the

others to join in. Acceptable arrangements being agreed, a single commission was formed in May 1941, of which Lord Dawson was a member. Sir Harold Himsworth, later secretary of the Medical Research Council, said that the meetings were a stimulating mixture of realism and idealism, seen at its clearest in the interim report, produced in 1942 after a series of plenary meetings.¹⁵ It was a remarkable and radical document, in which the more controversial proposals were only agreed after hard-fought discussions. It is doubtful whether the report as a whole carried the support of all sections of the committee, indeed the medical officers of health produced their own document. But the profession appeared to accept not only the notion of a comprehensive health service in principle, but to foresee the nature of the changes which would have to come about. Amongst other recommendations the report accepted the need for new local health authorities, serving a population of at least half a million, advised by medical advisory committees to which professional problems would be referred.

The joint coordinating committee

The King's Fund and the Voluntary Hospitals Committee established a joint coordinating committee soon after the Minister's announcement to the House. It first met in November 1941 to consider regionalisation and the repercussions this might have on London's voluntary hospitals, for the Nuffield Trust's moves were not without their dangers. The establishment of self-contained regions in the home counties might lead to a clash with London on issues such as cases for teaching hospitals, appeals, and contributory schemes. Neither was it clear that London would fit neatly into the Nuffield pattern of regions and divisions. At fortnightly meetings the committee discussed how 'adequate provision of the best possible treatment' could be achieved.⁶ It rapidly concluded that the area to be considered was the counties of London, Essex, Hertfordshire, Middlesex, Kent, Surrey, and probably East and West Sussex and south Buckinghamshire. However the voluntary hospitals in the home counties had misgivings that their interests might be adversely affected by the work of a London-based committee. In January 1943 representatives of the home counties were therefore invited to join the committee. Once the Ministry's survey was under way attention was turned to the definition of an ideal form of teaching hospital. The conclusion was that it should have at least 750 and preferably 1,000 beds, possibly achieved by grouping hospitals together. Medical staffing, and special hospitals, were

examined at some length. The Sankey Commission had been critical of the special hospitals but a united front was now required, and the committee asked each one the part it would wish to play in a coordinated service in London. The private view of the committee members was that whilst there was scope in London for those which had established an international reputation by their work, with the exception of the maternity hospitals there was no room for more than two in each specialty, and that these should be of university standard with at least 100 beds. Smaller hospitals might be associated with a neighbouring teaching hospital. However these robust sentiments were softened a little when, in July 1943, the joint committee's interim report was drafted.¹⁷

The Gray-Topping survey

The survey the Minister had announced was undertaken in London by Dr Archibald Gray, an eminent dermatologist, a senior member of the London Voluntary Hospitals Committee, Dean of UCH and President of the Royal Society of Medicine. He was assisted by Dr Graham Topping, deputy medical officer of health of the LCC. Gray had an unassuming manner but an impressive grasp of medical administration and wide contacts through the King's Fund and the University of London. He could select the key issues for which a solution was required and much of the thinking behind the survey was his. Topping was something of a cynic, who had been heard to say that the council's hospital service was the best of its size in the world. John Pater, from the Ministry, acted as the secretary, and the team worked well together, visiting virtually every hospital in the south east of England.

The survey was designed to collate the facts about existing and pre-war hospital accommodation, including a description of the available hospitals, the clinical conditions treated, the geographical origin of patients, and the relationship of supply and demand for hospital facilities. The surveyors were asked to advise on the role of each hospital, those which were redundant, the places where new accommodation was required, and the 'area surrounding London which would appropriately be served by a hospital system centred on London, which would fit in with other areas so as to form part of a comprehensive scheme covering the whole Country'.¹⁴ They were not to consider political matters, like finance or the pattern of the administrative structure, but medical issues - the services which could

be provided within a locality and those which should be based upon a distant centre. The King's Fund had been planning to send a questionnaire of its own to the voluntary hospitals to determine their views on regionalisation. It now offered the draft to the surveyors, and after amendment this was sent out to all hospitals in the London area, both municipal and voluntary. Copies also went to hospitals outside the capital, although the covering letter they received suggested that the primary concern of the surveyors would, no doubt, be hospitals within the Metropolitan Police District - the area of the King's Fund.

Both the King's Fund and the London County Council were involved in the mechanics of the establishment of the survey. They were provided with the draft terms of reference and the surveyors' instructions. The council suggested amendments, as it wished to get away 'from the crisp (and to our way of thinking) dangerous phrase "London Hospital area".' The instructions to the surveyors remained confidential; neither was it proposed to publish the final report, partly to enable the Ministry to keep a completely free hand on questions of major policy, which might include matters like the removal of hospitals from London.¹⁴

During the first part of 1942 the area covered by the London survey was enlarged; some counties were asking for their services to be surveyed alongside those of London, and the British Hospitals Association and the Nuffield Provincial Hospitals Trust acted as the surveyors' agents in obtaining data on hospital facilities and catchment areas in the home counties. In October the extension of survey was announced formally. The press began to take an interest.

'LONDON'S LITTLE HOSPITALS DOOMED'

'The majority of the capital's smaller establishments will disappear after the war. That is the view of the medical experts representing both municipal and voluntary hospitals, appointed by the Ministry of Health ... "We have found that both municipal and voluntary hospitals are today collaborating and doing a first class job of work", one of the experts told the *Evening Standard*. But the smaller unit is not nearly so suited to modern hospital treatment as the big establishment, both economically and administratively.' *Evening Standard*, 7 May 1942

'HOSPITAL SYSTEM THREATENED'

"So far as I can make out", said Viscount Davidson, "a vast amount of planning is going on. But it is being done by those who have no urgent

desire to see the voluntary system preserved, or by those who are eager to see it destroyed". *Daily Telegraph*, 28 October 1942

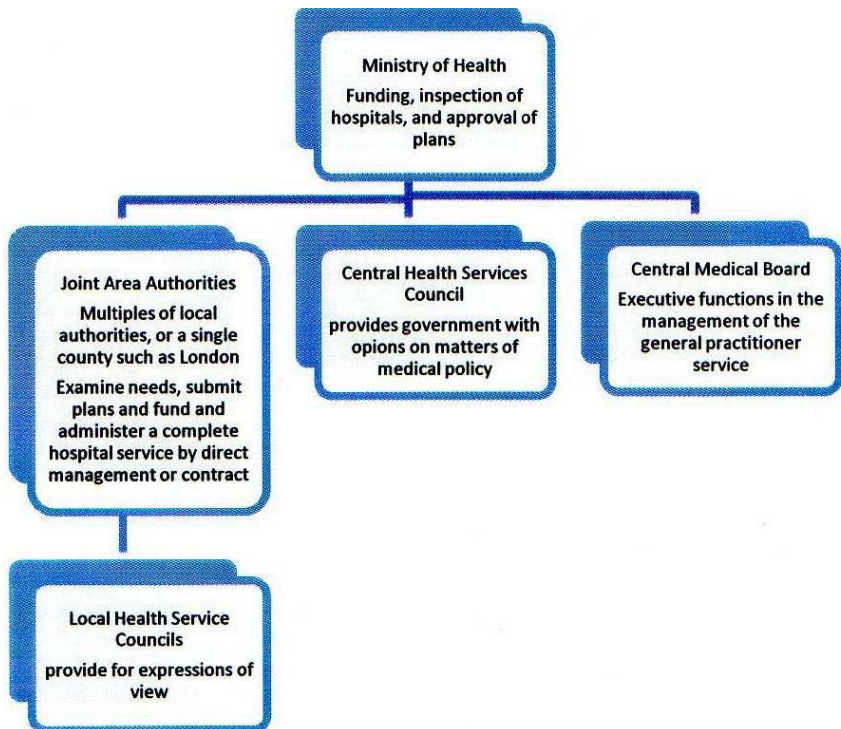
By the end of 1942, other hospital surveys were being established under the auspices of the Nuffield Provincial Hospitals Trust, and meetings were arranged between the surveyors to discuss the survey boundaries. The extension of the London survey outside the Greater London area led the voluntary hospitals in the home counties to fear that the fate of the hospital services in their areas would be decided by 'a London committee'. The King's Fund and the Voluntary Hospitals Committee therefore widened the membership of their joint coordination committee to include representatives from the home counties. The Ministry was also asked what the consultative procedures would be when the survey was complete. The Fund was told that the factual information and the Minister's decisions would be published, but the surveyors' advice to Ministers would remain confidential. As the months passed the London survey area continued to expand, and Dorset and Bedfordshire were taken on at the end of 1942.

The White Paper on a National Health Service (1944)

The preliminary results of the hospital surveys were already available to those drafting the White Paper on a future national health service and it was apparent that in many areas the hospital services were badly coordinated. Organisation was therefore to be based on 'joint authorities', joint because county and county borough councils would be grouped together for efficient management. Municipal hospitals serving a county town, and those serving the surrounding countryside, were often managed independently and restricted to one or other group of ratepayers. However the White Paper accepted that in London no combination was necessary, and the existing authority would be able to undertake the new functions.¹⁸ Plans would in future be prepared for a comprehensive service, and be subject to ministerial approval. The voluntary hospitals would remain as independent contractors, free to participate in the scheme if they wished. The London County Council welcomed the White Paper, and the recognition that the county council should act as a single unit within the comprehensive medical service proposed. The British Hospitals Association and the King's Fund were, to put it mildly, unhappy.¹⁹ They saw no sign of a partnership if the responsible authority was to consist entirely of the elected representatives of local government. The

British Hospitals Association thought that the White Paper proposals left the voluntary hospitals a wholly inadequate voice in planning and administration. Instead of joint boards, the Association argued for regional councils, each region to include at least one teaching hospital. Finance being the touchstone of independence, the voluntary movement wished to see a continuing income from voluntary sources, and the scheme did not seem to make this practicable. The London County Council, for its part, objected to any suggestion that the managing committee of a National Health Service area should have any non-elected members representing specific interest groups, like the doctors.

Increasingly there was pressure for the publication of the survey. In April 1944 Kent County Council asked for details of the survey, so that its own hospital planning would not proceed on lines incompatible with a wider scheme of things. In reply Mr Pater made 'few rambling remarks' which indicated the lines upon which the surveyors had proceeded in delineating districts:



'In the first place they mainly follow existing local Government boundaries; this was done merely to make it easier to arrive at an estimate of the population to be served and not because the boundaries are regarded as lines which patients should not, and will not, cross. Secondly, the districts were defined having regard to transport, density of population and so on, in order to provide a population and an area which could be reasonably expected to support a large and efficient district hospital. By this is meant a hospital with the normal range of special departments staffed by specialists and consultants and catering for maternity, fevers and the chronic sick in the sense of the bed-ridden as well as for general and special acute work. It is assumed that even these district hospitals may not stand on their own legs for all normal purposes but may, for example, look to a neighbour to supply beds for skin or eye cases....' 14

It was agreed that the survey should be made public. Hospitals wrote in for advice on postwar planning; the Soho Hospital and the Samaritan Hospital were considering amalgamation - how would this fit in with plans? The Ministry and the surveyors found themselves having to respond helpfully and the only document available to them was the draft of the hospital survey.

Dr Gray submitted the survey to Sir John Maude at the Ministry on 29 April 1944. He pointed out that the factual material had been collected before the most recent series of air-raids on London and south eastern England, which had led to further damage to hospitals, and that the second part of the document had been drafted in advance of the proposals of the 1944 White Paper, and without knowledge of what they might be. However Gray did not believe that modifications were necessary or that there was any conflict of principle.²⁰

It was generally known that the survey was complete. A continuous stream of letters was received by the Ministry from local authorities and hospital managers who wished to plan hospital developments, and who wanted to know how the surveyors had regarded the local services. Under wartime conditions it was difficult to get the survey printed, and the Ministry advised correspondents to delay action until it was available. The publication date was postponed first until Christmas 1944 and then to the New Year. In any case it became clear that the survey could not be regarded as the last word on hospital planning. The Minister wrote to one correspondent in January 1945 that 'the

suggestions made in it are not, of course, final, and future action will depend amongst other things on the Government's general proposals for the health service'. People were therefore advised not to launch into schemes which might not be in the best interests of good hospital services until they had read the survey.²⁰

The survey was finally published in April 1945 while the debate on the proposals in the White Paper was still in progress.²¹ It created little stir, for most people were far too bogged down in national issues to worry very much about its contents. A series of categories had been devised and hospitals, or those proposed for the future, were allocated to one or other of them. Similar classifications later appeared in the surveys of other parts of the country, and most groups of surveyors recognised the following:

- a. Regional university centres providing both local district services and regional units for plastic surgery, thoracic surgery, radiotherapy and neurosurgery. Most regions had only one of these centres, but some like London and the north western region had more.
- b. Local cottage hospitals staffed by general practitioners with varying levels of visiting consultant support. These were uncommon in central London but were found on the outskirts.
- c. An intermediate category of divisional, area or district hospitals providing all day-to-day services with full time resident staff and cover from consultants living nearby.

While the surveys had been in progress an attempt was made to develop a common terminology and Sir Wilson Jameson took a personal interest in their progress. The London surveyors provided an indication of the type of district hospital they thought appropriate to a densely populated area. They estimated that an urban district with a population of 120,000 might support a hospital of 650 beds containing:

General medical beds	220
General surgical beds	220
Children's beds	100
Maternity	50
Gynaecology	30
ENT	30

There would also be 150 beds for the chronic sick, but dermatology, genito-urinary and ophthalmic work would be sited at selected hospitals only; otherwise the size of the units would be too small. In

general, the hospitals would be about 800 beds in size, neither larger than 1,000 nor smaller than 400, serving a district of 100-200,000, a range of size which was larger than most of the voluntary hospitals. The surveyors thought that the smaller local hospitals had little part to play in densely populated areas. Special centres serving wider areas would be required when a high degree of concentration of equipment or staff was necessary for maximum efficiency.²¹

Authority boundaries

The parallel provincial surveys had been organised by the Nuffield Provincial Hospitals Trust and a number of them proposed that services should be organised on a regional basis. These surveys often defined the boundaries of the region and indicated its centre, the town in which the university teaching hospital was situated. In London the surveyors were silent on such issues. The Minister had asked them to state the area which would be appropriately served by a hospital system centred on London but they did not do so and nobody was very surprised. While the boundaries of most regions in the provinces were pretty obvious that was not the case in the south-east and Topping might have been out of a job had the surveyors disregarded the London County Council's opposition to regionalisation. Geographical areas were a political matter to be fought out at a higher level.

District boundaries were less contentious, although in London the areas served by the hospitals generally overlapped and the movement of patients was often determined by features like the Thames, the Hackney marshes and the radial network of railways. In general, the surveyors said: 'Each county area has been divided for planning purposes into a number of districts suitable according to size, population and transport facilities to be served by a district hospital. For practical purposes the boundaries of these districts normally follow local authority boundaries; but we fully realise that in practice the boundaries between hospital service areas will be indistinct and may not coincide with administrative boundaries. We assume that present or future boundaries will not be permitted to interfere with the flow of patients according to their needs.'

The effect of bombing on the hospital services of the capital was found to be considerable. The surveyors estimated in 1943 that 3,000 beds had been lost in general hospitals within the London County Council area, and more were subsequently lost in the flying bomb and rocket

attacks of 1944. Major damage had been sustained by both the voluntary and the municipal hospitals, and while hospitals like The London and St Thomas's were instructing architects to prepare plans for reconstruction before the war in Europe had ended, the gains by wartime rebuilding were small.

A major virtue of the survey of the London area was that it presented an overview of hospital facilities throughout the south-east of England which was detailed, consistent from area to area, and supported by factual information derived from analysis of the questionnaires. Conceptually, the surveyors selected from the ideas already under discussion, pulling them together into clear and concrete proposals. The survey remained an essential tool for hospital planners until the publication of the *Hospital Plan* in 1962.

The surveyors adopted a norm of five acute beds per thousand population and assessed local deficiencies against this. As had been the case for many years, provision was worst in south London, especially in Lewisham and Wandsworth. Ealing, Finchley, Harrow, Tottenham and East Ham also had problems. As a whole however, as Burdett had said in 1903, the area of the London County Council was adequately served; it was the distribution which was poor, with comparatively few facilities at the periphery. To make this good the surveyors envisaged a first phase of short-term measures, often involving a degree of overcrowding, followed by longer term schemes as labour and building materials became available. Recognising the movement of the population from the centre of London, and the likelihood that this would continue, they recommended that the question of hospital building in London be 'approached with circumspection', apart from making good war-damage by temporary repairs. ²¹ Most of the proposals for major development were for the home counties. In Middlesex they suggested a new hospital at Harrow, rebuilding at Hillingdon, extensions at Ealing and a new hospital in Enfield. In the London County Council area they believed that new hospitals should be provided in Tooting and Sydenham. New hospitals being required on the outskirts of London, they suggested that three teaching hospitals should move out. It was proposed that Charing Cross Hospital should move to Harrow, St George's to Tooting, and the Royal Free to Highbury. During their visit to the Royal Free Hospital the surveyors had touched on the idea of removal, and when a bomb subsequently fell on the hospital, matron blamed the surveyors. Sir Archibald Gray, coming from University College Hospital

which had itself taken over a number of small hospitals, saw no reason why the same should not happen to others. The survey suggested that the special hospitals should either be closed, amalgamated with undergraduate teaching hospitals, or rebuilt on a site near the University. As the years passed, Gray said, those who had opposed amalgamation gradually retired. Death, he said, was a great healer; and as he was also a member of the Goodenough committee on medical education it is not surprising that the recommendations of the two reports were compatible.

The reaction to the survey

The survey was not to everybody's liking and some were incensed to find that their local hospital was marked down for closure. Others wrote to correct minor factual errors. St Monica's Home Hospital, Brondesbury Park, the Hospital of St John and St Elizabeth and the Weir Hospital protested that their facilities had been criticised unreasonably. Croydon General requested a 're-survey' as they disagreed with the surveyors' comments that they were on a restricted site. They already had plans to double the number of beds. Battersea General and Wandsworth Borough Council also protested.²⁰

The Ministry replied that the survey was the personal view of those conducting it. For the present the Minister did not propose to indicate his views on any individual proposal, but that did not stop some from acting upon its recommendations. Westminster Hospital began negotiations with the governors of the Infants Hospital and it was agreed that the institutions should merge. The surveyors had laid out the pattern of a coordinated hospital service for London and the home counties, district by district. Some might not like the pattern, but it lay to hand for the use of those whose job it would be to take matters further.

The voluntary hospitals' planning

The joint coordinating committee established by the King's Fund and the Voluntary Hospitals Committee issued its own report on postwar hospital problems in London and the home counties after the London hospital survey and the Goodenough report on medical education had appeared.²² The members of the committee had kept in close touch with the Nuffield Trust and the chief medical officer, Sir Wilson Jameson - who they thought were in sympathy with their views. The

joint committee's report outlined a future hospital service as the voluntary movement would like to see it, largely rejecting the surveyors' criticisms of inequitable distribution of hospital staff and facilities. The committee opposed the idea of a single system, believing that standards were maintained by competition, and the voluntary hospitals provided the standard by which public hospitals could be judged. It viewed freedom of choice by patients as essential, wished the London region to be extended to include the home counties, and to see the influence of the University of London reach out until 'the area of influence of other universities was reached'.

Some faults of the voluntary system were admitted and remedies were suggested. Too many voluntary hospitals were small, ill-equipped and could not accept the whole range of acute work in their locality. Medical and nurse staffing needed overhauling, but while a hospital of under 150 beds could not provide full general hospital services, there 'lurked a danger that arguments in favour of a large hospital could be carried too far'. Smaller hospitals possessed advantages, they served a more local population, were well known to patients: and could ensure a friendly personal atmosphere. 'Very large hospitals could easily become the coldly efficient kind of institution, so terrifying to the sensitive.'

The joint coordinating committee believed that there was little justification for hospitals of 100 beds or less; these should amalgamate or move to the periphery. In the 'industrial and dormitory zone' an ambitious programme of voluntary hospital development should be encouraged, and in the home counties the municipal hospitals and the voluntary hospitals should build up links through joint staff appointments.

The Inter-Departmental Committee on Medical Schools 23

The presence of a medical school had always had a significant effect on the hospital to which it was attached, but educational factors as such had had little effect on the hospital system until the inter-war years. Thereafter there was increasing appreciation of the special nature of teaching hospitals, and academics were more frequently in evidence on major policy-forming committees. The Goodenough committee was established in 1942 in the wake of the announcement of the government's post-war hospital policy.²⁴ This had suggested that special financial arrangements might be needed to assist the

teaching hospitals, and it was decided to set up an advisory body to consider this, amongst other educational issues. The committee was a classic example of how to get the recommendations wanted by handpicking the members who were going to make them. Wilson Jameson, the Ministry's chief medical officer, took a leading role in the selection of a committee which was likely to suggest a much wider admission of women to medical schools, a larger development of professorial units particularly in London, and the abolition of non-university medical education. There were two representatives of UCH, which had the most highly developed professorial system of all the medical schools of London, including the dean, Dr Archibald Gray. Janet Vaughan, a haematologist and the Principal of Somerville College Oxford, was likely to have the interests of women at heart. Wilson Jameson was himself a member, and the chairman, William Goodenough, had an excellent grasp of hospital problems as a result of his work at the Radcliffe Infirmary and the Nuffield Provincial Hospitals Trust. The secretary to the committee, Farrer-Brown, was already well known to him. The committee first met on 14 April 1942 to enquire into the organisation of medical schools, particularly in regard to facilities for clinical teaching and research'. While much of the committee's remit was national in nature, its attention was directed at the outset to two London problems: the organisation of pre-clinical teaching, and the possible amalgamation of the smaller clinical schools. It was suggested that schemes for coordinating hospitals would make the continued existence of the small schools as completely self-contained and independent units unnecessary. Coordination of hospitals would also make it possible to link hospitals for teaching purposes so that a school, while primarily associated with one hospital, would be able to call upon the facilities of others.

The Goodenough committee took a wide range of evidence, consulted all medical schools and professional organisations, was invited to visit the London County Council hospitals, and explored their educational potential. Few things in London are secret, and the county council's officers received covert copies of the committee's papers.²⁵ Dr Somerville Hastings, Mr Reginald Stamp and Lord Latham all wished the council to play a larger part in medical education, perhaps by the establishment of a municipal teaching hospital if recognition by the General Medical Council could be assured. The council gave evidence on undergraduate medical education in November 1942 and on postgraduate education in February 1944. Pointing out that it was the largest single civilian employer of doctors in the country, the council

wanted medical education to cover a wider range of subjects in the future, including preventive medicine. The council suggested that its hospital service could provide an excellent and complete medical training, were it to become the basis of a medical school. Such a school might be established at one of its larger hospitals, using the others as required.²⁶ The council pointed out that it already supported the Postgraduate Medical School at Hammersmith. Behind this proposal lay a hope that the London School of Medicine for Women might leave the Royal Free Hospital and attach itself to the Highgate group of hospitals.

Witnesses were questioned about the number of beds required to teach an intake of 100 clinical students. The British Medical Association's memorandum of evidence was the most specific on the subject, and Professor Henry Cohen, from Liverpool, explained how the Association's figures had been worked out. The Goodenough committee found that there was a wide measure of agreement with Cohen's estimate, and the table presented in the report is substantially the same as the guidance of the University Grants Committee in 1976, thirty years later. The British Medical Association saw no reason why a local authority hospital of the requisite standard should not be the 'parent hospital' of a medical school.

Beds for an annual entry of 100 students to the clinical course

<i>Goodenough 1944</i>	<i>Subject</i>	<i>UGC 1976</i>
250	General Medicine	200
250	General Surgery & orthopaedics	200 + 100
100	Obstetrics	100
50	Gynaecology	50
150-200	Special departments	170
50	special purposes psychiatry & geriatrics	90/40

The Goodenough report was published in 1944²³, and was the most important statement on medical education since Sir George Newman's Notes on Medical Education (1918). It provided a clear statement of the aims and methods, and how these might relate to a national health service. The report recommended that medical education should become more educational and less vocational in nature. Every medical school should be a university medical school, and an integral part of a

university. In London, only two were independent bodies - St Bartholomew's and the London Medical School for Women; all the others were ultimately under the controlling power of the governing body of the parent hospital. The committee believed that teaching hospitals should be full partners in the hospital service of the district in which they were situated, but saw that the population of central London would become less and less able to support the needs of medical education. Underlying the recommendations lay the concept of a university medical teaching centre, consisting of a university medical school and a group of teaching hospitals, one parent hospital to which others were associated. By the standard it set, based on Cohen's figures, ten of the medical schools were short of medical beds, and seven of surgical beds as well.

Goodenough saw the need to expand the medical intake. But the number of medical schools in London was large, possibly too large. The report recommended that the West London Hospital Medical School, which had assisted since 1937 with the education of women, should close.²⁷ Instead it was suggested that exchequer grants to medical schools should be dependent on a policy of coeducation. It was proposed that specific municipal hospitals should be associated with nearby parent teaching hospitals, that Charing Cross Hospital and its school should be moved to a site in Middlesex, St George's to another outer suburb, possibly in south London, and that the Royal Free Hospital should move to a northern suburb.

Associated hospitals for the medical schools 23

Guy's	St Olave's
Kings College Hospital	St Giles' and Dulwich
The London	Mile End
The Middlesex	One of the Whittington group
St Bartholomew's	St Leonard's or Bethnal Green
St Mary's	Paddington
St Thomas's	Lambeth
Westminster	St Stephens & small special hospitals
UCH	Nearby voluntary hospitals or a general hospital in Hampstead or Highgate.

While educational purposes might best be served by concentrating schools in central London, the future hospital requirements of London seemed unlikely to justify the continued existence of all the teaching

hospitals in the middle of town. An outward movement seemed inevitable, and was not without educational advantages. Charing Cross and St George's had raised the possibility of relocation in their evidence to the committee and it would provide breathing space for the other teaching hospitals. The amalgamation of the smaller schools was considered, but the balance of opinion was against the proposal, favouring the transfer of entire institutions to the periphery. When implemented, this recommendation had the effect of re-establishing preclinical departments at two hospitals which had lost them prior to the First World War.

Goodenough saw no reason in principle why a municipal hospital should not form the basis of a medical school; but in London medical schools were already too numerous to warrant an addition to their numbers. Expansion of existing schools seemed preferable and one possibility might be to use a local authority general hospital as the basis of an existing medical school which would be relocated. The members and officers of the London County Council considered these recommendations carefully, discussing them with Sir Wilson Jameson and representatives of the voluntary hospitals. The Council decided to cooperate, where possible on a basis of equality, in the provision of teaching facilities, rather than press its claim to its own teaching hospital. The alternative was to criticise the Goodenough report, to include a teaching hospital in its own plan, and to fight for it. Reginald Stamp, for the Council, thought that this was not the best tactic, because the Council would find itself planning London's health service with the voluntary hospitals and the doctors 'in the wrong mood.'²⁵ While 'association' carried the risk that all the interesting and acute cases would go into the parent teaching hospital and not the municipal one, the cost and complexity of developing a teaching hospital was considerable. Finally, the Goodenough report concluded that there was a need to organise and develop facilities for postgraduate education.

The London County Council's hospital planning

Responsible as it was for three-quarters of the hospital beds in London, the council was making its own plans.²⁸ Daley, who had now received a knighthood, was respected in voluntary hospital circles, as Sir Frederick Menzies had been. He was frequently invited to discuss hospital problems. At the request of the chairman of his committee, the structure and staffing of the LCC hospital service was reviewed. The

medical superintendents of the council's hospitals discussed reports such as that of the Medical Planning Commission as they appeared and the superintendents were asked for their view of the internal administration of the hospitals, their staffing, size and medical advisory committees. Sir Allen Daley kept himself well informed about the progress of the London hospital survey and the work of the Goodenough committee. He was invited to St Mary's to speak about the probable attitude of the county council to the voluntary hospitals, and to St George's to consider its possible relocation in south London. His draft plan for the council hospitals was prepared towards the end of 1945, after the other reports had already appeared. Commenting upon Daley's plan, Mr Reginald Stamp, chairman of the LCC Hospital and Medical Services Committee, suggested that Daley had paid too much attention to the hospital survey, on the assumption that it would command a greater measure of support than was likely to be the case. He had also shown a tendency to accept the voluntary hospital point of view, 'rather than indicating what was or could be the best proposals to provide an improved municipal service'. Daley pointed out that the survey had in fact been published by the Ministry of Health, and even though it was the work of independent surveyors, it was inevitably going to be regarded as a key document.

In November 1945, Sir Allen Daley sent the final version, which was to go to the committee, to Sir Arthur Rucker, Deputy Secretary at the Ministry. The London County Council plan was consistent with the recommendations both of the hospital survey and Goodenough, and proposed a series of main hospitals of 400—1,000 beds linked with smaller hospitals nearby. The administrative county was divided into twenty-one districts, in line with the neighbourhood units of the County of London plan. In eleven of them the main hospital would be a municipal one; but in ten in the centre of London it would be one or more of the teaching hospitals, linked to municipal hospitals by staff-links.²⁹

LCC Hospitals identified as "main hospitals."

St Mary Abbot's,	St Alfege's,	The Archway group
Lewisham,	Hackney,	St James',
St Andrew's,	Hammersmith,	The Brook,
St Charles',	St Nicholas'	

Daley thought that the pre-war total of beds was adequate but that local shortages would have to be remedied by new building, including

a new main hospital at Tooting, one in the Crystal Palace area, considerable development of the Fulham Hospital, and 'certain integrations of the Archway group'. The outpatient departments in many of the LCC hospitals were regarded as inadequate as the old infirmaries had never developed this service to the same extent as the voluntary hospitals, although some voluntary hospital staff like Lord Dawson undertook regular clinics in municipal hospitals. This shortcoming would be remedied, and appointments systems would be introduced as soon as possible. It was suggested that ground should be bought near hospitals with restricted sites; some hospitals were listed for closure.

Sir Allen Daley drew attention to the considerable expenditure by the Council since 1934, but a major capital programme was clearly required. The Comptroller of the Council believed that the new proposals were difficult to cost, and it would be some time before the more ambitious features of the programme could be carried out. The report covered specialties like radiotherapy, plastic and thoracic surgery, problems of medical and nurse staffing, and administrative matters. It reiterated the London County Council policy of centralisation.

'The Council, since its creation, has for very good reasons attached great importance to the principle of central control in all major matters. This principle ... has necessarily imposed limits on the autonomy of various local institutions and services.'

Nevertheless both Sir Allen and the council were anxious to do everything possible to foster the individuality of hospitals subject to the overriding goal of a hospital service for London and the Londoner. Sir Allen thought it inappropriate to re-examine the policy of centralisation until the government had announced its policy on a national health service. However, he proposed improved medical advisory machinery and believed that thought should be given to allowing hospital committees a small budget to dispose of as they wished, up to a maximum of £200 per year in the larger hospitals.

The report concluded with 43 recommendations. It is of particular interest for the tables and appendices which provide a bird's eye picture of the London County Council hospital service, and an insight into how the National Health Service might have developed in central London had its management fallen to the county council. On 27

November 1945 the LCC Hospital and Medical Services Committee referred it to the council's finance committee. It was considered again in December and the views of the medical officer of health were generally endorsed. The report was then referred to the council with an indication that the government proposals for the health service were awaited. In the meanwhile, it was suggested, the various proposals might be the subject of specific reports with estimates of cost. The council received a shortened version on 19 February 1946 but gave no instruction for specific action to be taken. 30

The report received a mixed press. *The Lancet* said that it made stimulating reading, and welcomed the possibility of expenditure on the hospitals. *The Medical Officer* said that it was clearly a long term plan. *The Economist* thought it might soon be outdated, and that continuing to pay the medical superintendents of council hospitals more than clinicians would deter many clinicians from joining the council's service. *The Economist* was right; the publication of Aneurin Bevan's proposals outdated the plan very soon indeed.

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Chapter 11 Bevan and the NHS, 1945-1948

Until 1945 the safest assumption in London was that the hospital services would be based upon the local authority, with a regional advisory council to coordinate planning with the counties surrounding the capital. The Conservatives had produced a White Paper along these lines in 1944. Labour's election victory in July 1945 led to a dramatic change. Aneurin Bevan, the new Minister of Health, had wide responsibilities including the problems of post-war housing. Nevertheless he moved rapidly and within days was submitting lists of questions for his civil servants to answer. He took quiet soundings from professional bodies and associations, and senior civil servants soon came to understand the new Minister's thinking.¹ Bevan believed that the state should guarantee a free health service for all,² which automatically deprived the voluntary hospitals of their traditional sources of money. Public funding implied public control. Bevan had at his disposal a wide range of expert reports; service considerations were covered by the hospital surveys, which confirmed the haphazard growth, the unevenness and the deficiencies of the existing arrangements; there was a report on medical education from Goodenough, and reports on London from the county council and the joint coordinating committee.

Bevan took radical new proposals to Cabinet in October 1945. His chief opponent was Herbert Morrison, a defender of local government in general and the London County Council in particular. Bevan's scheme excluded local authorities from a role in hospital management, for he had come to believe that as 80% or more of the cost would fall upon central funds, full central control was needed. Local government already had enough to do. National ownership would be combined with regional planning and local administration. With the exception of the teaching hospitals, which would have boards of governors directly accountable to the Minister, hospital services would be managed by regional boards on his behalf. The regions would be based upon university medical centres, 'the natural focal points of specialist medicine and therefore of the hospital services'.

In January 1946 the proposals were circulated on a confidential basis to key associations and interests. Bevan did not intend to reopen the long drawn out discussions of the previous four years, and the confidential meetings he held with the local authority associations, the British Medical Association, the King's Fund and the British Hospitals

Association were not so much for the purpose of consultation, but to prepare people for what was to come.¹ The British Hospitals Association, once it was aware of what was in the wind, chafed at the temporary ban on wider discussion. The details were made public on 19 March 1946 when a summary of the National Health Service Bill was presented to Parliament. Sir Bernard Docker, the chairman of the Westminster Hospital and of the British Hospitals Association, opposed the plan at once, saying that it was not in the interests of the patient to eliminate all sense of local pride, interest and responsibility in local hospitals, as must be the case if local management committees were autocratically appointed and made responsible only for minor day-to-day affairs. Lord Latham, the Leader of the London County Council, said that his council had devoted much thought and effort to the task of making its hospitals the finest in the world, and it was therefore with great reluctance that the council would see them pass into the ownership of the state. However the council would insist that the interests of the people of London were fully safeguarded by adequate council representation on the proposed regional hospital boards.³

As far as the hospital service was concerned, the new proposals went a long way to meet the desires of the medical profession and the voluntary hospital movement. The doctors had feared a salaried service, with loss of clinical freedom. This risk had been averted, and to the avid socialist Bevan's scheme appeared almost reactionary. The voluntary hospitals had looked for a way to preserve their independence, though dependent on public funds. They had therefore opposed local authority control, seeking instead partnership on a management body alongside the representatives of local government. This had been achieved. A regional solution was in sight, within which university hospitals would have a special place. Indeed the British Hospitals Association wrote to Bevan that 'so far as concerns the arrangements for the general administration and financing of the service we are satisfied that a substantial measure of common ground is already in sight'.⁴

The residual problems

The issues likely to prove sticking points for the London voluntary hospitals were the 'seizure' of the hospitals by the state, endowments and trust funds, and regional boundaries. Sir Bernard Docker and the British Hospitals Association remained violently hostile on these

matters throughout the negotiations. The Association raised with Bevan 'the crucial question of ownership ... by involving the extinction of entity, confiscation, elimination of personal interest, and a most autocratic method of appointing persons at all levels for the provision and management of hospital services, the present proposals bear no relation to our accumulated experience or to the historical evidence of achievement of voluntary as compared to other hospitals.' The King's Fund presented its case more sensitively when its representatives met Bevan on 5 February 1946. Bevan agreed to examine the question of the retention of the endowments of the teaching hospitals.¹ The Fund subsequently wrote to the Minister pointing out the importance of independence of management of the individual hospitals, and the need to find some acceptable arrangement whereby the funds of the hospitals might be respected. The Fund said that only in a few cases, such as St Bartholomew's, Guy's and St Thomas's would the income be substantial, and these institutions were of such importance to the future that they could certainly be trusted to spend the money wisely. Much in Bevan's scheme had proved to be entirely in line with the views of the King's Fund.^{4, 5}

Sir George Aylwen (London Voluntary Hospitals Committee and St Bartholomew's) was present at one of the early confidential discussions and wrote to Bevan asking whether existing boards and board members could be retained, and for clarification of Bevan's intentions for the endowment funds of the teaching hospitals. Bevan replied that the new boards would be designed to include the more valuable members of the old ones and that he intended 'the reconstructed teaching hospitals to enjoy the various endowments vested in them'.

And what about historical treasures? Guy's was worried about the fate of an almost unique set of Hepplewhite chairs - would they be snatched away to the Victoria and Albert for the benefit of the nation as a whole? An assurance was given that the value of historical tradition was appreciated, and no such action would be taken. The summary of the Bill confirmed that the endowments of the voluntary teaching hospitals would pass directly to the new boards of governors.
6

Before he took the chair at a meeting of representatives of the London voluntary hospitals, Sir George Aylwen wrote again to Bevan to ask for 'a local solution' for the trust funds of the smaller voluntary hospitals.

He hoped that the Minister would reconsider the question, to enable him to 'influence at least the London hospitals to give you that measure of support which will so definitely be needed in the early stages'. Bevan replied that it was part of his deliberate purpose to redistribute income to regional boards to reflect 'the actual needs of each rather than the largely accidental effect of past benefactions'. However he agreed that further moneys collected up to the start of the National Health Service could be held on a local basis.^{1,4}

The senior members of the London County Council had used their influence to pacify their colleagues. In the course of a debate in April 1946 Lord Latham said that he and his party deplored the taking away of the LCC hospitals and the encroachment upon local government. But one quarter of the hospitals in the country were voluntary and the remainder were municipal, and the government had decided to take over the voluntary ones. There could not be two systems, and the only way was to combine both into one unified and comprehensive organisation. He did not believe that the people of London would wish the council, either directly or indirectly, to sabotage the National Health Service for narrow, selfish interests.

Bevan was faced with the need to balance the claims of many opposing interests. During the committee stage of the Bill, he told Parliament that he had been careful to devise a scheme which gave teaching hospitals the utmost autonomy. Most were delighted because their financial situation would be infinitely better. Traditions would be preserved. Bart's would still be Bart's and Guy's would still be Guy's. But if every teaching hospital in London went on record against the scheme it would still go through. Though it was not a threat, he would like some teaching hospitals to bear in mind that if they insisted on some modifications, other modifications might also have to be made, less to their liking, to increase the enthusiasm for the scheme in other quarters.⁷

Most teaching hospitals appreciated that they had much to gain. The financial state of many had indeed been parlous until their survival had been assured by wartime subventions. Under peacetime conditions difficulties would recur. Two-thirds of the income of St Thomas's Hospital in 1947 came from state or local authority sources, and the situation was much the same at Guy's and the other teaching hospitals. While they feared the loss of autonomy associated with 'nationalisation', 'municipalisation' would have been worse. One of the

St Thomas's staff wrote that had the hospital had the power to decide its own fate in a national health service, it could hardly have chosen better than to follow the course laid down for it by Parliament.⁸ Boards of governors were comparable in size to the previous management committees, and not dissimilar in membership - although doctors were now members of all boards as of right. The sometimes substantial endowment moneys had been preserved, and the boards were corporate bodies with the power to hold land and property and act as principals carrying out functions on behalf of the Minister. The burden of debt had been lifted and the extent of local autonomy was considerable. In a memorandum sent to all chairmen the Minister said that they were to enjoy the largest possible measure of discretion. He wanted them to feel 'although acting as his agents, a lively sense of independent responsibility' (RHB(47)1). Planning would be a process of continuing informal consultation between the board, the university, the teaching hospital and the Minister. Many of Bevan's appointments preserved continuity with the past, although in a few cases like the Westminster Hospital it was clear that the previous chairman would be totally out of sympathy with the new order, and a new man was essential.

The smaller voluntary hospitals were in a less happy position. They were to lose a larger measure of their independence and would in future be managed by regional hospital boards alongside the municipal hospitals upon which they had looked down. They were asked to make no plans for their future, pending the establishment of the regional boards which would determine the future pattern of services in each locality. Their financial position was also precarious. Sir Austin Hudson, writing on behalf of the Metropolitan Hospital, said: 'Like all hospitals, we have always run on an overdraft from the bank, taking care that it did not get too large, and by means of special appeals at not too frequent intervals.' Bevan's announcement had dried up all the large subscriptions and made an appeal impossible; yet the cost of running the hospital had increased as a result of the introduction of national salary scales. The bank was now pressing the Metropolitan to repay its overdraft. The Ministry's reply confirmed that overdrafts as well as assets would be taken over on the appointed day. If hospitals were in immediate financial difficulties they could utilise remaining assets, or the Ministry would examine their situation. The King's Fund raised the same problem with the Minister, and Bevan replied that some hospitals might have to incur overdrafts or eat into their capital, but that financial assistance could be offered to those in difficulties.⁹

His reassurance was circulated to the hospitals by the British Hospitals Association.

Regional boundaries in the south east of England

The question of trust funds had been settled rapidly. Another problem, unique to the south east, remained. The nature of regional boundaries in London and the Home Counties became the subject of a bitter fight between the voluntary movement and the London County Council. The emotion and energy expended on this question is at first sight surprising, since patients are able to cross boundaries for treatment at will. Deep feelings were clearly involved.

Since 1900 legislation had increasingly placed vast responsibilities on local government. In 1940 the London County Council provided about 40,000 general hospital beds and another 35,000 in mental illness hospitals, making it the largest hospital authority in the world. The quality of the council's hospitals, the size and excellence of the voluntary hospitals, and the council's attitude to regionalisation created problems in London which did not exist elsewhere. It was one thing to consider regional councils and cooperation by committee in rural counties where the services were in any case often deficient; in London traditions and attitudes were different.

Sir Frederick Menzies had drawn attention to a further complication. London had the advantage of the King's Fund, but the Fund's area was not a local government one. It was the Metropolitan Police District, which covered the administrative county of London but which penetrated deeply in 'starfish' pattern into each of the home counties. The area of the Metropolitan Police District was several times that of the administrative county, and it was in Menzies' view an impossible area for any form of voluntary hospital and local authority cooperation. Yet Menzies' successor, Sir Allen Daley, had once said that on a purely medical basis a sector system was probably best. It was the relationship of medical services with other council services which led him to prefer a central London region. Lord Latham, as Leader of the London County Council, made his position clear to ministers in March 1943. He hoped that the administrative county of London would be regarded as a sufficiently large unit of administration for the new hospital service.

By early 1941 the London Voluntary Hospitals Committee recognised

that whilst regional councils were being established in many parts of the country, London was playing no part in the movement. A subgroup of the committee considering the possible repercussions on the voluntary hospitals of regionalisation accepted that London was a particularly difficult problem. The LCC was unique as a hospital authority, a large number of voluntary hospitals could justifiably claim to be regarded as key hospitals, and local authority areas did not match the spheres of influence of the large hospitals. Nevertheless, the subgroup considered that regionalisation was as necessary in London as elsewhere, although it could not be achieved without LCC cooperation. The most suitable area was, in its opinion, the administrative county of London plus the adjoining home counties of Essex, Hertfordshire, Middlesex, Surrey and, possibly, Sussex. Whether or not the LCC was willing to cooperate, the group suggested that the voluntary hospitals should get a regional scheme into operation for themselves.¹¹

Menzies, now retired, agreed. However he thought the King's Fund area should be extended to cover all the home counties. The Nuffield Trust, believing that the local authorities in the home counties would not be prepared to work with the LCC, proposed a London region consisting merely of the administrative county and Middlesex.^{12, 13} The policy of the King's Fund was first clearly defined on the publication of the White Paper on a National Health Service in 1944.¹⁴ The Fund said that the London region must cover part or all of the home counties.¹⁵

'The White Paper contains a hint that it will be necessary to have regard to administrative convenience, and implies that the area of the London County Council will constitute a single authority. The experience of the King's Fund in the Metropolitan Police District proves unmistakably that such an arrangement would only perpetuate one of the primary sources of maldistribution of hospital facilities in the metropolitan area. Insofar as there is a lack of adequate hospital services in the London area, it is to be found on the periphery of London where populations have sprung up in recent decades, where it has proved difficult for voluntary provision to keep pace with the growth in population, and where the local authority has equally failed to meet the situation. If ever there was a case for coordinated planning, it is over this wide area which transcends the County boundaries.'

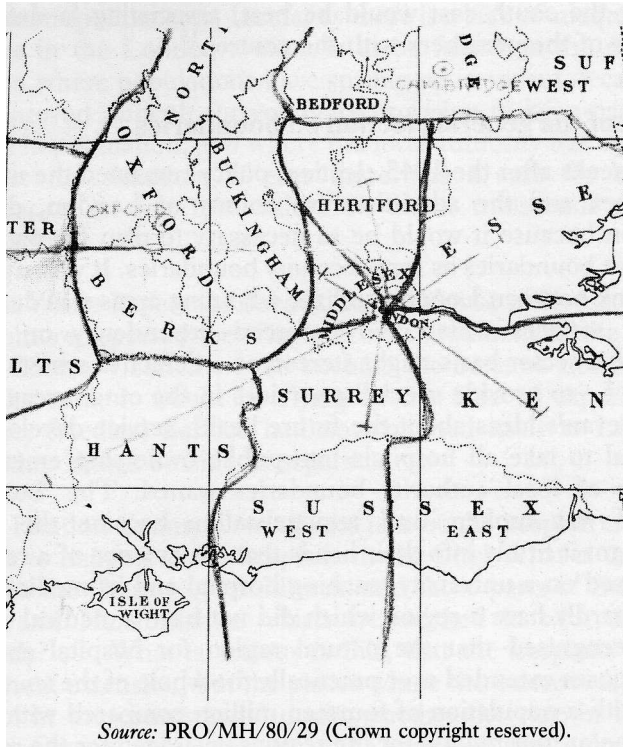
When the White Paper was debated in the House of Lords, the Earl of Donoughmore repeated the King's Fund's argument. If the area of the London County Council was to become the basis of London's health service, he said, it would be flying in the face of experience. The Emergency Medical Service had not confined itself to London, and treated other things outside as separate.

'If the London County Council area is to be the hospital area by itself, what is to happen to the hospitals in the City? What is to happen to those in the County of Middlesex, and those parts of Surrey, Kent, Essex and Hertfordshire which are worked in with the London hospitals? ... What is serious is this, that the hospitals of London want great extension, but the places where the extensions are wanted are not in the centre and I doubt whether they are in the London County Council area - they are in the periphery where there has been an increase in population. Whatever is done in London, reorganisation has to be based on hospital needs, not based on geographical accidents which arose in days gone by through totally different causes.'" 16

The importance attached by the Fund to university influence was explained by Lord Donoughmore at a meeting with the Minister, Mr Henry Willink, in March 1945. The Fund wondered whether it would not be possible to devise planning areas radiating outwards from central London? The Minister agreed that there must be a regional council to coordinate the plans of a wide area, including central London, but thought that proposals to split the metropolitan area on a sector basis would result in considerable difficulties 'which could hardly be faced in connection with the forthcoming health legislation'. Nevertheless, on 25 July 1945 Sir Bernard Docker wrote to Lord Donoughmore at the Fund to say that the British Hospitals Association had met representatives of the British Medical Association and found that they were in agreement that domination by the London County Council must be avoided, that there were dangers in a single planning area coterminous with the county council boundary, and that a 'cutting the cake' method of dividing the south east would be best, associating 'a definite and natural part of the periphery with the centre.'¹⁵

The effect of the general election on boundaries

For a few weeks after the 1945 election, policy remained the



Freehand map in Ministry of Health file of a early idea of London regions

unification of Middlesex and the administrative county of London, discarding sectorisation because it would be as necessary to plan for patient-flow across sector boundaries as across county boundaries. It was argued that the close link between London and the adjoining areas was due to their inadequate services which had enforced dependency on London. Planning on a sector basis might stereotype a defective system, and the aim should be to provide specialist services in the outer areas.

But as Bevan's ideas about the future health service developed, and the proposal to take all hospitals into public ownership emerged, the significance of local authority boundaries waned. The 'bondage of boundaries' was broken, and regionalisation became the keynote.

Everybody got it firmly into their heads that the essence of a region was that it focused on a university teaching hospital and its medical school; one could hardly have a region which did not have a medical school. It was well recognised that the natural region for hospital and health service purposes extended over practically the whole of the south east of England, with a population of fourteen million compared with populations of three or four million for the regions envisaged for the rest of the country. The surrounding areas of cities like Liverpool and Manchester were dependent on their university hospital just as the south east was dependent on London; but in London the difference in size was so great as to present a different problem.

Towards the end of 1945, Ministry officials were drawing rough maps of regional boundaries, in the south east arranged on a radial basis. The early maps showed five regions, three north of the Thames and two south. But in January 1946 when Bevan circulated his provisional proposals for the health service on a confidential basis he referred to 'about twenty natural areas of regions for hospital organisation' without any precise indication where their boundaries might lie. On 20 January 1946 he met the negotiating committee of the medical profession. Amongst the many questions, he was asked for an assurance that the area of the regional board or boards for London would not be the administrative area of the London County Council. Bevan immediately answered 'yes'.¹⁷ He repeated this statement to the King's Fund on 5 February 1946.'

On 16 April Reginald Stamp, chairman of the Hospital and Medical Services Committee of the LCC, wrote to Bevan with two requests. Pointing out that he and Lord Latham had done much to secure support for the Bill from the LCC and the Associations of County Councils and Municipal Corporations, Stamp asked that personal and domiciliary services should remain with the Council rather than with the boroughs. Bevan replied that he wanted to be as helpful as possible on that point.¹⁸ Stamp's second request was more significant. 'You have been considering breaking London up into 5 Regions', he wrote.

'I beg of you not to reach a final decision on these lines now and to study closely the alternative. I have considered it very carefully and am convinced that unless you make the County of London one Region you will not get a good scheme and may even find the five regions attached to the provinces won't work smoothly. Further, you will play right into the hands of the Voluntary Hospital and Medical Profession

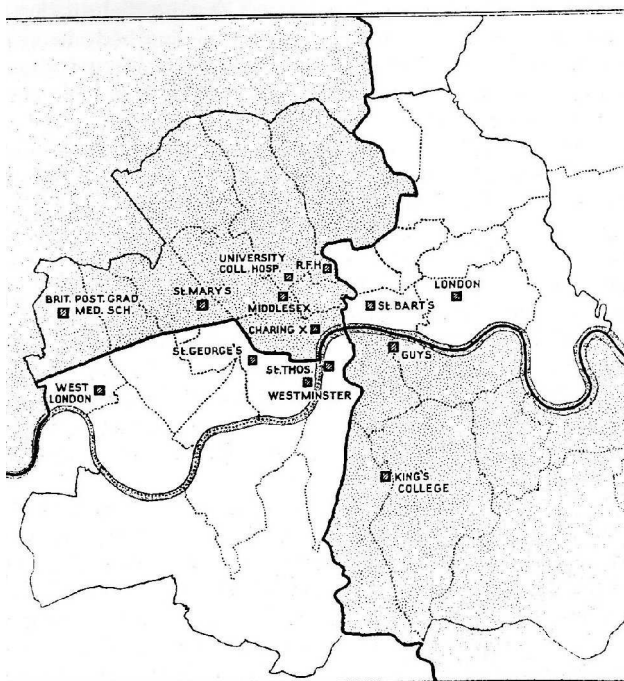
people, who wanted to do this under the old scheme to break the power of the LCC. I know the personnel available in London and Home Counties areas and I would say that if you have 5 regions with London in each, you will simply not have the effective personnel to work the Regional Boards. My friends and I can't physically serve 5 of them and the medical profession and the voluntary hospital people will hold full sway.'

Bevan signed his reply the day his officers were due to confer with local authority representatives. Sir Arthur Rucker's advice was that much as one would like to meet the LCC who had done so much to meet the Ministry, the assurance sought by Stamp was impossible to give. Bevan's reply said that to make the London County Council area a hospital region in itself would be utterly inconsistent with the whole conception of the Bill as far as hospital services were concerned. One of the main objects of the proposed new regional administration, and the taking over of hospitals everywhere, was to enable organisation to follow natural functional boundaries. It would defeat that object completely to adopt the county boundary of London as demarking a separate region. He was not making up his mind yet what the actual regions affecting London might be, and he would want Reginald Stamp's help and that of many others when the time came; but he could not possibly accept the suggestion made.

The LCC, controlled by Labour for many years, had not expected such treatment from a Labour administration. There was a feeling of hurt that not only were its hospitals to be taken away but the boundary of the region would not be its own. In April 1946 the Hospitals and Medical Services Committee of the LCC considered a carefully argued paper and recommended to the council that it should:

- i Aim for a London or central London region including all LCC hospitals and any others outside which London needed.
- ii Try to get 50 per cent of the regional hospital board members appointed in consultation with the LCC.
- iii Aim to get 50 per cent of the hospital management committee members representative of the LCC.

On 26 April 1946, Sir Arthur Rucker met local authority representatives, including seven from the London County Council. The LCC pointed out the difficulties of a smooth change-over if existing services were not allowed to carry on substantially as working organisations. Sir Arthur made it clear that the council's proposals ran



Source: The Lancet, 1946, ii.

**The pattern of the regions in the south east.
The Lancet 1946, ii., pp 842-4, 879-80.**

counter to ministry policy. It was contemplated that there should be nothing in the nature of a central London region and that, indeed, substantial reorganisation in central London would be carried out. The question was one of major policy and if the council disagreed with this line it should make its representations to Parliament.

During the second reading, Bevan said that the local authority area in London was an example of being too small and too large at the same time. He regarded administrative boundaries as a matter he should determine, and not an issue for the consideration of Parliament. This was challenged at the committee stage of the Bill, and whilst Bevan won by 20 votes to 17 he subsequently agreed to define regional boundaries in regulations to be submitted to Parliament, once the Bill

had passed through all stages and become law.

The definition of regional boundaries

Under Bevan's scheme local authorities and their boundaries had become less significant. The Ministry now argued that the regional system was designed purposely to avoid adherence to local authority boundaries in hospital planning, and that 'London was the case par excellence for ignoring the county boundary, which was without meaning as demarking any special group of persons or type of district, which cut across normal flows of population by rail and road, and included a far larger proportion of hospital provision than was proper to the population of the county. The perpetuation of the London County Council area as a unit could scarcely fail to arouse the suspicion that the existing system was being continued, and that the voluntary hospitals were to be "sold" to the London County Council or its successor. The way would, in fact, be paved for a reversion to county council management were there to be a change in political policy.'

Once the National Health Service Bill had been published, discussions on regional boundaries began to take place more openly. There was little difficulty in defining regions outside London. With only one teaching hospital per region, boundaries were not too difficult to draw. But in London twelve teaching hospitals had to be catered for somehow or other. Applying the principle of a university focus, the only solutions were a massive region or a sector system based upon groups of teaching hospitals. For advice the Ministry turned to the only group which had experience of managing all the hospitals in the south east - the group which had managed the Emergency Medical Service and its London sectors. The first meeting of the 'London syndicate', as it became known, was held on 4 December 1945.¹⁹ The Ministry was represented by Dr John Charles, a deputy chief medical officer, and the members were Sir Claude Frankau, Sir Francis Fraser, Sir Ernest Rock-Carling and Sir Archibald Gray. The constitution of the group enabled it to take account of both educational needs and the problems of running a hospital service.

In April 1946 the London County Council submitted its proposal for a central London region. The arguments adduced were continuity of service, the easier job of a county council which could relate to one region rather than five or six, and the fact that a radial division of the south east of England would make a coordinating body necessary to

consider the problems of London as a whole. Opponents of the council's plan argued that a central London region would undermine trust and goodwill of the voluntaries, risk the perpetuation of 'the existing unwieldy machine', and establish a precedent for other parts of the country. By May the syndicate had concluded that the difficulties of radial sectors had been exaggerated and further discussions in June and July centred on two alternative schemes. In Scheme A, four regions for London and the south east each included a number of metropolitan boroughs. In Scheme B, only two of the four regions contained parts of the London County Council area, the north east (19 boroughs) and the south east (10 boroughs). Scheme A was chosen and, with minor revisions, was adopted by the syndicate on 7 November 1946. The National Health Service Act had now passed all its stages and time was pressing if the order was to be laid before Parliament before the Christmas recess. On 9 November the submission went to the Deputy Secretary, Sir Arthur Rucker, and on 15 November Bevan discussed it with senior officials including the chief medical officer, Sir Wilson Jameson.²⁰

Bevan agreed the proposals on 15 November and they were issued for consultation that day, with a month allowed for comment. It was thought unlikely that changes would have to be made as a result of consultation, and in London but not elsewhere this proved the case. Simultaneously the regional hospital boards were christened, and in London they were named metropolitan hospital boards. In most parts of the country county boundaries had remained intact, but not in London. Sir Allen Daley wrote a letter of protest to Sir Wilson Jameson and Sir Arthur Rucker. To his colleagues in the home counties he wrote: 'our county is split into four in an extremely arbitrary fashion dictated solely by the need to apportion twelve teaching hospitals among the four regional areas. The Ministry's officers have no idea of the complexities of hospital administration ... if they go about it like iconoclasts destroying what is good instead of building up from it they are heading for disaster.' Sir Allen was not being entirely fair, for some care had been taken to adjust the four regions so that the populations were approximately equal and no region was overloaded.

Sir Allen Daley reported the position fully to the General Purposes Committee of the London County Council on 27 November 1946, and made an attempt to rally his medical officer of health colleagues to fight the proposals. With Dr Macaulay of Middlesex County Council, and Dr Patterson from Surrey, he attended a syndicate meeting on 7

December but nothing was gained. Surrey County Council decided to make no observations on Bevan's proposals. Daley hoped that Kent and Middlesex would support the London County Council and, after a careful briefing session, members and officers of the county councils met Bevan on 13 December.²¹ The LCC representatives said the proposals would subdivide the local health authorities and metropolitan boroughs. The geographical areas of the regions were too large, united services which had taken many years to build up would be disintegrated, and there would be grave transitional problems. The council suggested an entirely different arrangement, a central London region surrounded by four home counties regions. Bevan said that he found the discussion depressing, for local authority boundaries had nothing to do with the hospital services. Regional boards were confined to hospital purposes, and local authorities had no right to have wounded feelings because county boundaries were to be ignored. Bevan agreed that there would be a need for a coordinating committee between the four regions because of London and Greater London problems, and officials were left to pursue this. But on the key issue Bevan gave no ground. The LCC representatives subsequently reported to the Council that the interview had been 'unsatisfactory'.

The University of London had no comment to make upon the proposed division of London, save to note that the teaching hospitals were unevenly divided between the regions, with six in the north west. Several of the medical schools submitted their views; St Bartholomew's wanted the regional boundary moved west, even though this would bring the Royal Free and UCH into the same region. St Mary's and Charing Cross also thought that this would be a good idea. The London Hospital Medical College wanted to be in a region by itself. King's College Hospital wanted Croydon included in the south east region. *The Lancet* had doubts as to the wisdom of splitting London arbitrarily into four zones and feared that the London end of the regions would be the tail which wagged the dog. Perhaps London should have a region of its own.

The King's Fund said that the proposals were fully in accord with the views it had expressed from time to time. However it drew attention to the suggestions of the Voluntary Hospitals Committee for London, which included the transfer of the Royal Free Hospital and University College Hospital to the north east region. Bevan acknowledged the letter which he said would receive very careful consideration. At the end of the consultation period he wasted no time. Five days later, on

20 December 1946, a statutory order was laid before Parliament.²⁴ A final meeting between Bevan and the London County Council took place on 25 February 1947, after which Lord Latham reported to the council that the Minister had not been willing to modify his proposals. However, Bevan had agreed to set up machinery, with which the council would be associated, for the coordination of the work of the four proposed regional hospital boards and the local authorities in other areas. On this understanding the Council had decided not to take action in Parliament over the order, and had agreed to assist the Minister in dealing with problems of supplies.²⁵

There the matter rested, but the local authorities did not forget that their boundaries had been ignored. Sir Allen Daley's annual report said little about the transfer of the council's hospitals to the regional boards, although two of the council's officers were congratulated on their appointment as senior administrative medical officers. Of the other two metropolitan posts, one went to the Medical Officer of Health of Middlesex, Dr Macaulay, and only one - the south east metropolitan job - to an 'outsider'. The establishment of the National Health Service had an immediate effect on many organisations whose objectives would now be a matter for the state. Most voluntary hospitals had associated Samaritan funds, organisations of 'friends' and other bodies engaged in charitable, fund-raising and social activities. The wives of members of the staff were often involved, and not only did they raise sizeable sums, they provided corporate spirit.

The British Hospitals Association, which had represented the interests of the voluntary hospitals at national level for the previous thirty years, could not continue its traditional function. Although it was consulted about the membership of the regional hospital boards it had no further role to play and was wound up in March 1949.²⁶ It had never been a rich organisation and it only had assets of a few thousand pounds. Partly in its place, representatives of Guy's and St Bartholomew's founded the Teaching Hospitals Association in 1949. The Charity Organisation Society's functions spread far beyond the hospitals; it was renamed the Family Welfare Association. It continued to help families in difficulty, aiming to remove the cause of distress and not to merely deal with immediate need. Hospital Saturday continued to provide health insurance and financial benefits for subscribers. The revenues of the Metropolitan Hospital Sunday Fund had been diminishing and it decided to make grants available not as in the past for maintenance but to provide additional amenities.

The King's Fund had far greater resources. The four metropolitan boards asked it to continue to run the Emergency Bed Service and to plan its extension with them. With reserves of between five and six million pounds the Fund could use its moneys in new ways to promote progress in directions outside the immediate purview of the state hospital service. One initiative was to establish a bursary scheme to recruit and train young administrators, posting them to teaching hospitals for practical experience. In addition the Fund now had a wider constituency which included the old municipal hospitals. It was free to foster those things which make a hospital a human and sympathetic place, rather than merely an efficient machine.⁵

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Chapter 12 Hospital Development : 1948-1968

In the nineteenth century, hospital practice had been revolutionised by the introduction of anaesthesia, aseptic technique and skilled nursing. The hospitals which the National Health Service inherited also faced the challenge of continually evolving medical techniques. Amongst the advances which had taken place between the wars were improvements in diagnostic methods, the introduction of contrast media into radiography, the isolation of insulin, the introduction of liver extract for pernicious anaemia, the first effective sulphonamide and the development of cardiac catheterisation. The war had stimulated advances in the treatment of trauma, spinal injuries, fractures and burns, and of course had brought about notable developments in plastic surgery. The introduction of penicillin, streptomycin, PAS and INAH continued to modify the work of the hospitals and the demand for beds for chest diseases and tuberculosis fell. Soon cortico-steroids and anti-coagulants were introduced. Measles, which before the war had been responsible for many hospital admissions, could now be treated more easily at home. Mastoiditis and rheumatic fever began to disappear. Immunisation against diphtheria and poliomyelitis also had its effect.

The work of the hospitals was continually changing. Clinical physiology and new methods of investigation, associated with such doctors as Paul Wood, Sir John McMichael and Sheila Sherlock, brought more diseases within the reach of curative medicine. Thoracic surgeons who had been treating cancer of the lung and tuberculosis were soon performing closed valvotomies for mitral stenosis, and then replacing aortic valves and repairing congenital heart defects with the aid of the 'heart-lung' machine. Renal dialysis and transplantation followed. Orthopaedic surgeons who had learned to pin fractured femurs were soon creating a new market for their skills by replacing hip-joints. The dangers of bed rest were increasingly appreciated, partly as a result of Asher's writings ¹, and an active approach to the care of the elderly was fostered by men like Lord Amulree at University College Hospital. Psychiatric practice was modified by the introduction first of chlorpromazine, and then of the anti-depressants. Patients returned home more rapidly, and the possibility of an acute psychiatric unit within a district general hospital became more widely accepted. The work of the hospitals was changing, the length of stay was falling, more disciplines were involved in the treatment of the patients, and higher levels of skill were called for. The number of beds needed fell;

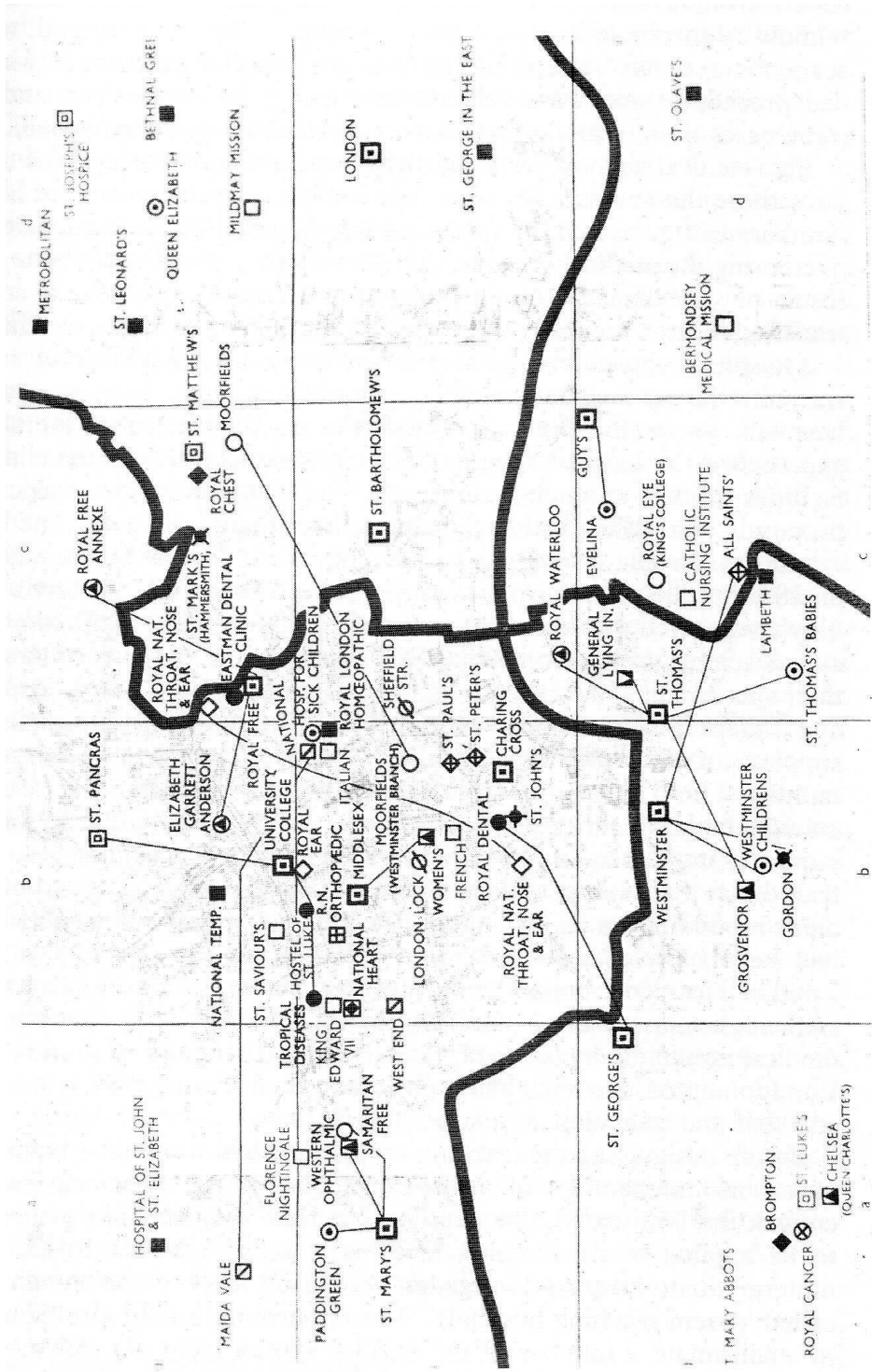
the numbers of staff required rose.

Organisational developments

Much had to be done between the passage of the NHS Act in November 1946 and the appointed day, 5 July 1948. Chairmen and members of the new authorities had to be appointed, and they had to select their officers. The pattern of organisation below regional level remained to be worked out on the basis of the principles published in a Ministry circular. Grouping of hospitals was to be approached from the point of view of *function and character* rather than *size or geographical* situation. Hospital management committees were to be responsible for a large and more or less self-contained general district hospital, created by grouping several hospitals and clinics together. 2 Schemes for the groups had to be submitted by February 1948. Dr Macaulay, the senior administrative medical officer for the North West Metropolitan Hospital Board, completed the task while in bed with *flu*. Grouping did not affect the teaching hospitals which had retained their own boards. But the smaller voluntary hospitals and the municipal hospitals whose traditions owed nothing to the voluntary system, were grouped together and had to develop new internal relationships. In the voluntary hospitals it had been traditional for there to be a partnership between the governing body, the chairman of the medical committee representing the visiting staff, and the matron. The new hospital management committees were less accessible to the hospital staff than the old boards. The municipal hospitals, on the contrary, had enjoyed little local autonomy. The chairman of any local hospital committee had few powers; the medical superintendent was responsible to County Hall for the running of his hospital, and the matron and the lay staff reported to him. The problems of the new situation, to which both types of hospital were having to adjust, were examined by the Bradbeer committee, established in 1950 by the Central Health Services Council.³ The committee recommended the continuation of the partnership of administration, medical and nursing staff which had characterised the voluntary system, the strengthening of the medical committee system, and a move away from medical superintendent posts.

Medical schools and teaching facilities

The Goodenough report had pointed to the great variation in the constitutions of the medical schools. Two were apparently autonomous



bodies, but in fact none had any real independence from their hospitals, nor any close association with the University of London. Bevan did not nationalise the schools along with the hospitals, so that the same Act which brought the health service into being established the medical schools as corporate bodies. New governing bodies were formed, with academic councils quite different from the hospital committees which had preceded them. New relationships had to be established, and in some cases there was marked distrust between hospital and school.

The medical schools were faced by large student intakes. Not only were there the students who had just reached university age, but large numbers had gone into the forces during the previous six years instead of entering the medical schools. The schools were also short of beds as a result of war damage. Goodenough had sold the idea of university teaching centres - groups of associated hospitals - to medical schools and hospitals accustomed for six years to a sector system. During those six years the staff of the teaching hospitals had come to know nearby hospitals very well indeed. Several of the teaching hospitals therefore approached the London County Council, seeking access to the clinical facilities of the municipal hospitals. Before agreeing to particular proposals, Sir Allen Daley thought it best to see what the medical schools as a whole wanted, and a conference was held at Senate House on 18 July 1946. Three types of proposal were advanced. St Mary's and Guy's suggested that voluntary and municipal hospitals might combine as a teaching group. Some like St George's wished to accommodate their special units like ear, nose and throat at a nearby council hospital, and others wished to use existing wards in municipal hospitals to supplement their own resources. 4.

Crucial decisions had to be taken rapidly. The University, while supporting the principles of Goodenough, had no defined policy of its own, and in any case had no way of imposing its will upon the medical schools. Some teaching hospitals feared that if a London County Council hospital was taken over it might delay rebuilding on its own site, or lead to the loss of a hospital which had been closely associated with it during the war years, like The London Hospital's branch at Brentwood. Senior medical and nursing staff might oppose the assimilation of LCC staff, or the education of medical students by council doctors. St Bartholomew's and The London agreed that their main objective should be rebuilding on site, and that amalgamation should be played down.⁵

Before designating the teaching hospitals which would have boards of governors independent of the regions, the Minister was required to consult the University. The London syndicate discussed the principles to be applied in determining teaching groups in March 1947. The undergraduate hospitals designated would be those Goodenough had called 'parent teaching hospitals'. The opportunity would also be taken to amalgamate a number of the smaller special hospitals with undergraduate teaching hospitals along the lines suggested by Goodenough. The syndicate held a second meeting with Sir Allen Daley to consider the possibility of linking London County Council hospitals with the teaching groups. Sir Allen said that two conditions must be met: London patients must not be deprived of hospital accommodation, and there must be no injustice to the staff of the council's hospitals.

The teaching hospitals suggested various types of linkage with the municipal hospitals, simple association for the purpose of teaching, or full absorption with management by the board of the teaching hospital. Absorption had a disadvantage - it cut across the most cogent argument for a radial pattern of regions, that the regional boards would themselves have a substantial holding of beds in all areas.⁶ Bevan decided to designate only those hospitals bearing primary and major responsibilities for undergraduate and postgraduate teaching. Even though absorption would have helped the teaching hospitals to obtain adequate facilities, it would remove from the regional boards the beds they needed to fulfil their own responsibilities. The University of London was consulted on the designation of teaching hospitals in June 1947 and replied in October. Most of the proposals were approved, although the University wished to associate St Mark's with the Hammersmith rather than St Bartholomew's. Five medical schools asked for municipal hospitals to be designated to their associated board of governors, and the University supported their requests.⁷ These were the London Hospital Medical College (Mile End Hospital), the Westminster Medical School (St Stephen's Hospital), St Mary's (Paddington Hospital), Guy's (St Olave's Hospital) and King's College Hospital (Dulwich or St Francis' Hospital).

The Ministry asked the regional hospital boards for their comments on the University proposals, and with one accord they opposed the absorption of London County Council hospitals. The Minister agreed with the regions, but on a number of occasions Bevan preferred to

amalgamate small hospitals, particularly special hospitals and those for women and children, with teaching hospital groups. In May 1948 twelve undergraduate and fourteen postgraduate groups were designated. Only one municipal hospital, St Pancras, became associated with a teaching hospital, University College Hospital. An understanding existed between the Ministry, the University and Charing Cross Hospital that the latter would move to Harrow where a new hospital was needed. With the agreement of the boards concerned, Harrow and Wembley hospitals were transferred to the Charing Cross group. Similarly the use the Royal Free Hospital made of the North Western Fever Hospital, and the possibility that it might itself move to Hampstead or Islington, led to the designation of the fever hospital to the Royal Free group.

Postgraduate medical education

The Goodenough report had stated that whilst facilities and men of outstanding distinction were present in London, the necessary organisation for postgraduate education remained deficient. The report suggested the establishment of a series of institutes, each based upon the most suitable special hospital in its particular field. All would form part of a federal organisation which would relate to the University of London. The British Postgraduate Medical Federation was established by the University, in accordance with these recommendations, in April 1945. Special hospitals had been discussed in some detail during the meetings of the Goodenough committee. Some were thought to be excellent, but others were not and it became University policy to establish no more than one institute in respect of each specialty, and to bring the educational facilities up to university standard.⁸ Sir Francis Fraser became the director of the new federation, with responsibility for the postgraduate institutes, and his membership of the London syndicate made coordination of service and academic policies easier. Appropriate special hospitals were recognised as teaching hospitals and, sometimes at their own request, sometimes at the request of the University, special hospitals in the same field were brought together under the governance of a single board. The pattern in London therefore came to differ from that in the provinces, where universities did not establish separate institutes and the special hospitals were usually grouped with the parent teaching hospital.

In February 1947 Sir Francis Fraser wrote to Aneurin Bevan to say that the committee of the British Postgraduate Medical Federation was

agreed that the Postgraduate Medical School and its associated hospital were inconveniently situated, and the school should if possible be placed more centrally so that it was more accessible. Fraser thought that the ideal solution would be the association of the school with an existing hospital, perhaps the Middlesex. But as, in the view of the federation, it was unlikely that any existing school would be prepared to exchange its undergraduate role for a postgraduate one, the possibility of building a new hospital on a central site should be considered. He suggested the site of the old Foundling Hospital, where a hospital might be built to replace those likely to move from the centre of London 9, and he sought Bevan's advice on how to proceed.

The question was referred to the London syndicate which replied that whilst the Hammersmith might indeed be inconvenient, to build a new hospital in the centre of London would seem contrary to the recommendations of the hospital survey and the Goodenough report. Instead, a development at St Mary Abbot's might be considered. It was clear that any proposal to bring together the Hammersmith and all the specialist postgraduate hospitals would be expensive, and in view of the time it would take to acquire the land adjacent to St Mary Abbot's it would be of a long term nature. The building situation also precluded an early start. Nevertheless the British Postgraduate Medical Federation continued to press for a decision in principle, returning to the possibility of a new hospital near Mecklenburgh Square, on the Foundling Hospital site. In March 1948, when this site was purchased by the Dominion Students' Hall Trust, Sir Francis Fraser once more proposed a hospital development to which the nearby specialist hospitals and institutes could relate. While the Foundling Hospital site was near both Senate House and a number of existing hospitals, Sir Wilson Jameson was not enthusiastic. He reserved his position about further hospital construction in central London, and replied that the first step would seem to be the provision of suitable accommodation for a postgraduate medical school, the need for which was greater than for a postgraduate hospital.

Hospital planning

The medical officers of health of the LCC and the home counties did not wish there to be a delay of two or three years in hospital planning, whilst the health service was established and the new regional boards set up planning departments. Sir Allen Daley, Dr Macaulay of Middlesex, and Dr Patterson of Surrey - a county which had already

produced its own plan for future hospital development - wrote to the Ministry. As a result the London Hospitals Working Party was established, which met for the first time at the Ministry in June 1946. The working party discussed a wide range of issues during the following months, but as the metropolitan hospital boards had not been formed, and there were many uncertainties, little could be accomplished. Meetings between the London County Council and voluntary hospitals like the Royal Free and the Prince of Wales Hospital Tottenham were more productive. The council made facilities available to them at the North Western and North Eastern Fever Hospitals. 10

A great fault of the new health service administrative structure was the multitude of authorities; they made effective planning virtually impossible. The nature of the services provided, rather than geography, was the basis of health service organisation. Teaching hospitals, ex-municipal district general hospitals, and mental illness hospitals might lie within a stone's throw of each other but be managed by different authorities because, in some respects, they performed different roles. As early as 1949, the *Hospitals Year Book* said that there was little regional hospital boards could do in the way of planning without securing the cooperation of the teaching hospitals in their areas. As far as could be ascertained, the principle of service had been upheld, and there had been no tendency to regard management committees as administering geographical areas. The year book said that a large number of geographical boundaries had been swept away, and some of the happenings in the past which had aroused either public resentment or public ridicule should not occur in the future. There were no boundaries on the map to indicate where 'A' management committee area finished or 'B' management committee area started.

It was only human nature for the new authorities to express their individuality. They did. The house governor of a royal endowed hospital was reputed to throw any letter from the Ministry into the wastepaper basket if it did not contain a cheque. The regional boards had no control over this elite. Conversely, some of the teaching hospitals who tried to involve the metropolitan board in their planing had no response at all. The Ministry attempted to coordinate where it could, but the tense relationship which had existed between the voluntary and municipal hospitals persisted, albeit in a lower key, between teaching hospitals and regional board hospitals. The old

guard remained in control, continuity had been maintained, but attitudes of separatism persisted. Although people accustomed to taking a broad view - such as Dame Barrie Lambert of the London County Council and Sir Allen Daley - became members of the metropolitan boards, the problem was not solved.

Bevan had placed the ultimate responsibility for the provision of services on the regional boards and had been unwilling to designate municipal hospitals to teaching groups. In November 1947, he replied to a letter from the Socialist Medical Association saying that while teaching hospitals should in part serve their neighbourhood, the exact functions they performed must be depend on the educational needs of the schools with which they were associated. It did not seem possible to lay down any general rule as to the extent to which they should be local hospitals.¹¹ The same policy was expressed by the Ministry in a memorandum suggesting 'tentative answers to questions each board must necessarily face'.¹² Drafted with the help of senior members of the medical profession, the circular considered the relationship between regional centres, which included the teaching hospitals, and smaller 'hospital centres' providing a less extensive range of facilities. The regional centre would provide, in addition to the services found in all districts, 'exceptional services' like radiotherapy, plastic surgery, thoracic surgery and neurosurgery, which required the collection of cases from a large population to make full use of the medical teams. Teaching hospitals would have to select cases with their educational role in mind, and in view of their 'special functions' they would not be able to undertake all varieties of special treatment. They would not be district hospitals, but would provide the number of beds required to support teaching and research effectively. The memorandum, an attempt by an advisory committee of senior consultants to frame ideal standards for the future staffing of the hospitals, was republished under the title *The Development of Consultant Services*.¹³

The specialties which emerged during the nineteenth century dealt with conditions which were found in considerable numbers in every district, like ophthalmology and diseases of women. Specialty development in the London hospitals between the wars had been comparatively slow, even in fields like radium treatment. Under the stimulus of war, new specialist units developed, dealing in the main with traumatic injury, but most were sited away from central London, on the periphery. The specialties developing after the 1939 - 45 war had new characteristics. They dealt with rarer conditions, and required

larger catchment populations. Complex equipment and scarce skills were also needed. Physicians and surgeons with special interests, like cardiology and thoracic surgery, were keen to develop them but met with considerable opposition from the bulk of the consultant and academic staff in the teaching hospitals. They often had to do their main work in a specialist hospital, which might expand into a new, although related, field. The battle for beds was on, and the teaching hospitals ceased to be the province of the generalist - an ideal man to teach undergraduates - and became filled with special units under the control of men with rather esoteric interests.

The annual report of the Ministry of Health in 1941 had commented on this trend to specialisation. 'Through the growth of the emergency hospital scheme a new conception of hospital treatment can be seen emerging. The old, all-purpose conception of a general hospital has given way to a pattern of hospitals in which some specialise in one service, some in another. The patient goes to the hospital best suited to his needs, instead of, as would have happened before the war, remaining in the first hospital suitable.' The London County Council also accepted the principle of centralisation in its hospital planning, and proposed the establishment of a second postgraduate hospital south of the Thames, at Lambeth. The London syndicate discussed specialty planning briefly, and as Sir Ernest Rock-Carling was a member it is understandable that radiotherapy should have been considered early in 1947.⁶ Plastic surgery was also discussed, but thereafter a London-wide approach to specialty planning lapsed.

Many of the deans wished for nothing more than a return to the pre-war situation, but this was impossible. The report of the medical visitors of the University of London in 1950 drew attention to the incursions which specialist units were making into the beds available for fundamental teaching of medical students.¹⁴ This, combined with the effects of war damage, made for a shortage of teaching beds which was acute and severe. The principal of the University wrote to the Ministry to say that the Senate saw an urgent need for additional beds, and that the maximum number possible should be provided in the teaching hospitals. He also reopened the question of transferring regional board hospitals to the boards of governors of the teaching hospitals.

Cross-boundary problems

Bevan had appreciated that there would be cross-boundary problems, and had agreed to the establishment of a coordinating group. The 'metropolitan regional hospital board liaison committee' was therefore formed to consider matters of common concern. The first meeting was attended by the chairmen and senior officers of the London County Council and the regional boards. The transfer of municipal hospitals and liaison with the King's Fund were discussed, but after two meetings the committee fell into abeyance. According to Sir Allen Daley the senior officers involved had little time for extra meetings, the regions were afraid that the committee would become a 'super-board' whose wishes they would be expected to implement, and most matters were best dealt with at a local level anyhow.

The Central Health Service Council, noting difficulties which were arising nationally from the multiple authorities, established a committee on cooperation between hospital, local authority and general practitioner services in 1949. Three years later it reported that in London the geographical problem was so complicated that it was difficult for any one authority to be conscious of its opposite numbers.¹⁵ Sir Allen Daley submitted two detailed papers. His monthly meetings for medical officers of health had been attended, since the advent of the NHS, by senior administrative medical officers and the Ministry. But London had 60 local authorities, 26 boards of governors and four metropolitan boards, as well as its general practitioners. While the problems of London were indivisible, a group to coordinate the capital would be a mammoth affair. But to break up into regional groups would not be a complete answer, although local groups would of course be needed. Sir Allen Daley suggested that there should be a home counties conference, chaired by Bevan, to set them up.¹⁶

Rebuilding the hospitals

The damage sustained in the war was vast, and there was a large backlog of maintenance work. Few of the voluntary and none of the municipal hospitals had escaped bombing. The London survey recognised that little more than minor work would be possible for some time.¹⁷ Housing, education and industry had priority for scarce building materials like steel, and all that could be done for hospitals

was to improve efficiency through minor schemes involving operating theatres, outpatient departments and laboratories. Because of its poor structural condition, permission to rebuild Guy's was given as early as 1949 but work could not begin straight away. St George's was prepared to move to Tooting, but, in spite of the availability of the Grove/Fountain site, it was told that high priority could not be given to the scheme.

Because medical education was suffering as a result of poor facilities, the University of London wrote to the Ministry of Health asking for an assurance that it would be consulted before decisions were taken. The University's priorities were ward blocks at Guy's and St Thomas's, the outpatient department at the Hospital for Sick Children, and reconstruction at St Bartholomew's. Bevan accepted the importance of such schemes, but with limited funds and little steel there was no chance of rapid progress.¹⁸ In November 1953 the Ministry of Health produced a capital investment programme for the years ahead which included a number of hospitals for the new towns and redevelopment projects for the teaching hospitals. The programme slipped considerably, and Brian Abel-Smith wrote in 1956 that central government had proved a sterner master in terms of capital expenditure than the local authorities, or those who had directed the voluntary hospitals.¹⁹

Some expansion was possible from 1955 onwards, and major projects were selected and funded directly by the Ministry. Because the hospital surveys were becoming out of date, neither the regional boards nor the Ministry had a detailed idea of the hospital stock they had inherited. Even more difficult was the continuing uncertainty about the relocation of central London teaching hospitals. In 1948 policy had been clear and was accepted by all parties. Seven years later doubts were creeping in.

A new hospital survey

The post-war Greater London Plan had aimed to reduce the population of inner London by about 1,250,000 compared with 1938, in order to eliminate the housing shortage, ease traffic problems and improve access to leisure and recreational facilities. The projections of the fifties ultimately proved wide of the mark and the reduction of population, considered a good thing at the time, went beyond the

wildest dreams of the planners.

In 1955 four Ministry officers were asked to visit all the hospitals in the Greater London area to review the recommendations of the Gray-Topping London hospital survey.²⁰ They were asked to consider what modifications might now be appropriate on service grounds, in view of population trends. The purpose of the new survey was partly to assist the Ministry in the selection of building schemes but it was also to form the basis for discussions with London University on the relocation of teaching hospitals.²¹ The survey analysed the changes in the catchments of the teaching hospitals as a result of the establishment of the new towns and the hospitals developed in them. The surveyors, Clark, Winner, Barrett and Gregson, found that hospital services on the periphery of London had developed slowly and unevenly as a result of the restrictions on capital developments. In only a few of the teaching hospitals had there been a decline in the number of patients from outside London. Some, like University College Hospital, the Westminster, St Mary's and Guy's, still served large local populations and the percentage of their patients who lived in the County of London had increased slightly. Others, like St Bartholomew's, the Middlesex, St George's and The London had a falling local population and the proportion of patients from outside London had increased. It had not been possible to build hospitals fast enough outside London to cope with the population expansion. The peripheral populations were therefore increasingly dependent on central London hospitals. In general the new survey confirmed the policy of Goodenough and the hospital survey of 1945.²⁰ There were too many teaching hospitals in central London and three should move out.

Most of the London medical schools continued to be slow to develop medical education on an academic rather than an apprenticeship basis; the university approach was adopted more readily in the provinces. The University Grants Committee consistently followed the Goodenough ideal that medical students should receive an education on broad and liberal lines. When, therefore, money became available for redevelopment in London, the University Grants Committee and the University of London restated their policy, placing emphasis on the association of medicine with the basic sciences in the undergraduate course and the development of cultural activities in the student body. The University wished to see the London schools of medicine as close as possible to the university precinct. It supported the development of St George's Medical School at Hyde Park Corner, questioned the

removal of the Royal Free to Hampstead, and refused to sanction the removal of Charing Cross Medical School to Harrow. After consultation with the University Grants Committee, Charing Cross was told by the University in January 1958 that it was not willing to agree to the siting of the medical school in Harrow. The hospital was not prepared to move without its school, and suggested that the general medical and surgical beds might be kept in the Strand whilst a new unit was developed in Harrow for specialty work. This duplication of facilities appealed neither to the Ministry, nor to the regional board, which did not see that it would solve the problems of shortage of beds in Harrow. However, the recent Ministry survey showed the need for hospital development in Fuiham. In August 1958, the Ministry suggested that Charing Cross and its school might be rebuilt there, in association with the West London Hospital. The University for its part agreed to reconsider its opposition to Hampstead as a site for the Royal Free.

During 1957 the Medical Research Council reviewed its policy on clinical research. The Council's secretary, Sir Harold Himsworth, and a committee which included Sir George Pickering, concluded that a measure of concentration on a single site would be preferable to a larger number of widely dispersed units. The concept emerged of a clinical research centre associated with a hospital, and by June 1959 medical staff of the Ministry and of the Medical Research Council were visiting possible sites, including the Central Middlesex Hospital and Chase Farm, Enfield. Northwick Park, Harrow, was a last-minute suggestion by Sir Charles Harington, a member of the North West Metropolitan Board, just as the board was about to sell part of the site to the Middlesex County Council. A joint project to build both a hospital and a research centre was the result, building starting in 1966.

The planning of hospitals wishing to rebuild on their existing sites also suffered delays. Sometimes the hospitals themselves were responsible. Grandiose and inflexible plans might be prepared which had to be abandoned when difficulties became apparent. One hospital planned a tower block directly over an underground line; another a complex of towers which could not be commissioned in phases - the hospital would not work till the last one was in place. There were protracted discussions about hospital size, because whilst for educational purposes a hospital of a thousand beds was best, this contravened civil defence planning and a smaller hospital was better for ease of management and good staff relationships.²² Whilst the Ministry's survey had drawn attention to the risk of overprovision, it

proposed that some new hospitals should be built, and others, like St Alfege's in Greenwich, should be redeveloped.²¹ Guy's thought the Greenwich redevelopment would lead to an excess of beds in an area in which it was interested. The region was not enthusiastic, but the scheme went ahead. The existence of endowment moneys helped Guy's, St Thomas's and The London, for they could pay for preliminary planning and make a rapid start if money became available. It also enabled the hospital to influence the shape, design and location of the buildings on the site, and the nature of the wards - whether Nightingale or 'race-track'. Endowment money made it possible for St Thomas's to enlarge its site by six acres, when Lambeth Palace Road was diverted, at its expense.

The Hospital Plan 23

National expenditure on hospital building rose slowly from £10 million in 1956-7 to £31 million in 1961-2. All three political parties included promises about hospital construction in their 1959 election manifestos; the economy was expansionary and there was a vogue for planning. Mr Enoch Powell became Minister of Health and pressed for an urgent hospital building programme. Officials worked late into the night, often with the Minister sitting in. The plan was based upon a bed norm of 3.3 acute beds/thousand, although studies like those of the Nuffield Provincial Hospitals Trust showed that more efficient use of beds was possible and it was recognised that the norm might require revision downwards. The aim was not merely to modernise and rebuild many hospitals, but to change their pattern and content, integrating them with health and social services provided in the community. The Ministry survey provided information about the requirements in London, enabling the plan to take account of the special requirements of teaching hospitals, and the inflow of patients into London.²¹ While it provided for a substantial reduction in London's acute beds, the proportion in population terms would remain higher than elsewhere. Enoch Powell insisted that when a new hospital was planned, older hospitals which were to be closed should be named. Three undergraduate hospitals were to be re-sited and postgraduate hospitals brought together in two groups, in Chelsea and Holborn. The service contribution of teaching hospitals was recognised, but it remained implicit that their size and location would be determined primarily by their educational role.

An attempt was made to ensure that the plan was financially viable, but it proved not to be and within four years a major revision was required. Mr Kenneth Robinson, in opposition, maintained that the Ministry had no idea of what it cost to build a modern hospital, and the Ministry admitted that many of the schemes were inadequately defined and imprecisely costed.²⁴ The 1966 revision was more modest, but it too was based upon over-optimistic population projections and an under-estimate of costs. Policies were also changing; it was recognised that fewer beds/thousand were required and the Ministry began to embrace a new philosophy - that the pattern of service should not be distorted by teaching requirements. Teaching hospitals should act as district general hospitals, the students being taught where patients required treatment - not vice versa.

Most of the building schemes in the centre of London were teaching hospital projects, handled centrally by the Ministry. The regional board schemes were generally further from the centre. One, the Northwick Park development, was the result of a tri-partite agreement made in 1960 between the North West Metropolitan Regional Hospital Board, the Ministry of Health and the Medical Research Council. It provided a new hospital for Harrow and a research centre which enabled the Medical Research Council to concentrate clinical, para-clinical and non-clinical research on a single site. A major objective was to encourage collaboration between research workers and clinicians serving the community. The Ministry participated in the planning because of the national role of the centre. Both the hospital and the research centre were integrated as one building complex, the first phase of which opened in 1970.

The fever hospitals

The remarkable fall in the incidence of the more dangerous infectious diseases left hospital accommodation for fever cases unused. The fever hospitals of the Metropolitan Asylums Board had retained their original function under LCC control until the outbreak of war in 1939. Then there were higher priorities; some beds closed as a result of the blitz, some because of a shortage of nurses. Sir Allen Daley said that of 4,000 - 5,000 beds in the fever hospitals before the war, only 800 were available afterwards. Even so, there were more than were needed and some were already being used for other purposes.

<i>Voluntary</i>	<i>Opened</i>	<i>Current name and use</i>	<i>Site size*</i>
London Fever Hospital	1849	Liverpool Road Hospital (closed)	4 acres
London Smallpox and Vaccination Hospital	1846	Part of Whittington Hospital	
<i>Municipal</i>			
Eastern Hospital	1871	Site of Homerton Hospital	15 acres
Northern Hospital	1887	Highlands Hospital	35¾ acre
North Eastern Hospital	1892	St Anne's Hospital, Tottenham	28 acres
North Western Hospital	1870	Now the site of the Royal Free Hospital	12¼ acre
Western Hospital	1877	Closed 1978, site sold 1983	13¾ acre
South Western Hospital	1871	South Western Hospital (St Thomas's group)	8½ acres
South Eastern Hospital	1877	New Cross Hospital (Guy's group)	13 acres
Brook Hospital	1896	The Brook Hospital	29¼ acre
Grove Hospital	1899	Site of St George's Hospital, Tooting	22¾ acre
Park Hospital	1897	Hither Green Hospital, Lewisham	23 acres
Joyce Green Hospital	1903	Joyce Green Hospital, Dartford	254 acres
Southern Upper	1890	Darenth Park Hospital Dartford (mental handicap)	} 160 acres
Southern Lower	1890	Mabledon Hospital, Dartford (psychiatric)	

*Site size as listed by the London County Council 1945.

When the problem was discussed by the London County Council Hospital and Medical Services Committee in May 1945, one speaker said that the soundest hospitals structurally were those which the council had inherited from the Metropolitan Asylums Board, and they should be used to full capacity. Those in the centre could be converted to acute use, infectious diseases being sent to the periphery. The North Western, Northern, Southern, South Eastern, and Joyce Green hospitals might have a new function. Change of use was slow but progressive; solidly built and on large sites, the fever hospitals were an asset of great worth to the National Health Service. Patients with chest diseases and tuberculosis were admitted to some wards, and orthopaedic units were opened in others. Some of the hospitals began to develop into acute district general hospitals in their own right.

The 1956 Ministry survey complimented the regional boards on the extensive and skilful use being made of the fever hospitals at a time of restricted hospital building.²¹ Redundant accommodation was being adapted for more urgent needs, including units for poliomyelitis and regional specialties, like neurosurgery and thoracic surgery. The metropolitan hospital system was slowly being reshaped, but in a disjointed way as opportunities presented themselves. The Ministry made an attempt to regulate developments, and to concentrate regional services, as the hospital survey of 1945 had suggested. But according to John Pater it was a pretty forlorn hope. Better mechanisms were called for if unnecessary developments were to be avoided.

Redevelopment and postgraduate hospitals

The Goodenough report and the hospital survey of 1945 had proposed that there should be a reduction in the number of specialist hospitals. 25, 20 A number were amalgamated with other groups at the inception of the National Health Service. It was proposed that others should be regrouped around the university area as occasion permitted. The Ministry's new survey in 1956 said that lip-service had been paid to the concept of grouping, but restriction on capital investment had limited progress. Many postgraduate boards had made plans for redevelopment on their existing sites. The surveyors considered that whilst it was reasonable to take advantage of sites already near the university area, to relocate structurally sound hospitals was

uneconomic to do so in the centre also ran counter to the precepts of city planning.²¹ Redevelopment proposals were announced by Mr Enoch Powell in the House on 27 June 1961. He suggested that as far as possible the specialist hospitals should be concentrated into two groups, one in the Holborn area and the other in Chelsea, around the Fulham Road. To make the Chelsea postgraduate centre possible the site of the old municipal St Luke's Hospital, and the Chelsea Hospital for Women, would be used. The Chelsea Hospital for Women would be rebuilt alongside Queen Charlotte's, which, like the Bethlem Royal and Maudsley, would remain outside the two groups. The position of the Royal National Orthopaedic Hospital would be considered at a later date.

To determine the general principles which should guide the organisation of a postgraduate centre a committee was established by the Ministry under the chairmanship of Sir George Pickering.²⁶ The report was short. Visiting the institutes, the authors became only too aware that scientific facilities were often limited and there was sometimes an atmosphere of isolationism. In general the institutes to be associated in Chelsea were outward looking, but this was less evident in the Holborn grouping. The report stressed that institutes and their hospitals could not hope to lead in their fields if isolation continued. With the broad advancement of medicine, innovators needed access to a wide range of facilities. Independent access was impracticable on the ground of cost. Institutes might amalgamate either with each other, with general medical schools, or some might move into a relationship with the Royal Postgraduate Medical Schools at Hammersmith.

The final recommendations reflected the views of the institutes that association with a general medical school might lead to loss of identity. Amalgamation with each other was therefore favoured. It was envisaged that hospitals would be built on the periphery of an area in which joint scientific facilities and individual institutes would lie. Neighbouring institutes would communicate physically with each other and with central supporting departments. Shared facilities would include pathology, tissue and organ culture and cytology. Since close architectural and functional association was envisaged it was hardly surprising that the cost of the proposals was considerable.

The two suggested postgraduate hospital groups

1 Holborn

National Hospital for Nervous Diseases. Hospital for Sick Children. Royal National Throat, Nose and Ear Hospital, Eastman Dental Hospital, Moorfields Eye Hospital. (On the Royal Free Hospital site in Gray's Inn Road

2. Fulham

Brompton Hospital, Royal Marsden Hospital, St. Peter's, St. Paul's and St. Philip's, St. John's Hospital, St. Mark's Hospital, National Heart Hospital, London Chest Hospital

The plans for the Holborn group were the first to run into trouble. The committee formed to develop the proposal found that ground adjacent to Great Ormond Street and Queen Square was not available - it was being used for new housing. An alternative site in Gray's Inn Road was considered but the borough objected to it being zoned for hospital use. This led to some of the specialist institutes and their hospitals becoming increasingly attracted to the idea of a close association with an undergraduate teaching hospital, and in view of the many uncertainties it was decided to drop the proposal in 1966. There was no problem finding a site for the Chelsea postgraduate centre. The sites of the old St Luke's Hospital, the Chelsea Hospital for Women, the Royal Marsden and the Brompton were available. A project team was assembled and an outline development plan was prepared with the assistance of Llewelyn-Davies Weeks and Partners.

It envisaged a series of eight-floor buildings providing about twelve hundred beds, together with accommodation for the institutes of St Mark's, St Peter's, St John's, the Brompton, the Marsden and the National Heart. There were to be five phases as hospitals were demolished and rebuilt in turn. By now rumors were beginning to circulate about the line the Royal Commission on Medical Education might take on postgraduate hospitals.²⁷ It was the alternative option, that postgraduate hospitals and their institutes might be integrated with teaching hospitals and general medical schools. This, together with the horrific cost of the Chelsea scheme, led to the final abandonment of the policy to establish two postgraduate groups.

The district responsibilities of teaching hospitals

The Goodenough report stated that teaching hospitals should see themselves as full partners in the hospital service of the district in which they were located, and that equal emphasis should be placed upon the treatment of patients and the training of students. However, the voluntary hospitals had been founded to provide particular types of care of the highest possible quality to as many of the sick poor as possible. They were still doing so, although an increasing number of their patients were coming from further afield for specialist treatment. They could not easily accept that they should change their role to provide comprehensive care for a defined population, nor see how they could simultaneously serve patients from a distance needing specialist care, and still maintain standards. Traditionally teaching hospitals were more prepared to cut quantity than quality, to maintain the standard of their service and teaching. Most of them had insufficient beds to provide all the services now being asked of them. 28 In any case the ultimate responsibility for the provision of a service had been laid upon the metropolitan hospital boards.

By 1960 the old guard of chairmen and administrators was being replaced by a younger generation. Many of the new house governors knew each other, having been trained under the King's Fund bursary scheme. They also met regularly in a hospital discussion group. There was a new problem to be faced: the movement of the population away from central London and the improvement of hospital facilities in the peripheral areas made it more difficult for teaching hospitals to obtain a supply of 'ordinary patients'. A ring of hospitals was being planned and developed around London, but any suggestion that a teaching hospital might find itself out of business if it did not mark out a district for itself was at first received with incredulity.

In the North West Metropolitan Region the board had particular difficulty in meeting its responsibilities to provide care, as there were few regional board hospitals in the central area. In November 1960 the senior administrative medical officer, Dr Frank Fowler, arranged to meet the secretaries of the five teaching hospitals in his region. He raised the question of accepting a district responsibility — taking all patients from a specific area if no other arrangements could be made.

He pointed out that as the board carried responsibility for providing

care, it would have to make other arrangements if the teaching hospitals were unwilling to play their part. The medical committee of University College Hospital saw that the falling population might leave them without enough 'average' patients, and that it was undesirable for medical students to become practised merely in the more exotic forms of care. The additional load proposed would not be great and refusal was risky. The medical committee recommended acceptance to the board of governors and University College Hospital assumed district responsibilities in November 1961, becoming in its view the first teaching hospital in London to do so.²⁹ Hammersmith was probably the last. Although it had originally been a municipal hospital with a defined catchment - albeit a hospital to which the British Postgraduate Medical School was attached - it had changed its nature considerably in the early fifties. Under the influence of men like Sir John McMichael new techniques of investigation were developed. Open heart surgery was introduced, and the creation of specialist units left little room for clinical work of a more mundane nature. In spite of attempts to alter this ethos, for some years neither the hospital nor its board saw any purpose in attempting to provide a district service. However from 1967 onwards its policy began to change, and it was appreciated that there were benefits in the application of advanced clinical and scientific techniques to common conditions found in a local community.

Medical school expansion

During the fifties the size of the medical school intake had been reduced as a result of the Willink report *30*, but the University Grants Committee recognised that a shortage of doctors was developing and began to plan for expansion. In 1961 the Minister of Health made a statement in the House recommending an increase of 10 per cent in the intake. In January 1964 the health departments considered that a further increase of 15 per cent was called for. The University of London sought the views of the medical schools on the possibility of achieving this. The schools stated that given the necessary resources 145 additional places could be provided within four years; within a decade an increase of 268 places was possible. However an increase of this order would involve major development at a number of medical schools and access to more beds. In February 1964 the Minister of Health, Mr Anthony Barber, addressed the Teaching Hospitals Association and referred to an agreement with the University Grants Committee that an intake of 100 students might justify a new hospital of 1,200-1,300 beds, though not necessarily all on one site. The plans

for the reconstruction of St Thomas's and St George's were sized on this basis. Other medical schools already had loose arrangements with ex-municipal hospitals to provide them with access to beds, but with expanding intakes something more formal was called for.

Dr James Fairley, senior administrative medical officer of the South East Metropolitan Regional Hospital Board, and a governor of several teaching hospitals, believed that the transfer of regional board hospitals to teaching hospitals was the most satisfactory approach. 31 Mr Mellish, the chairman of the Bermondsey and Southwark Hospital Management Committee, favoured this type of development and approached Guy's, but the teaching hospital was not initially interested in taking over the regional board hospitals. When an alternative approach was made to King's College Hospital, however, Guy's reconsidered the possibility. A working party in the South West Metropolitan Region came to a similar decision, and recommended to the Minister that Lambeth Hospital should be transferred to St Thomas's.³² This transfer took place in 1964 and St Thomas's explicitly accepted ultimate responsibility for a population of 200,000 in Lambeth. The teaching hospital had lost the privilege of picking and choosing its patients, but had gained closer links with its neighbourhood.

Lord Inman, the chairman of Charing Cross Hospital and the London branch of the Teaching Hospitals Association, put in a strong plea to his fellow chairmen to wake up to coming problems. In April 1964 the hospital secretaries met at the Hospital Centre to discuss what might happen to the authority of the London undergraduate teaching hospitals if and when Labour returned to power. They agreed that much closer coordination of their activities was desirable, and a small sub-group was established which expressed strong but divergent views. Brian Abel-Smith suggested that a body with power to enforce budgetary control might be desirable, an idea which did not appeal to the hospitals. The chairmen, meeting in June 1964, agreed that they needed to coordinate their activities more closely, and established a working party chaired by Sir Desmond Bonham-Carter to consider how the teaching hospitals might work together to meet their district and other responsibilities. They concluded that to make economic use of their facilities, and create a well-balanced flow of clinical material, they would need to draw upon a population of 2½-3 million, and that more beds were required. They favoured designation of regional board

hospitals, because it was easier to teach students in hospitals under unified medical and nursing control with similar standards, easier to obtain university funds, and easier to obtain university recognition of teaching staff in hospitals which had been designated.³³

There was however an alternative form of organisation. The overlapping responsibilities of the regional boards and the boards of governors led to recurrent suggestions that teaching hospitals should lose independent status and be managed by the regions, although both the Guillebaud report on the cost of the National Health Service in 1956³⁴ and the Acton Society Trust in 1957³⁵ rejected the idea. In evidence to Guillebaud, the Teaching Hospitals Association said that any rationalisation of medical services involved a danger to professional standards. The risk was minimised, in the Association's view, if teaching hospitals were allowed to work like universities to their own clinical and academic standards, and in their own traditions, protected from the levelling-down too often seen in large groups.³⁶ Some teaching hospitals saw yet another possible form of management - the unification of the London teaching hospitals in a central region of their own, reducing the area of the regional hospital boards.

In October 1964, Labour came to power for the first time in thirteen years. The following February the new Minister, Mr Kenneth Robinson, addressed the Teaching Hospitals Association and called a halt to further designations of regional board hospitals whilst the policy was reviewed. The review was completed in May, and it was announced that further designations might be considered if they were in line with regional policy and the teaching hospitals would accept ultimate responsibility for the provision of a district service. The review was prompted by doubts in some quarters about the efficiency with which teaching hospitals would provide district services, because of their high degree of specialisation and their alleged bias towards 'interesting cases'. Were they prepared to give the same weight to the needs of a local community for a balanced service as they did to their teaching functions? Some teaching hospitals certainly did see it as vital to their future to keep a close hold on a district, and easy access to its patients. Others equally certainly did not. To meet the challenges which were coming the undergraduate hospitals strengthened their London committee by adding medical representation. The deans and the chairmen of the medical staff committees were invited to join.

The Minister's conference, July 1965

With a view to resolving some of the problems of medical education and hospital administration, Mr Kenneth Robinson spoke to the chairman of the London committee of the Teaching Hospitals Association, Sir Desmond Bonham-Carter, and called a conference of the regional boards and the boards of the teaching hospitals.

Mr Kenneth Robinson pointed to the improvements in the services provided by the peripheral hospitals, and to the reduction in patients' length of stay which made it essential for the teaching hospitals to extend their catchment areas if they were to meet the needs of clinical teaching. The time was in sight when a large part of central London would be provided with hospital services mainly by the teaching hospitals. It was going to be of the greatest importance for them to accept full responsibility for all local hospital services as well as accepting some patients referred from greater distances. As to the final solution of the problem of hospital administration in London he had an open mind; teaching hospitals might be absorbed into regions, or a central London hospital authority might be established. For the present he proposed an interim solution which would associate boards of governors with regional boards in planning. A consultative committee might be established in each region to advise the regional board on hospital and specialist services in the central part of the region. 36,37

There was a wide measure of agreement with the Minister's proposal although the Guy's representative said that he was terrified of bureaucracy and that there was more harness than horse about what was suggested. Could not each region be left to work out the most suitable committee structure for itself?

Three weeks later the Minister wrote to the chairmen of the regional boards asking them to establish committees with representatives from their own boards, those of the teaching hospitals, London University and the Inner London Executive Council that dealt with GPs. The most urgent problem to be tackled was the joint provision of district services and access to sufficient beds to meet the teaching needs of the medical schools. He also asked for views about the possibility of a forum within which the problems of health and welfare services of central London as one entity could be discussed, having in mind the

problem of the rationalisation of the regional specialties. As a first stage, four regional joint consultative committees were rapidly formed. The north west committee soon submitted proposals for the designation of further regional board hospitals to the teaching groups of St Mary's, the Royal Free and University College Hospital.

Progress in the south west committee was slower. There was a serious division of opinion in the north east committee about whether the additional beds needed for teaching should be provided by designation or by a system of association, which had little appeal to the teaching hospitals concerned. The south east committee was asked to consider the catchment areas of King's and Guy's, in the light of the proposal to undertake major redevelopment at Guy's. A special study was commissioned which later proved useful in determining district boundaries. In the south east committee 'there was helpful cooperation on all sides', and the teaching hospitals accepted full district responsibilities.

Further designation orders were soon made on the recommendations of the joint consultative committees, and the negotiations were generally amicable. St Giles' and St Francis' joined King's College Hospital in 1966. Other hospitals were taken over by St Mary's, The London and St Thomas's. The change in management led to the appointment of new consultant medical staff with the needs of medical education in mind, and the boards of the teaching hospitals put considerable effort into the improvement of both staffing and the buildings. Not all problems could be solved by designation. There might be no suitable hospital nearby, as in the case of the Middlesex, or, as at St Bartholomew's, there might be an unwillingness to allow students to work in a 'non-teaching hospital'.

By the mid-sixties the hospital service in central London had largely settled down. Sir Desmond Bonham-Carter thought that the boards of the teaching hospitals were about the right size, and less fettered by regulations governing their number and composition than were the regions. Local management was near the point of activity, and the four joint consultative committees which soon encompassed postgraduate interests provided a mechanism for working together. Other problems which were being addressed included the organisation of medical work in hospitals. The developments in medical science and the growth in the size of the hospital team had not been accompanied by changes in the relationship of the medical staff with each other, or with the

hospital management. The 'Cogwheel' working party, chaired by Sir George Godber, recommended a divisional system to overcome this problem.

The representation of senior nursing staff, alongside the doctors and administrators, and the need for chief nursing officers to have well developed managerial skills, were discussed in another report on senior nursing structure.³⁹ However the University Grants Committee was still finding it impossible to grapple with the educational problems in London. The tripartite structure of the health service was the subject of increasing criticism, fuelled by the existence of the Royal Commission on Local Government. It was a calm before a storm.

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Chapter 13 Rationalisation and reorganisation

By the mid-sixties, London's hospitals had got over the initial upheaval of the introduction of the National Health Service. Financial allocations were increasing year by year, relations with the Ministry were reasonable, and new services could be offered to patients. Planning to rebuild three teaching hospitals further from the centre of London was at an advanced stage. Most of the undergraduate teaching hospitals had accepted a district hospital responsibility and a joint consultative committee had been established in each quadrant of London. However not all was sweetness and light; some tensions persisted between boards of governors and regional boards. The planning of regional specialties, if not non-existent, was certainly ineffective. Finally, while earlier reports like Guillebaud and the Acton Society Trust papers had concluded that the basic organisation of the service was sound, there was increasing criticism of its tripartite structure. 1.2 In 1967 the Minister, Mr Kenneth Robinson, announced that he planned to issue a consultative paper on the administrative arrangements in the National Health Service, and in London hospital staff knew that they would also be affected by a forthcoming report on medical education. Change was in the air.

The Royal Commission on Medical Education 3

The proposal to establish a royal commission was made by the University Grants Committee in the early sixties. A memorandum written to its medical sub-committee argued that there was a need to tackle three problems which could not be solved by the sub-committee alone. They were the organisation of postgraduate education, which required not only efficient training but its association with the university education recommended by Goodenough; the problem of London where half the country's medical students were educated; and the further expansion of medical education. In London it had proved difficult to increase the contribution of university medicine within the teaching hospitals, where there was resistance to making room for clinical academic units. Money from the University Grants Committee therefore tended to go into the provincial schools. The many semi-autonomous bodies, both service and academic, made it difficult to obtain the agreement necessary for any major change. Dr John Ellis, physician to The London, a member of the medical sub-committee of the University Grants Committee, and a part-time principal medical officer at the Ministry, was the author of the original memorandum. In

his Schorstein lecture 4 he listed the recommendations ultimately made by the commission which were specific to London:

- The number of pre-clinical places in London should be increased from around 800 to 1,200 in the first instance, to allow maximal use to be made of the country's greatest concentration of medical resources.
- The number of medical schools should be reduced from twelve to six by pairing them, so as to allow pre-clinical departments of a viable size and each school to have access to a full range of clinical departments, adequately staffed.
- Each paired medical school should come into association with a multi-faculty college so as to enable the teachers in the medical schools to have close contact with teachers in other university disciplines, and vice versa.
- Money should be provided to start filling the gaps in academic staffing.
- Postgraduate institutes should come into association with the paired medical schools so as to end the isolation of the former and provide the latter with academic staff in the specialties.
- General responsibility for the implementation of the plan for London should be placed in the hands of a committee with representation from the university, the UGC, and the health authorities, with an independent chairman, and the committee 'should remain in being long enough to ensure that, in future developments, short term convenience is not allowed to nullify long term planning'.

The commission reaffirmed many of the principles laid down by Goodenough, and it did so at a time when people were more inclined to pay attention than they had been in the midst of war in 1944. It accepted Goodenough's assessment of the clinical facilities required by students and thought it would be desirable for the medical schools to have access to patients in the new hospitals which were being built away from the centre of London. Paired schools would have an annual clinical intake of around 200 students and would need access to about 2,000 beds. The commission calculated that by 1976 the areas for which the teaching hospitals accepted ultimate responsibility, and in which the students would be taught, would have a population of 2.8 million so that virtually all hospitals in central London would be needed for teaching. It was accepted that all hospitals should be managed within the framework of regional authorities, discontinuing the system of boards of governors.

1. St Bartholomew's Medical College and The London Hospital Medical College;
2. University College Hospital Medical School with the Royal Free Hospital School of Medicine;
3. St Mary's Hospital Medical School with the Middlesex Hospital Medical School;
4. Guy's Hospital Medical School with King's College Hospital Medical School;
5. Westminster Medical School with Charing Cross Hospital Medical School;
6. St Thomas's Hospital Medical School with St George's Hospital Medical School.

Many of the medical schools objected to the pairings. Guy's and King's held discussions without commitment on either side. Over the following months the University Grants Committee, London University and the Department of Health and Social Security considered the report, and in August 1969 simultaneous statements were issued by the Department and the academic authorities. The academic bodies accepted the first four pairs but proposed to associate St Thomas's with the Westminster. Charing Cross and St George's were left unpaired because the university and the Department agreed to ignore the recommendations and stick to the plans to rebuild them at twice their previous size.

The Department considered that there was scope for reorganising the clinical services between pairs of teaching hospitals, and that as far as possible the service links should follow those of the medical schools. However it did not see that St Thomas's and the Westminster could be paired sensibly for health purposes, as one served areas to the south of the Thames and the other to the north. Instead the Department proposed that each should coordinate its services with other hospitals on the same side of the river.⁵

Implementation of the recommendations

While many of the medical schools would have liked to secure the future by expanding their intake, the University Grants Committee and London University were alert to the danger, for much of the increase in students recommended by the commission would be absorbed by the

increased size of the rebuilt St George's and Charing Cross. Expansion came mainly in the early seventies, when the deteriorating financial situation made it plain that the development of new or greatly expanded provincial schools was out of the question. The target of 1,200 was reached without the completion of the building work which had been thought necessary. The university and the University Grants Committee required each of the medical schools it was proposed to pair to form joint policy committees, and a university steering committee was formed to foster developments. The essence of pairing was the formation of joint academic units, often in emerging subjects, rather than rebuilding. Considerable progress was made at The London and St Bartholomew's, but many schools resisted closer association. The postgraduate institutes, in particular, were united and effective in their resolve to resist association with a general medical school. Neither were the undergraduate hospitals always enthusiastic. University College Hospital and the Middlesex, under the influence of Sir Max Rosenheim, had been discussing closer cooperation. The proposal that University College Hospital Medical School should associate with the Royal Free instead received little support in any quarter. Money to permit the recruitment of academic staff, which the royal commission had considered necessary, was initially lacking. However the University of London received a significant addition to its revenue in the early seventies, allowing a considerable number of new chairs to be established in the schools. Virtually no attempt was made to 'pair' these posts.

The Todd working party for London

The royal commission had recommended the formation of a committee for medical education in London, with an independent chairman and members, and representation from the University Grants Committee, the University of London and the Department of Health and Social Security. This was rejected by the university, and not until 1971 was the Todd working party for London assembled. It was chaired by the Permanent Secretary of the Department and consisted of a very few representatives from senior levels of the three bodies. The delay in forming the working party, which was meant to ensure that short-term convenience did not nullify long-term planning, resulted in a situation in which the *possibility* of a long-term plan insured that short-term progress was difficult.

The plans for rebuilding Charing Cross, and later St George's, were given the go-ahead, undermining further the royal commission's scheme. It was agreed to begin work on sketch plans for 'UCRF' (the medical schools of University College Hospital and the Royal Free), and 'BLQ' (the medical colleges of The London Hospital, St Bartholomew's, and Queen Mary College). However, 'KTW' (King's College, St Thomas's Hospital Medical School and the Westminster Medical School) was a more doubtful starter as the site costs were high & the development would take some time to bring to fruition. The relocation of the Westminster Hospital and its school at Roehampton, Guildford, Croydon or Brighton was considered, and postgraduate associations were examined at considerable length, for there were many practical problems in moving and rebuilding them to bring them into closer association with the commission's pairs. Most of the schemes were costly, involved building on over-crowded sites, or led to an inappropriate pattern of service. Once the effects of an impending economic crisis came to be appreciated the commission's proposals began to appear increasingly unrealistic. A century had passed since *The Lancet* suggested, in 1870, that medical schools should amalgamate, with little progress having been made.

Construction of the three teaching hospitals which were relocated

	Work begins	First admissions
Charing Cross	1967	11 January 1972
Royal Free Hospital	1968	1 October 1974
St George's Hospital	January 1973	January 1980

Coordinating London's joint consultative committees

At his conference in 1965, Mr Kenneth Robinson had raised the possibility of far reaching changes in the administrative structure and had asked the four joint consultative committees to consider the establishment of a forum to consider health and welfare problems of London as an entity. One committee, that of the south east, replied a few months later that such a step would be premature, for on present experience the ordinary methods of consultation were adequate. However, in June 1965, the Permanent Secretary, Sir Arnold France, wrote to say that the government might take powers to place certain teaching hospitals under a specially constituted hospital management committee, itself responsible to a region. This seemed likely in the case of Nottingham where a new medical school was under

development.6

The Teaching Hospitals Association was almost unanimous in its opposition to this idea. Sir Desmond Bonham-Carter drafted a memorandum to inform the Ministry of Health of the strongly held view that the direct access to the Ministry enjoyed by boards of governors was so valuable that it had to be preserved at all cost. Goodenough, Guillebaud and Porritt had all concluded that teaching hospitals should be administered separately, and that a high standard of medical education could best be maintained by very close links with academic medicine. This depended upon the constant and intimate links of hospitals with medical schools. Regional boards were preoccupied with a wide variety of problems and could not be expected to give a proper measure of support to teaching hospitals, or encourage an adequate concentration of skills. Sir Desmond hoped that an alternative solution might be found to the problems peculiar to London. In November 1965, Sir Arnold France proposed a conference of teaching hospitals and regional boards. The chairmen of the South East Metropolitan Regional Hospital Board, of Guy's, King's and the Maudsley, wrote jointly to say that it was unnecessary and undesirable to make statutory change in the relationships between their authorities. Their committee had been successful in solving problems and had shown unanimity of purpose; the machinery already in existence was best geared to producing the results desired. Nevertheless the chairmen recognised that some problems faced each quadrant of London which could not 'be wholly and unwastefully resolved individually', and they welcomed the possibility of an advisory body to which the four joint consultative committees could refer problems when wider consultation was necessary. The Minister replied that he had an open mind on hospital administration in central London and decisions could not be made until the Royal Commission on Medical Education had reported. Just before the conference on 30 January 1967, Dr James Fairley, the senior administrative medical officer of the South East Metropolitan Board, drafted a proposal suggesting that the existing machinery should be strengthened by the addition of a standing joint advisory committee to coordinate the four regional joint consultative committees.

He submitted the proposal to the Ministry just before the hospitals and boards met to discuss the experience of the four regional committees. The chairman of the north east committee was afraid that the functions of the regional boards might be usurped, but there was wide

agreement that coordinating machinery was necessary. Fearful that control of the new body which was being proposed might fall into the hands of the Ministry, James Fairley circulated his suggestions widely and submitted them to *The Lancet*, which rapidly published them.⁷ They received considerable support, and when the Ministry produced its own document in May 1967, a coordinating body similar in nature was suggested. This was later to become the Joint Working Group of the Thames Joint Consultative Committees. Fairley became the secretary and driving force of the new group, which was chaired by Dame Albertine Winner, a recently retired deputy chief medical officer of the Ministry. The key issue was whether the group should be given the teeth to influence planning through control of financial allocations. There was resistance to this, as a result of which the group was less effective than it might have been.

The new group took over responsibility for a study of radiotherapy which was already in progress. It also produced a series of reports on the main specialties, including accident and emergency services, ophthalmology, neurosurgery, cardiac surgery, audiology and ear, nose and throat disease, psychiatry and mental handicap.⁸ The reports broke new ground by examining requirements on a London-wide basis, taking into account bed numbers, length of stay, occupancy and turnover interval. Some reports made firm recommendations for the closure of units, or cast doubt upon the need for redevelopment. The neurosurgery report made it clear that facilities in London were adequate, and a new joint unit which three teaching hospitals were planning was unnecessary. Other reports provided population projections, or promulgated principles which the four regional joint consultative committees could apply within their own quadrants. The implementation of the recommendations was the weak point, for neither the regional boards nor the boards of the teaching hospitals were bound by them. As a result, the Ministry came to question the desirability of a free-standing body independent of the hospital authorities.

The approach to reorganisation

Reorganisation of the health service was in the air. In November 1967, Mr Kenneth Robinson announced that he intended to review the administrative machinery of the NHS, looking particularly at its tripartite structure of hospital services, family practitioner services and local authority health services. He pointed to the existence of the Royal

Commission on Local Government 9, and to the Seebohm Committee on Local Authority Social Services.¹⁰ A number of parallel activities was in progress; the Royal Commission on Medical Education was nearing the end of its work as was the Salmon Committee on Senior Nursing Staff Structure.¹¹ At the time of his announcement staff within the Ministry of Health were already considering the details of a proposal to abolish regions and replace them with 40 to 50 area boards - and the way in which this concept could be applied to London. The next five years saw a succession of attempts to define a better pattern of organisational structure, and the resistance of groups who feared that they would be placed at a disadvantage.

The appearance of so many reports was in itself the cause of problems. For example the Royal Commission on Medical Education reported before the Ministry's proposal for area boards was known. If the University of London moved fast and amalgamated medical schools, should the pairs be placed under the existing regional hospital boards, or if area boards were just over the horizon would it be better to avoid two upheavals by delaying until the area boards were in place? The possibility that teaching hospitals might benefit from a change in governance found little acceptance amongst the chairmen and officers of the boards of governors, or in the forum of the Teaching Hospitals Association. The direct link with the Ministry was highly valued. While some hospitals like University College Hospital, under Sir Desmond Bonham-Carter who was also the chairman of a regional hospital board, and Charing Cross which was secure in its new development, viewed assimilation into a region in a relaxed way, others like Guy's took a harder line. They felt that regions would swallow them with the result that services of high quality would be levelled down. Nevertheless a common front was displayed in public. The possibility of uniting hospital and community health services under the same authority increased the significance of boundaries, which had been less important when only hospital-based services were involved. Local authorities, and the Inner London Education Authority regarded boundaries as of crucial importance; those concerned with hospital administration believed that hospital 'districts' depended primarily on transport patterns.

The first Green Paper 12

Following the publication of the reports of the Seebohm committee on local authority social services and the Royal Commission on Medical

Education, Kenneth Robinson published his Green Paper on the administrative structure of the NHS in July 1968. The Paper proposed that regions should be abolished, to be replaced by a single tier structure with forty to fifty area boards that would plan and operate services. The teaching hospitals would lose their independent management bodies, the membership of their area board being specially adapted to the teaching responsibilities. Not surprisingly there was opposition. The regions (that would have disappeared) felt that the Ministry was ill-equipped to deal with as many as fifty areas, and that the areas would be too remote to manage the hospitals effectively. Dr James Fairley thought that amendment of the existing structure would be preferable¹³, the new proposals being particularly difficult to apply in London, where a coordinating body directly accountable to the Minister would inevitably be required. He thought that the possible submergence of university hospitals was to be avoided if the cuffing edge of British medicine was not to be blunted.

Meeting to consider the double impact of the Royal Commission on Medical Education and the Green Paper, the Teaching Hospitals Association agreed on five principles: the need for a direct relationship both with the Ministry and with their associated medical school; the right to appoint their own staff; adequate financial allocations; and continuing responsibility for their endowment funds. The association's chairman, Sir Desmond Bonham-Carter, was also chairman of University College Hospital and the South West Metropolitan Regional Hospital Board and his colleagues were well aware that he believed that teaching hospitals should be brought under the regions. He resigned.

To study the pattern of area boards that would be desirable in London a working party was established by the Ministry, chaired first by Lady Serota and later by Lord Aberdare. London boroughs had changed their boundaries in 1965, reassuming responsibility for community health services from the London County Council. Two alternative patterns of area boards were suggested in the Green Paper. One was a 'starfish' with five area boards each serving two or more inner boroughs and several outer London boroughs. Populations would be about 1.5 to 1.75 million and the arrangement would accord generally with the Todd pairs. The alternative was a 'doughnut', with the cream in the middle. There would be two teaching area boards, one north and one south of the river, surrounded by four areas for outer London. The five or six area boards would cover between them the whole of the

Greater London Council area, and the need for a mechanism to provide for collaboration was recognised.

The teaching hospitals had little enthusiasm for either proposal, based as they were on a desire to follow local authority boundaries, and the loss of boards of governors. A memorandum prepared in September 1968 by the Teaching Hospitals Association questioned the advantages which might come from a new and untried structure. However, if reorganisation was to come, the association would prefer the doughnut arrangement, or a single board for all of inner London with continuation of the existing system of joint consultative committees. The Ministry, for its part, tended to favour a 'starfish' organisation; the Royal Commission on Medical Education had also settled for a radial solution. The commission had suggested a fifth north central region to reduce the complexity of the management of a large number of teaching hospitals by any one region.

When the Royal Commission on Local Government in England reported, it suggested that the possibility of unifying responsibility for the NHS within the new system of local government should be considered; failing that the commission wished to see coterminosity of health and local authority areas, but did not support either the 'starfish' or the 'doughnut' conclusively.

Richard Crossman, as a successor Secretary of State, had to conduct negotiations on his predecessor's Green Paper. There were three strong criticisms: the risk that the areas would be remote from day to day activity, the possibility that boards would be dominated by the hospital service, and the absence of provision for regional planning. Mr Crossman met regional chairmen and the Teaching Hospitals Association in November 1969 to discuss the form a second Green Paper might take. The government subsequently announced its decisions on the Report of the Royal Commission on Local Government, rejected the management of the health service by local authorities, but decided that in general the number and areas of the new health authorities must match those of the new local authorities, that area authorities should remain directly accountable to the Department of Health and Social Security, but added regional health councils to undertake those activities for which the areas were too small. In the south east there would be four regional councils, covering much the same areas as the metropolitan boards. A coordinating body would be created as a successor to the joint working

group. It was suggested that there might be five inner London areas and 10-12 covering the rest of the capital. The London working party was asked to consider the new proposals, but by this time the teaching hospitals were becoming rather cynical about the whole procedure, and its emphasis on borough boundaries.

The proposals of the second Green Paper, 1970 14

Consultation on the second Green Paper was affected by a change in administration. The new Conservative government came to the conclusion that some of the proposals were sound but others were not. Sir Keith Joseph, the new Secretary of State, announced that the government was not satisfied that the 1970 proposals would create an efficient structure for a unified service. A new consultative document was issued in May 1971 15, which proposed that instead of regional councils there should be regional health authorities responsible for general planning, allocation of resources to area health authorities, and the coordination and general oversight of the latter's activities. Study groups were rapidly established to consider management arrangements and the way in which the health service and local authorities might cooperate.

Regional boundaries were reviewed. The cost and complexity of the recommendation of the Royal Commission on Medical Education for the establishment of a new north central region became apparent. Five regions were also considered undesirable because of the sacrifice of continuity. One region for the whole south of England would be too large. Two regions, north and south of the river, or two north plus one south, were also discussed. A two region arrangement would make it unnecessary to set up coordinating machinery for the London area. Keeping the number of inter-regional boundaries to the minimum would help strategic planning, and simplify the problem of the postgraduate hospitals, most of them being north of the river. However the size of the regions, if there were only two or three, would increase the complexity of management at a time when regional responsibilities were being widened. The view which prevailed was that a single authority for Greater London would produce an undesirable concentration of specialised health services and deprive the surrounding regions of essential facilities. The creation of viable regions around London would be difficult without running contrary to the natural lines of communication. It became accepted that a four-region structure would persist, but the application of the principle of

coterminosity - that health and local authority boundaries should match
- meant that adjustments had to be made to the regions. The

Department proposed that the north west/south west boundary should be moved south to the river, that Camden and Islington should move into the north east region, and the whole of the borough of Lambeth should be included in the south east region.

The Starfish and the Doughnut

Regularly two alternative patterns of regional boundary have been considered, they are a 'doughnut' which is concentric, and a 'starfish' with a radial arrangement of boundaries and communications.

The arguments in favour of the doughnut concept were:

- (a) It would be easier to reduce excess hospital beds in central London.
- (b) It would favour rationalisation of the regional specialties between the teaching hospitals, and assist coordination in inner London in general.
- (c) It would tend to make outer London less dependent on inner London and improve the services in the peripheral boroughs.
- (d) There was a deficiency of hospital services in the counties contiguous to London, and if these counties were linked to the outer London boroughs the latter could assist in making good the deficiencies.

The arguments against the doughnut were:

- (a) Undue concentration of influence, wealth and power in inner London.
- (b) The perpetuation of a direct relationship between the London teaching hospitals and the Ministry.
- (c) The problems faced by the teaching hospitals, which were relying on a falling population for their teaching material. Education would be carried on in an atypical environment and the possibility of students gaining experience in non-teaching hospitals might be smaller.

The London working party continued to spend much time exploring the points of view of the bodies it represented. The London boroughs showed great reluctance to part with their share of the NHS. In any event they wished the new health authorities to match boroughs on a one-to-one basis. The executive councils wished to preserve their

large areas of administration on the ground of efficiency. The Greater London Council argued the case for a regional planning unit corresponding to its own area. The regional boards wanted to perpetuate the metropolitan regions stretching out from London into the home counties. The teaching hospitals were unable to find common ground with the other parties, rejecting coterminosity and disliking the thought of officer-management at hospital or district level. They favoured a sector scheme with larger areas, so that they were not 'shut up in London';¹⁶ each sought a population of around 300,000 to meet its educational requirements. The Teaching Hospitals Association thought more time should be allowed to study the problem in London, and commissioned SCICON to undertake a study of the appropriate 'boundaries for health care'.¹⁷

The likelihood of agreement being reached by the working party was slight. However the Department felt a sensible compromise was beginning to emerge. Time was pressing and quick decisions were needed if health service reorganisation was to take effect on the same day as local government reorganisation, 1 April 1974. It was felt that reasonably sized, self-contained teaching areas could be formed from grouped London boroughs. Each would have two or more districts, not necessarily coterminous with the boroughs, the management within the districts resembling the pattern elsewhere in the country.

Consequently on 29 March 1972 the Department issued new proposals for the creation of regional and area authorities in London¹⁸, allowing six weeks for consultation. The Department accepted that the problem was difficult, and not capable of an easy solution satisfactory to all parties. Sixteen areas were suggested for Greater London, with a London Coordinating Committee to assist the planning of facilities for teaching and research, and the regional and sub-regional specialties. SCICON suggested an alternative pattern with comparatively few areas of substantial size, an approach which reduced the need of patients to cross into another area to obtain a full range of services, and related teaching hospitals more closely to the districts from which they drew their patients.¹⁷

The White Paper on reorganisation appeared in August 1972.¹⁹ *The Lancet* said that it was 'welcome and wise, and that the future looked bright.'²⁰ The White Paper set out the government's decisions on the changes necessary to establish an integrated service. In general they were similar to those proposed in the consultative document, but

instead of area health authorities being required to set up a teaching district committee for districts containing substantial teaching facilities, there were to be area health authorities (teaching) with specially constituted membership.

The postgraduate hospitals managed to avoid radical constitutional change. In June 1971, Sir Keith Joseph wrote to Lord Cottesloe to say that Lord Aberdare's working party was coming to the view that it would not be possible for the postgraduate hospitals to be managed by area health authorities (T) from April 1974 and that their boards should continue for a period of five years. This would allow time for the development of convenient associations between the postgraduates and other hospitals. Subsequently the Teaching Hospitals Association commissioned SCICON to undertake a further study on the functioning of postgraduate hospitals and their relationship to other parts of the health service.²¹

The four joint consultative committees were clearly going to be unnecessary once the regions took over responsibility for the teaching hospitals. Some of them ceased to meet. However the Department had recognised the need for a coordinating group which was advisory in nature; it could not be an executive body or there would be conflict of authority with the regional health authorities. The Teaching Hospitals Association told the Secretary of State that it regarded such a group as important, and there were debates about the role and composition of the new body. The joint working party had shown something of a tendency to determine matters of health service policy for itself, rather than rely on expert advice. There had also been a lack of commitment to its recommendations. The main role for a new London coordinating committee would seem to be rationalisation of the work of hospitals in central London, including the postgraduate ones; coordination of regional specialties; coordination of work in central London where patients frequently crossed regional boundaries; and the inter-relationship of service and teaching needs. In the meanwhile a group of Departmental officers were at work and after two years produced a plan for inner London hospitals which set out a pattern of district general hospitals thought appropriate for the new health authorities. This was sent to hospital authorities and other interested parties in October 1973.

Reorganisation was to create a radically different situation, much of which not to the liking of the teaching hospitals. The Teaching

Hospitals Association had fought to retain their autonomy and their direct link with the Department and had lost. Teaching hospitals no longer had their own management bodies and authority membership was removed from the point of local activity. Hospital administration was undertaken by officers responsible to a more distant area. Larger groups of hospitals were created, with all the consequent problems of management and maintenance of esprit de corps.²²

When the area boundaries were announced the application of the coterminosity principle meant not only that two or three boroughs matched each inner London area authority, but two or three teaching hospitals might be placed under a single management body. Guy's, St Thomas's and King's College Hospital fell within Lambeth, Southwark and Lewisham AHA(T), and the Westminster, the Middlesex and St Mary's were managed by Kensington, Chelsea and Westminster AHA (T). The London and St Bartholomew's were managed by the City and East London AHA(T), and Charing Cross and the Hammersmith by Ealing, Hammersmith and Hounslow AHA(T). Each of the four Todd pairs accepted by the Department lay within a single area, but other hospitals which were not part of that pair might be included. Teaching hospitals faced the future with apprehension, fearing that they might be swallowed up in a larger and more impersonal organisation.

The new management bodies were not like the old ones. Some of the members had experience of the old regime, but a significant group owed their place to membership of local authorities. The boards of the teaching hospitals, before they were abolished, wanted to find an alternative body to manage their endowment funds. Guy's took the lead in negotiations with the Department of Health, so that the Act contained a provision for the special trustees to look after the hospital endowments.

The era of 'lively independence' for the teaching hospitals had been brought to an end by the integration of the three branches of the National Health Service: the hospitals, general medical services and local authority health services. A period of tranquillity was now needed to allow the health service to become used to the new arrangements. This was not to be. In the last three months of 1973 the Oil Producing and Exporting Countries (OPEC) imposed a substantial rise in the price of oil. A period of industrial unrest was followed by a general election, and by a new administration in March 1974. The new Labour government was

out of sympathy with some features of the reorganisation about to take place, but felt that it could not be postponed. In any case here was a general desire to try to make the new system work.²³

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Chapter 14 Strategy and Stringency

.....there is nothing more difficult to arrange, more doubtful of success, and more dangerous to carry through than initiating changes ... The innovator makes enemies of all those who prospered under the old order, and only lukewarm support is forthcoming from those who would prosper under the new. Their support is lukewarm partly from fear of their adversaries . . . and partly because men are generally incredulous, never really trusting to new things unless they have tested them by experience.

Machiavelli, *Il Principe* 1

The nature and outcome of the 1974 reorganisation of the National Health Service can only be touched upon briefly here. It was planned by a Conservative administration as part of the government's wider programme of administrative reform, which aimed to make it easier to plan and develop services across authority boundaries and to give scope for changing the balance of resource allocation between them. Just before the date of reorganisation a general election brought Labour to power. Mrs Barbara Castle became Secretary of State for Social Services in March 1974 and Dr David Owen the Minister of State for Health. Some features of the reorganisation did not appeal to the new administration but the central aim of unifying community and hospital services was accepted as sound.

Reorganisation had a number of objectives. First was the unification of the three parts of the NHS, hospital services, family practitioner services and the health services provided by local authorities, into a single structure. Second, the new structure was expected to make easier a 'clear definition and allocation of responsibilities, with maximum delegation downwards matched by accountability upwards'. Third, there was to be a comprehensive planning system to ensure that policies were translated into action.² Though the changes in 1974 can now be viewed as no more than a single stage in the evolution of the health service system, it seemed a vast step to those working in London hospitals. With the exception of the postgraduates, the teaching hospitals lost their boards of governors, and hospital management committees disappeared. Newly created area health authorities and health districts served a defined population. They advertised for staff and many familiar faces disappeared from the hospitals, either by success in the competition for the new jobs or by early retirement.

The 'Grey Book' on management arrangements for the reorganised health service was the outcome of a study supervised by a committee whose members were drawn from the three branches of the service and the Department, chaired by its permanent secretary, with the assistance of McKinsey and Co and the Health Services Organisation Research Unit of Brunel University.³ Roles and responsibilities were defined with a precision not to everybody's liking. The concept of management by consensus among chief officers of different disciplines was introduced. With few exceptions the officers of the regional health authorities were those of the old regional hospital boards; they had many new things to learn. Health authorities now had a wider span of responsibilities, ranging from community health services to the regional specialties and the high technology of teaching hospitals. Authority meetings were now to be held in public and the membership of area health authorities included four nominees of local authorities. Each health district related to a new consumer organisation, the community health council, which had a right to be consulted on changes in service and to oppose significant alterations at ministerial level.

These organisational changes were carried out against a background of increasing stringency and the new structure was sometimes blamed for problems which were really caused by a shortage of money, particularly in London. There was widespread if spasmodic industrial action by many groups of staff. The teaching hospitals had difficulty in adjusting to the new order, and regretted the now distant relationships with the Department of Health and Social Security. Two were in the process of relocation, Charing Cross in Fulham and the Royal Free in Hampstead. Neither believed that the cost of running the new and larger facilities had been estimated correctly.

Medicine was not standing still. Diagnostic imaging was being revolutionised, ultrasound was developing and the first CAT scanners, soon followed by Magnetic Resonance Imaging, were being introduced into London hospitals. New methods of treatment were developed, often pioneered in the teaching hospitals but sometimes being introduced into the practice of district general hospitals. Coronary artery surgery and pacemaker insertion was expanding rapidly; oncology, bone marrow transplantation and joint replacement also had to find their place amongst the services offered, and had to be financed. Services for the elderly, the mentally ill and mentally

handicapped also needed improvement. These 'Cinderella services' were now unambiguously the responsibility of the same district authorities as were the teaching hospitals. They therefore came into direct conflict with new initiatives in acute treatment, within the same budget.

Strategic planning and finance

The introduction of a comprehensive planning system involving the Department of Health, the regions, the areas and the districts, was intended to be an essential component of the 1974 reorganisation. Nowhere was it more important than in London with its legacy of problems. The deficiencies in primary care and long stay services, the concentration on acute services, and the problem of reconciling London's role in medical education with the level of acute facilities likely to be available in the future remained unresolved.

The 'Grey Book' outlined not only the organisational structure but the nature of the health service planning system and a few regions such as North East Thames rapidly implemented it. Two years after reorganisation, in 1976, a guide to the NHS Planning System and a consultative document on *Priorities for Health and Personal Social Services* in England were issued to launch it more widely.⁴ Planning was now to be based upon the requirements of different 'client' groups, rather than proposals for capital developments at individual hospitals. It was also to take place within realistic resource assumptions. Here was a problem; the then current proposals for building far exceeded the funds likely to be available. Costs had often escalated and the new regional health authorities had the unhappy task of informing some hospitals that long-cherished developments were unlikely to come to fruition for many years to come.

In London even existing services were under threat. From 1977/8 regional authorities received allocations which reflected the decision to redistribute revenue in line with the recommendations of the Resource Allocation Working Party (RAWP).⁵ This proposed that the money available to a region should primarily reflect the size of its population, weighted by standardised mortality ratios and other factors, rather than the costs of services currently provided or its historic funding. On this basis the discrepancies between regional allocations were considerable. Target allocations, the money which a region would receive if equity ruled, were calculated. The four Thames regions were

considerably 'over-target' and their financial growth rate would now be below national average. Simultaneously the Thames regions were expected to redress their own internal inequalities and deficiencies in service. Some areas were far better funded than others and hospitals like The London realised that they would have to lose money to Essex, or to groups such as the mentally ill whose conditions required urgent improvement. The compounding effects of national and regional reallocation and the demands of the long stay specialties made the financial position of the allegedly over-funded central London teaching districts, and the continuing development of high technology medicine, look bleak. The University of London and its medical schools rapidly appreciated the potential effect upon acute hospital services and medical education and established a working party to look at the position.

The financial pressures upon teaching districts were now clear but the speed with which they could react was reduced by the need for public consultation, and local opposition to any reduction in health services. Some of the districts with the greatest financial problems were matched by local authorities that were left-wing in complexion. Their nominees on the area health authorities made it clear that any reductions were anathema. One teaching area, Lambeth, Southwark and Lewisham, passed a resolution in 1979 that in effect limited the extent to which it was prepared to cut clinical services. This action would inevitably have led the authority to exceed the cash limit it received. Mr Patrick Jenkin, the Secretary of State, appointed commissioners under section 86 of the NHS Act 1977, which permitted him to give directions for a specific period to ensure, in an emergency, that services would continue to be available. This decision was subsequently challenged successfully, but not before a measure of financial control had been re-established. The court ruled that Mr Jenkin had acted outside the power of the section by failing to specify the duration of the crisis. Instead, the court said, he might have acted under section 17, directing the authority to economise in specific terms.⁶

Planning in London

The forty years preceding the 1974 reorganisation had seen major demographic changes and the removal and rehousing of many Londoners in new towns as an act of policy. The population of inner London had fallen, faster indeed than the planners had expected, from

4,397,000 in 1931 to 2,772,000 in 1971. The number of acute hospital beds in central London had fallen somewhat, but the proportion compared with the residential population had risen.

When the figures from the joint survey carried out in 1931 by the Voluntary Hospitals Committee and the London County Council 7 are compared with hospital statistics for the same listed hospitals in 1973 (where they were still in operation) the number of beds in teaching hospitals had risen, mainly as result of post-war reconstruction at a larger size. Beds in specialist hospitals fell, largely because small hospitals for women and children had closed or been incorporated into general teaching hospitals. The capacity of the old municipal hospitals had fallen partly as a result of war damage and partly because some very large hospitals were reduced in size, while some fever hospitals such as the Brook in Woolwich and the Grove in Tooting had been converted into general hospitals or specialist units. Patients with acute illnesses were well served, but the position of the elderly and the mentally ill was less favourable. Services for these long stay patients were generally provided in old buildings, sometimes miles from where they had lived. The changing demography of London called for a different and leaner pattern of hospital service in central London, although the process of slimming down was complicated by the need to provide clinical facilities for the progressively expanding medical student intake.

The London Coordinating Committee

The London Coordinating Committee was established in 1975 to assist in the solution of these problems. There were long discussions about how, while remaining an advisory body, it might be given more bite than Dame Albertine Winner's joint working party that had been active from 1967-72. Its terms of reference were to 'coordinate the provision of health services in Greater London with reference to the matching of medical education and service need and securing rational distribution of specialised health services'. The Permanent Secretary, Sir Philip Rogers, chaired the first meeting. Members were drawn from the regional health authorities, teaching areas, postgraduate hospitals, the London Boroughs Association, the Greater London Council, family practitioner committees, the University Grants Committee, the University of London and the Department of Health. It proved to be too large and unwieldy a body. While it provided a forum for discussion it had neither the capacity nor the authority to take decisions. It identified

a number of local problems requiring urgent solution. Previous assessments of regional specialties such as those of neurosurgery and cardiothoracic surgery were brought up to date and the committee considered a possible strategy for the rationalisation of inner London hospitals which had been drawn up by Departmental officers. The tentative proposals included a suggestion that some recently completed hospital developments should not be used for the purpose for which they had been designed, but for other clinical requirements. The document was leaked in the Sunday Times creating concern amongst the staff of some prestigious hospitals.⁸ The Minister decided to make the document more widely available in an attempt to allay anxieties.

Meanwhile regional authorities, unimpressed by the potential of the London Coordinating Committee, were coming to believe that their own planning activities might provide more substantial and achievable economies. The committee gradually lost favour and held its last meeting in July 1976. For some time afterwards the members received briefing about London developments, but few regretted the committee's passing. Its ineffectiveness highlighted the problem of developing London-wide strategies which would achieve general acceptance. Yet the planning of the Thames regions was proceeding at widely differing rates, and it was clear that there would be a variation in comprehensiveness and quality. Nor would the four plans necessarily be compatible with each other. Elsewhere in the country this might not have mattered, but in London, where major reductions in services were likely to prove necessary and cross-boundary flows were significant, a measure of coordination was essential.

The London Health Planning Consortium

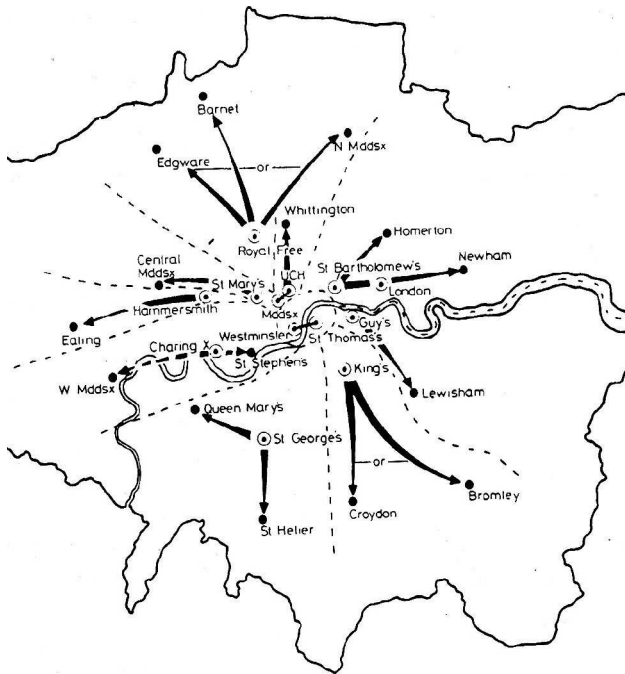
For these reasons approaches were made in 1977 to the four Thames regions, the University of London and the University Grants Committee. It was agreed that responsibility for health service planning rested with the regions, but some matters required the assistance of the university and medical schools, and others a uniformity of approach. The regions retained their reservations about the effectiveness of London-wide groups, unless given power to ensure the implementation of decisions, but accepted that some major decisions such as the future of the postgraduate hospitals were required before regional strategic plans could be finalised. It was agreed that the proposed group would only consider those issues

requiring a London-wide approach, and the London Health Planning Consortium was formed at the end of 1977 to 'identify planning issues relating to health services and clinical teaching in London as a whole, to decide how, by whom and with what priority they should be studied; to evaluate planning options and make recommendations to other bodies as appropriate; and to recommend means of coordinating planning by health and academic authorities in London'.

Dame Albertine Winner had retired from the civil service before becoming the chairman of the Joint Working Group in 1967. The Consortium, on the other hand, was chaired by a forceful and entrepreneurial departmental Under-Secretary, Mr J C C Smith, and received much support in the statistical and economic work required from the Department. The membership included officers and representatives of the four Thames regions, the University of London and the University Grants Committee, the postgraduate hospitals and the Department itself. It was not an executive body and decisions continued to lie with the statutory health and academic bodies, and where necessary with Ministers.⁶ Concurrently the University of London was under increasing financial pressure. To begin with it had not believed that it would experience financial cuts, although prepared to consider how best to maintain the quality of its medical and dental education with so many clouds upon the horizon. The position worsened and the principal of the university had to ask the deans how they were not going to spend the money they were not going to get.

The Flowers working party

In 1977, at the request of the University's Joint Medical Advisory Committee, the Conference of Metropolitan Deans set up a working party to consider rationalisation. However this group was unable to produce definitive recommendations even though there was an acceptance of the need for change, and that the number of medical schools might need to be reduced. As a result the vice-chancellor established a major review of the resources for medical and dental education in February 1979. It was chaired by Lord Flowers, rector of Imperial College. Lord Flowers' working party started to meet some time after the London Health Planning Consortium, and it had to work to a tight timescale. Basic assumptions were that the current intake of students and the existing level of funding would be maintained, but that regard should be paid to demographic trends and the Department of Health's resource allocation policy.



Source: British Medical Journal, 8 March 1980.

The coupling of London's acute hospitals suggested in 1980 by the London Health Planning Consortium

The Consortium's Reports

The London Health Planning Consortium faced two main problems. It was widely accepted that there were many small and medium sized units in specialties like cardiac surgery and radiotherapy, and a degree of rationalisation was desirable. The second problem was the need to reduce the level of acute hospital services in central London, to bring it into line with population and with the money likely to be available in the future. J C C Smith established a multi-disciplinary group of Department officials who were smart, enthusiastic and enjoyed skunk work. They drove the reports and provided the secretariat for the Regional specialties studies. These were examined by groups with an

independent chairman, specialist expertise being supplied by people who worked outside London and were less likely to be parti pris, whilst local knowledge of the London hospitals was available from consultants working in fields other than the one under examination. Between 1979-1980 a series of reports were published for consultation.

The level of acute services was assessed by examining such factors as the demographic change in population predicted over a decade, 1978 - 88, taking account of changes in the distribution of population and its age structure, hospital utilisation, admission categories, turnover interval and length of stay. Account was also taken of the extent to which people from outer London and beyond made use of hospitals in central London, some of the difficulties posed by social deprivation in inner London, and the shortcomings in London's non-acute services. This work was published in 1979 as a *Profile of Acute Hospital Services*.¹⁰ It showed how the progressive movement of population outwards had led to a marked inequality of access to acute services in the Thames regions, and - in service terms - to an over-concentration in central London. The study showed that there might need to be reductions of the order of 20-25 per cent in the number of acute beds, amounting in central London to cuts of around 2,300 beds in all. The consortium suggested that if this did not happen the health authorities in London would not be able to find the resources to improve the standard of services outside the acute sector, in the fields of geriatrics, mental illness and mental handicap.

Changes of the order suggested would be bound to have major implications for the medical schools. The consortium proceeded to study the problem of providing sufficient clinical facilities for medical education, in parallel with the work of Lord Flowers' working party. Two Department officers, Steve Godber and Geoffrey Rivett, visited all the deans of the London Medical Schools, to learn the size, type, and speciality mix that schools needed for their student intakes. Both groups published their reports on the same day in February 1980. 9, 10 The consortium's document, *Towards a Balance*, suggested a pattern of hospitals within which it would be possible to implement a variety of educational options. It indicated and mapped ways in which complementary hospitals in outer London, which were less affected by declining population, might be linked with the various medical schools and used for core teaching in medicine and surgery.

After the publication of Lord Flowers' report it was discussed at a conference at Senate House.⁹ Students from the Westminster Hospital, parading with coffins, made their views clear. The report suggested that there was over-capacity in pre-clinical provision, and regarded it as axiomatic that the University should use new buildings to the full, particularly as these often lay in areas which remained predominantly residential. A series of amalgamations was proposed as a result of which 34 separate academic institutions would be grouped into six schools of medicine and dentistry, some named after famous doctors like Harvey and Lister. One protagonist suggested that it was necessary to overcome 'tribal loyalties', a remark which merely united the tribes in opposition.

A *British Medical Journal* editorial expected that there would be wide protest, indeed that "the protests from each institution under threat will merge into an unintelligible Babel." Amongst the most controversial recommendations were the closure of the pre-clinical school at King's College, Strand, and Westminster Medical School.⁹ Both were bitterly and effectively opposed. Faced with such opposition the University could not come to immediate decisions, even though financial cuts were inevitable. The conflict spread wider than the medical faculty, for there were consequences affecting other institutions. In any case some recommendations did not seem viable and the University's joint medical advisory committee produced a revised plan for restructuring London medical and dental education which was likely to achieve wider support. The modifications were accepted by the university joint planning committee, but the Senate was divided and referred them back. There was to be further delay. A new working party was established chaired by the deputy vice-chancellor, Professor Leslie Le Quesne, to examine the costs and savings which would result from different patterns of closure and amalgamation.¹² The University employed management accountants to assist with this costing exercise and in the meanwhile it encouraged those schools wishing to proceed with closer association to do so.

The costing study necessarily made a number of assumptions, some of which were open to challenge. In general the high cost of running the newly built medical schools was confirmed. Merging medical schools appeared to be more cost-effective than merely phasing out a pre-clinical school. It was also clear that agreement would not be achieved purely by demonstrating that some solutions were cheaper

than others.

1982 - Restructuring

Rationalisation in London and changes in the organisation of medical education were now overtaken by the events which led to the restructuring of the National Health Service in England in 1982. The ever increasing demand for resources and the financial problems arising from a deteriorating economic situation were responsible for some disillusion following the 1974 reorganisation. By 1976 there was mounting criticism of a number of its aspects, particularly of what many felt to be an unnecessarily complex and cumbersome administrative structure. As a result the Labour government established a royal commission which carried out an extensive and wide-ranging study of the health service. It reported in 1979.¹³ The Conservative administration which took office in May of that year formally welcomed the report, but rejected one of the major recommendations, previously proposed by three of the regional chairmen, that regions should be accountable to Parliament for matters within their competence. The proposal for an independent enquiry into the health service in London was also rejected on the ground that many of the issues were already under study by the London Health Planning Consortium.

In general however the government accepted recommendations aimed at improving and simplifying the management and organisational structure of the health service. A discussion document,¹⁴ was issued in December 1979, setting out proposals for the simplification of the structure by removal of the area tier of health authorities, which intervened between regions and health districts, and for the strengthening of unit management by greater delegation of authority to the operational level. Instead, district health authorities were proposed, modelled on existing 'single district areas' which had generally been judged more effective than the areas which had the task of managing several competitive districts. Internal faction had been characteristic of a number of the area health authorities in London.

The structure now envisaged would place management authorities, the districts, close to the point of service delivery, while maintaining regional authorities for the purposes of strategic planning and resource allocation. *Patients First* stated that in London the government did not contemplate major changes in regional boundaries in the next few years - in other words the starfish arrangement would persist and a

central London health authority was not under consideration. It was also suggested that there would be advantages in the establishment of an advisory group, representative of major interests, to assist the government in considering major issues in London.

In May 1980 the Secretary of State established this as the London Advisory Group, chaired by Sir John Habakkuk (Principal of Jesus College, Oxford; vice-chancellor of Oxford University, 1973-7) to report to him and advise on the development of London's health services, and the restructuring of health authorities.¹⁵ Its first task was to suggest guidelines for determination of boundaries in London, a problem recognised as more complex than elsewhere in the country. These appeared as an appendix to a departmental circular on structure and management (HC(80)8). Two further reports published early in 1981 proposed a strategy for the future organisation of acute hospital services in London.¹⁵ They recommended a reduction in the number of acute beds to free resources for the elderly, the mentally ill and handicapped, and for a variety of community services. After examining its assumptions, the London Advisory Group accepted the conclusions of the London Health Planning Consortium.

The consortium had pointed to over-provision in relation to future needs and had predicted that because of shortening length of stay the same number of people could be treated in fewer beds. The group reported that in two years that had elapsed since the consortium's calculations there had already been a reduction of 1,950 acute beds, nearly seven per cent, a more rapid rate of decline than the consortium had projected.

Falling acute beds in inner London

1977 28,600

1979 26,650 - 6.8 %

1980 25,000 - 12.6 %

LHPC target for 1988 22,500 - 21.3 %

In contrast to this fall the number of beds in private hospitals in inner London was rising, more than doubling between 1977 and 1983 to over 1,300. Some of the private hospitals were themselves specialising, providing particular facilities such as radiotherapy or maternity and child care.

One of the most significant statements made by the London Advisory

Group was that full use should be made of major hospitals, reductions when necessary being made elsewhere, presumably in smaller institutions. One region, North East Thames, had already been pursuing this strategy, rationalising smaller hospitals and building larger district general hospitals at Newham and Homerton. This approach, which promised to free resources for other uses, received the endorsement of the Secretary of State. Both economic problems and the appreciation that London had more hospital beds than could be justified led to a series of closures of small hospitals where the accommodation was poor and other hospitals nearby could pick up the load. As an example, in east London, the Connaught Hospital was closed in 1977, the site being sold in 1979 for £365,000. There were many others including Poplar and the South London Hospital for Women. The closures were hard fought. Delegations including the unions came to see Labour ministers who sympathised but did not have the money to subsidise hospitals that clearly were unfit for modern patterns of hospital care.

Major hospitals of which full use should be made. 15

Charing Cross Hospital
Lewisham Hospital
St Andrew's, Bow
St Stephen's Hospital
Dulwich Hospital
The London (Whitechapel and Mile End)
St Bartholomew's Hospital
St Thomas's Hospital
Guy's Hospital
Middlesex Hospital

Districting

The regions were asked to submit proposals for the boundaries of the new district health authorities to be established, taking the guidance of the London Advisory Group into account. Because of the tendency to propose a district to match every viable district general hospital, the number of authorities created proved to be considerable. At the Secretary of State's request the London Advisory Group considered the submissions. Work was hampered by the fact that the University of London had not come to final conclusions on the Flowers report. This was particularly significant in the centre of London, where hospital

catchments seldom matched local authority boundaries, and the main academic institutions were sited. No ideal arrangement was possible in inner London, whereas in outer London there were few problems and in the main the regions' proposals were accepted.¹⁵

The university was considering the association of the medical schools of Charing Cross and the Westminster Hospitals, which led the North West Thames RHA to propose the establishment of a single district to be known as 'Riverside' to be responsible for both teaching hospitals. The university also suggested that the medical schools of the Royal Free Hospital, University College Hospital and St Mary's should be grouped together. This commanded little support in the committee established to consider the proposition, all three medical schools preferring a pairing which excluded St Mary's. This opened another possibility, a joint district to be known as Bloomsbury, to manage the Middlesex and University College Hospitals. The two teaching hospitals were close to each other, but lay on opposite sides of a regional boundary and the idea was initially opposed by the hospitals, the regions and the university.

The Secretary of State wanted to balance the conflicting requirements of coterminosity and practicability in NHS terms. His decisions sometimes differed from the recommendations of the London Advisory Group.¹⁵ In the one case where a district contained more than one teaching hospital, Bloomsbury, amalgamation was on the cards. Much work had gone on behind the scenes over the previous months; the suggestion of the amalgamation of the medical schools had been raised by Department officers with the Deans of UCH and the Middlesex Medical Schools who had spoken to each other and the staff. The University had been consulted and when it was clear that amalgamation was possible the Deans saw the Secretary of State. Similarly, off-the-record discussions took place with Deans of the general teaching hospitals about the integration of smaller postgraduate medical schools. The Westminster, sure that it was secure, refused to consider turning itself in part into a postgraduate centre. St Thomas' preferred dermatologists to urogenital surgeons. Once the decisions were announced they were accepted with good grace and an evident desire to take advantage of the consolidation of two undergraduate teaching hospitals and three postgraduate groups, St Peter's, the Royal National Orthopaedic and the Royal National Throat, Nose and Ear hospitals. The grouping gave the Bloomsbury district authority a worthwhile management task and avoided the risk

of separate authorities each bent on the defence of its own institutions. In London coterminosity remained a major feature. 27 out of 33 London boroughs related to only one district and 18 were coterminous with the matching health authority. Feelers to other medical schools put out by the Department showed that the ground was not fertile for other amalgamations.

With the publication of the London Advisory Group's last report its work was complete, and it was disbanded in 1981 at the same time as the London Health Planning Consortium and its supporting officers. There has been an unfortunate tendency to disband groups with expertise on the assumption that all will now be well.

The decisions of the University of London

In December 1981, a year in which the University Grants Committee announced a reduction in grant in each of the next three years, the University of London finally reached conclusions on the pattern of undergraduate medical education in London.¹⁷ It was decided to reduce the number of separate schools, only four remaining independent; the Royal Free, St Mary's, St George's and King's College Hospital Medical School which was in any case uniting with King's College Strand. Charing Cross and the Westminster Medical Schools would be strengthened by merger; the proposal by the medical schools of Guy's and St Thomas's to form the United Medical Schools under a single governing body was supported; the medical colleges of St Bartholomew's and The London should cooperate; and a joint school would be established between the Middlesex and the Faculty of Clinical Sciences of University College. The last would mirror Bloomsbury, creating an academic organisation of considerable size and prestige. The newly constructed medical school buildings at St George's and Charing Cross had proved expensive to run, largely because they provided a much higher standard of accommodation. But they were sited further from central London in the midst of large residential areas, and it seemed only sensible to exploit this advantage.

The governance of the postgraduate hospitals

The governance of the specialist postgraduate hospitals had been put to one side in 1974. It was difficult to see where they might best fit in to the reorganised health service. The 1972 reorganisation White Paper

suggested that they should become closely associated with other services in their vicinity, in line with the recommendations of the Royal Commission on Medical Education in 1968.¹⁸ The existing boards of governors were preserved and continued to function under earlier Health Service Acts.

The old antipathies between the specialist hospitals, which often formed the focal point of a specialty unable to claim many beds within a general hospital, and the undergraduate hospitals, persisted in the form of a mutual wariness. The association suggested in the White Paper had little appeal for the postgraduate hospitals, which had branches in several parts of London and seldom related clearly to a single region. To become too closely involved with a general hospital carried the risk of merger and ultimate extinction. Nevertheless, their future role required examination and in 1976 the university established a working party under the chairmanship of Professor Norman Morris to review the academic institutes with which the postgraduate hospitals were associated.

In March 1976, Dr David Owen suggested that a single authority might integrate the planning and management, and rationalise the services of three hospitals which lay next to each other: the Hospital for Sick Children, Great Ormond Street, the National Hospital for Nervous Diseases, and the Royal London Homeopathic Hospital. A steering committee accepted the possibility of such an arrangement, while pointing out the difficulties and complexities which would be involved. Incorporation of postgraduate hospital groups into area health authorities was another possibility. The postgraduate hospitals made it clear that the onus of justifying change lay upon those proposing it. Led by Sir Reginald Wilson, the boards pointed out that their activities spread far wider than the boundaries of any one district, and some groups managed hospitals in two or three different regions. They denied that planning arrangements with the regions were inadequate, were well satisfied with the status quo, and preferred to maintain their direct link with the Department of Health and Social Security.

In September 1978 after several meetings and conferences, the Department issued a discussion document which proposed the establishment of a London postgraduate health authority.¹⁹ This would take over the Department's role in planning and resource allocation, but would remain directly responsible to the Secretary of State. The existing boards of governors would remain in place for the

time being. Other options were also canvassed which involved the early disappearance of the boards, but in the absence of consensus the DHSS preferred to temporise. The proposal for an 'overlord' postgraduate health authority was regarded by the hospitals as very much second best; they preferred the status quo. The idea was criticised in the House by Mr Patrick Jenkin as the insertion of a further tier of management when simpler structures were in fact required. Shortly afterwards, in May 1979, a Conservative government was elected and Mr Jenkin became Secretary of State for Social Services. It was then decided to take no action until reports of the Flowers working party 9, and the Royal Commission on the National Health Service 13 were available.

The London Advisory Group had considered the management arrangements of the postgraduate hospitals in 1980 and visited all of them. The university was considering the possibility of merging some institutes with medical schools, but where it proposed to maintain a separate university institute this argued for the maintenance of an independent authority. The presence of university representatives on the London Advisory Group was therefore important, so that all could be made aware of the way university thinking was developing. In its report, the London Advisory Group distinguished between hospitals which were to be rehoused in close association with general hospitals, or where the matching institute was likely to be merged with a general medical school as a result of the decisions following the Flowers report; and those which were unlikely to move from their existing sites and where the institute was likely to continue in its present form for the foreseeable future.¹⁵ It recommended that the first group should be managed by the appropriate district health authority from 1 April 1982. Hospitals in the second category, in general the larger ones with more viable institutes, should be managed by newly established special health authorities in place of the existing boards of governors. Following consultation, the Secretary of State established special health authorities for six groups, and for the Hammersmith Hospital. The Hospitals for Sick Children, the Royal Marsden, the National Hospitals for Nervous Diseases, Moorfields, Bethlem Royal and Maudsley, and the National Heart and Chest Hospitals, remained independent of the regional health authority structure. The Hammersmith, associated with the Royal Postgraduate Medical School, while wishing to remain accountable to the North West Thames region, found to its surprise that it was reconstituted as a special health authority. Department officers visited teaching hospitals

such as St Thomas', the Westminster and the Middlesex, trying to find an appropriate and willing partner that would maintain the excellent features of these small postgraduates. The advantages of taking on a unit of prestige - and its budget - were not lost on some hospitals, and St Thomas' was a willing host for the skin hospitals. Others, such as the Westminster, felt it was in need of neither advice, help, nor a new unit and lost the opportunity. Four groups came under the management of a district authority: the Royal National Orthopaedic Hospitals, the Royal National Throat, Nose and Ear Hospitals, the St Peter's group and St John's Hospital for Diseases of the Skin. The first three came under Bloomsbury, and St John's under West Lambeth where it was likely to be relocated (within St. Thomas' Hospital).¹⁶ Decisions on the Eastman Dental Hospital and Queen Charlotte's were postponed.

During the months preceding the restructuring of the health service on 1 April 1982, chairmen and members were selected for the new district authorities and new officer teams were appointed. Once again management was to operate by consensus. Certain teaching districts were designated: those deeply involved in medical education because they managed the main university hospital used by a medical school.²⁰ Some of the medical schools prepared the private legislation needed to unite independent institutions, in line with the university's proposals.

The pattern of the acute services was changing; small hospitals were closing, small accident and emergency departments were disappearing. Progress was assisted in some places such as Bloomsbury, by the way in which restructuring changed the responsibilities of authorities. Amalgamation and rationalisation, the chosen tools of the King's Fund in earlier years, were once more the order of the day. Health authorities now, for financial if for no other reasons, had to grasp the nettle of reshaping the hospital services in central London more closely to national priorities. The pace of change was increasing; major hospitals felt threatened, and in fighting for survival might urge the closure of competitors. King's College Hospital, in particular, was under assault from Guys and St Thomas'.

Those who had hoped that NHS restructuring in 1982 had solved the problems from the 1974 reorganisation were to be sadly disappointed. Nineteen eighty two marked the high point of long term strategic planning, the view that the centre knew best and a tendency towards a

Stalinist and dirigist approach. With the Conservative government had come new ideas, the possibility that a looser system might deliver better results, the concept of an internal market, trusts with greater local autonomy, and the patient as key to the provision of services. National policies would now provide the backdrop to London's hospital and health services. It was going to be a wild and unpredictable ride.

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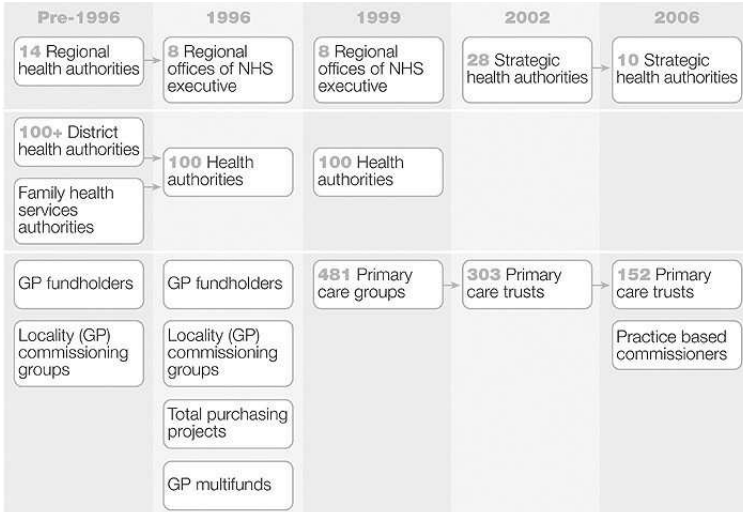
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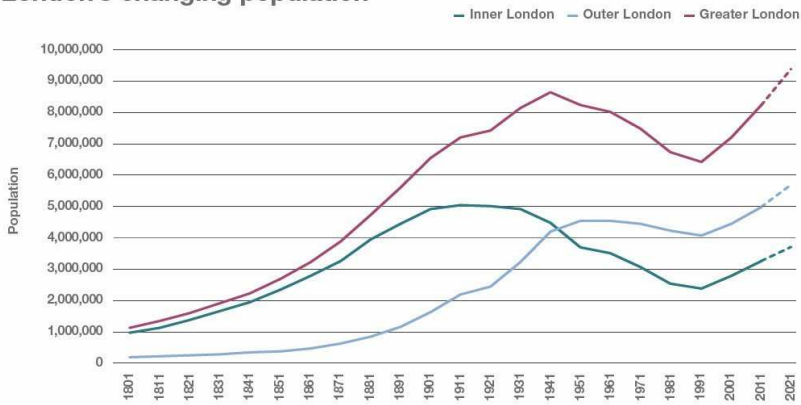
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The repeated structural reorganisations of the NHS,
 Source - Audit Commission 2008 - *Is the Treatment Working?*

GRAPH 2
London's changing population



Source: Census & ONS Projections

Chapter 15 From Districts to Trusts 1982-2020

A health care system, any health care system, is in a state of permanent reform. I understand that annoys and upsets everybody who works in it. But it is almost inevitable.

Kenneth Clarke in *The Wisdom of the Crowd*, 2013 25

The thirty years from the 1982 restructuring to 2012/3, when the NHS was reorganised yet again by the coalition government, saw a slow, progressive but massive change in the NHS. Organisationally successive Secretaries of State grappled with the problem of how to combine the central responsibility to Parliament for a health service, with the need for devolution of decision making. In social terms, a higher standard of customer responsiveness was required. Clinically, until in 2020 the service was near overwhelmed by Covid-19, it was moving from acute episodic diseases to the treatment of multiple chronic illnesses. Clinically the ability to make a diagnosis improved with vastly better tests and imaging. The ability to treat people improved with advances in surgery, anaesthetics and pharmaceuticals. Patients spent far less time in hospital, day care (ambulatory care) expanded, and there was financial pressure to treat disease as much as possible in the community. The need was increasingly for a service that treated multiple chronic illness in the elderly rather than acute episodic diseases.

In 1982 the hierarchy of the NHS was clear and strict, a planning system underpinned financial allocations, and in London as throughout England each area's system was the same as everywhere else - although devolution was beginning to create differences in the other territories of the UK. By 2012 there remained some common features but care was delivered by a wide variety of trusts, some of which were foundation trusts, but also by private independent treatment centres. Central financial allocations were fairer to the different areas of England, and at hospital level were determined by commissioning, those purchasing care being sharply separated sharply from those who provided it. Increasingly over the thirty year period the provider might be a private sector organisation because an internal market had been introduced. Although many of the services were still provided by staff employed by the NHS and in NHS premises, contracts were often placed with charities or other organisations. Indeed whole hospitals might have been designed, built and partly managed by the private sector, perhaps under the private finance initiative (PFI). People received care paid for by the NHS; who provided it became less

important both to Labour and the Conservatives. Yet at the same time quality and outcomes of care had achieved an importance never previously seen. Contracts might be placed on that basis. And from 2006 London had, for the first time, a single strategic authority, NHS London.

These changes were steady, progressive and had come about by fits and starts. Instability had been consciously introduced. London became slowly acclimatized to this as did the rest of England. New styles of management were called for and, as the market became competitive, new forms of regulation were needed.

Politically, the earlier years were dominated by the Conservatives, then for over a decade by Labour, and finally a coalition of Conservatives and Liberal Democrats. Nationally the economy expanded in the early eighties but in 1989 there was a recession after Britain's forced departure from the Exchange Rate Mechanism. By the mid-nineties the economy was once more healthy. An off-the-cuff statement in January 2000 by the Prime Minister, Tony Blair, on breakfast TV, that the proportion of GDP spent on health care would rise to the EU average, was followed over the next few years by an unprecedented increase in money for the NHS. In 2007 a world-wide financial recession brought to an end to this period of rapid growth.

Demography

London's population was changing substantially in numbers, distribution and characteristics.¹ From a peak of 8.6 million residents in 1939 it fell for half a century to a low point of 6.73 million in 1988, its size 80 years earlier. After 1981 inner London grew more rapidly than outer London and faster than the UK as a whole. By 2031 the population was expected to reach 8.8 million. In most of England the population was ageing, but in London it was getting bigger and younger, with an increasing birth rate and a net inflow of young adults. Docklands and the Light Railway, and building in Stratford for the 2012 Olympics, spurred regeneration in the east. There was an influx of people from Eastern Europe as the European Community expanded. Soon the indigenous population of London would become a minority.

NHS structural change

From 1982 onwards continuous structural changes were taking place

to the English NHS. The 1982 restructuring had placed more power at district level. The planning system had been simplified and made more flexible, necessary because there were too many priorities and too little money. In 1986 twelve London hospital consultants wrote to the *Times* talking of the reduced allocations and falling bed numbers.

"The inner London population is no longer receiving an adequate medical service. The future of the hospital medical service in London looks grim." There were demands for a review of the hospital and health service. What the professions got, the Conservative's NHS Reforms, was not that for which they had been hoping.

Underpinning the long term changes was the belief that competition was to be welcomed, not feared, and that incentives might deliver better performance. Change was driven by the financial climate, politically inspired organisational restructuring and the belief that patient choice was important. There was indeed some cross party agreement. In the first years of the new millennium, Labour's substantial increases in money for the NHS, expanded staffing and capacity. Activity increased steadily as admissions rose, lengths of stay fell and there were increases in day cases.

Important to London's health and hospital service was a new accent on quality presaged by the reports of the London Health Planning Consortium. Now no report on London could exclude two problems, of inner city primary care and the organisation of regional specialties to improve outcome.

The development of magnetic resonance and other forms of imaging, new pharmaceuticals increasingly based on genetic developments, rapid improvement in cardiac surgery, in minimal access surgery and in day care changed the hospital service. There was a welcome trend to organise services between hospitals concentrating activities on fewer sites. Major trauma, stroke and heart surgical services, as well as cancer care, were increasingly re-configured. In general practice family doctors gave up their 24 hour responsibility and considered the way in which they might cooperate across practices, establishing clinical networks or federations.

A series of London reports, (1992 - Tomlinson 3, 1997 - Turnberg 4 and 2007 - Darzi 19) created a hospital service that was smaller, stronger and with a more substantial research base and better infrastructure. Medical schools united and health service mergers

generally mirrored them. In multiple reorganisations district health authorities, which in 1982 had managed from a distance, disappeared. Regional health authorities went and new Academic Health Science Centres tended to replace them as the “big beasts” driving many changes. Of the five UK Academic Health Science Centres identified, three were in London.

The perception was that there were too many beds and too many small specialist units, with only a small throughput of cases probably associated with poor results. There was also a dearth of services in the long term sector, for the mentally ill and the elderly. The need to improve the education of junior doctors and changes in working hours driven by European legislation reduced the time they devoted to the service and affected the internal organisation of hospitals. To the imperative of keeping within budgets was added a new pressure for quality, fuelled by scandals of poor care in some hospitals.

Primary health care

Historically London's hospitals had ignored general practice. London seemed unique in its failure to resolve the problems. The mobile young, a multitude of ethnic and immigrant groups, an intelligentsia and users of drugs and alcohol all congregated in London. Academic general practice developed late in London, there were fewer innovative GPs and modern premises were less often to be found. High land values, unsavoury locations and planning problems made it almost impossible to find a good site in the right place. Recruiting young doctors was a perennial problem. Inner city GPs were, on average, older, often single-handed and many had trained overseas. Young doctors seldom wished to enter such practices. ‘Better’ doctors went to greener pastures.

It became received wisdom, without much supporting evidence, that substantial parts of care delivered in hospital could be moved into the community. In a report, *Primary Health Care in Inner London*, 1981¹¹ commissioned by the London Health Planning Consortium, Donald Acheson, later Chief Medical Officer, had provided an analysis of the problems. After the Acheson Report it was no longer possible to discuss health services in London without taking note of the condition of primary care and making at least a symbolic gesture towards the solutions of its problems. Brian Jarman wrote later than none of the report's London-specific recommendations had been effectively

implemented. Following Acheson, attempts to improve matters included a London Initiative Zone established after the Tomlinson Report 3 to improve GPs' premises, recruit a new cadre of GPs, introduce innovative approaches to old problems and develop cost-effective care outside hospital. A review five years later showed improvement in premises but in some areas the standards remained unacceptably low. London still had fewer young GPs, more single-handed practices and larger lists. There were more practice nurses, but although primary care in the capital was improving, it was doing so no more rapidly than elsewhere. The initiative was terminated. The Turnberg Report 4 in 1997 again recommended support for GPs and the need to improve recruitment and retention. It could be argued that the pattern of general practice that worked excellently elsewhere was unsuitable for inner cities and an alternative contract for GPs was introduced. "Personal Medical Services" made salaried service practicable and seemed particularly appropriate for London. After 2000, new national initiatives aimed to improve access to the NHS, for example walk-in centres - which were not particularly successful. Urgent care centres were established alongside hospital A and E units to filter off those not requiring the more intensive facilities. The importance of primary health care was stressed again by Darzi 19 (2007) who knowing the importance of primary care in chronic disease believed that larger units were necessary and wanted to see 150 large polyclinics from which all GPs and the associated staff would work. In many areas there were already plans to provide better and larger premises, and these initiatives were promptly renamed polyclinics. However the end of the responsibility of GPs for out of hours services in 2005 threw extra strains on the hospitals.

Health Service Boundaries in London

Boundaries have always been significant in London hospital planning. If hospitals were to be part of a system, they either had to be looked at in groups or else in terms of the specialist services that they provided. Over the years there have been discussions about whether London's hospitals should be considered on a concentric or a radial pattern. The doughnut (with all the jam in the middle) placed an emphasis on the teaching and specialisation in the centre, leaving the periphery alone. The alternative, the starfish (which had radial communications and relationships), tried to relate central expertise to the surrounding shire counties. In the late 1970s the London Health Planning Consortium had planned on a London wide basis, although the

implementation had been left to the four Thames Regional Health Authorities and most took little action. Rationalisation increased in tempo after the 1982 restructuring of the NHS, spurred by financial pressures. After the demise of the London Health Planning Consortium the chairmen of the twelve teaching districts examined what was happening and found it impossible to predict the future.

The spatial framework of planning in London often changed, confusing and delaying action. Sometimes the boundaries of the 4 Thames regions were used (1948 - 1994). Then there were Department regional offices (1996-2002). A five sector scheme proposed by the Turnberg report (1997) was used, reflected in five London SHAs (2002-2006) - North West London, North Central London, North East London, South East London, and South West London. The five were reduced to two and then a London wide Strategic Health Authority (NHS London, July 2006) was introduced, to be abolished in 2013 in favour of a London branch of a new NHS England.

National organisational changes and their London effects

There was turmoil in the organisation of the NHS because of changes in managerial or political philosophy and the search for cost-effectiveness and efficiency. Boundaries between the hospital and the community, the NHS and the private sector, began to blur.

1982-9 Conservative governments and restructuring

The General Management Function 5

NHS management changed after a major review in 1983 by Sir Roy Griffiths, an outcome of the industrial action of 1982 and the weakness of the 1974 restructuring. In a memorable sentence he said, 'if Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge'. Griffiths' recommendations included a small, strong general management board in Whitehall, that all day-to-day decisions should be taken in the main hospitals and clinicians should be involved more closely in management decisions and should have a management budget and administrative support.

A general manager should be identified (regardless of discipline) at each level and authorities should have greater freedom to organise the

management structure suited to their needs. Griffiths believed that the lack of a clearly defined general management function was responsible for many problems and that the development of management budgets was vital. Consensus had to go. The government accepted the report.

1989 *Working for Patients* 6

The next major organizational change took place under Mrs. Thatcher and Kenneth Clarke. Many of its concepts were later accepted by Labour. The basic NHS structure had not altered greatly either during reorganisation of 1974 or restructuring in 1982. Society, however, had changed and was more consumer-oriented. The Conservative government repudiated consensus, and partnership with the professions in policy making, and the broadly bipartisan approach to the NHS had ended. Among its beliefs were the importance of a sound economy without which public services could not be funded; the view that there was little the public sector could do that the private sector could not do better; and that managerial inefficiency was rife throughout the public sector. The changing approach in the NHS was only part of a wider ideological battle about society, industry and public services. The main ideas often attributed to Enthoven's *Reflections on the management of the NHS*,⁷ were current in radical-right circles. *Working for Patients* accepted many basic principles of the NHS. The NHS would continue to be funded centrally from taxation. It would remain largely free at the point of usage. The idea was rejected that a major injection of funds was all that was needed. Instead, reforming incentives and the introduction of a 'market' would improve productivity. The purchasing function would be separated from the provision of services. Health authorities would concentrate on the assessment of needs and contract for services; hospitals and trusts would provide the services. Good performance would be rewarded for money would follow the patients. The high costs of central London, compared with the lower ones of hospitals on the periphery, might be a problem for central hospitals.

Hospitals and community services could apply for self-governing status. NHS hospitals were progressively transformed into publicly owned substantially self-governing trusts. Managerially élite hospitals had substantial freedom. Seen by government as a potential flag-ship of the reforms, Guy's believed that trust status would ensure that a major building scheme would go ahead, guaranteeing its survival. The

idea of trusts had been developed with acute hospitals in mind, but applications were received from mental illness and community services. They too saw advantages in the freedom of action.

The Trusts generated their revenue from contracts with districts, commissioning agencies and GP fund holders. They needed good financial information but the data required to compare relative costs were poor; the necessary systems were not in place. Many hospitals had no price list. Block contracts, notional costs and wild price variations were commonplace. It took much work to sort things out. Over the first few years there was some change in the pattern of patient flows which had a potential to destabilise budgets, perhaps 5-10%. There had been anxiety that district purchasers would make more radical changes, building up services in local hospitals many of which were new with young staff and spare capacity, so avoiding high cost hospitals in the centre. The countervailing advantage in the centre was that a high proportion of the medical and surgical consultants had sub-specialty expertise making them the natural place for junior medical training.

Doctors were now employed by the trust and not the RHA, so they began to think in a more local way. At Guy's, a hospital that had major financial problems but wished to expand its services, clinical directorates were established under medical control on the 'Johns Hopkins' model. Decisions could be taken more rapidly, economies could be made, new patterns of staffing could be introduced and services could be improved without bureaucratic delays. Because their unit budgets were determined by contracts with purchasers, it was easier to persuade consultants to change their patterns of work.

The need for hospital trusts to generate income led to visible changes. Lilac coloured carpeting and easy chairs, smiling receptionists, a florist's stall bursting with blooms, a bistro coffee bar and newsagents would appear. Trusts spent money on glossy pamphlets on their services, and logos. Acute hospital trusts established private patient units to compete with private hospitals and sometimes developed outreach services; community trusts looked at hospital-type day care. The borders could blur. The boundary between the NHS and private medicine was indistinct and the phrase 'internal market' seemed increasingly inappropriate.

Commissioning

The introduction of the internal market meant that purchasers and providers had to negotiate contractual payments. Hospital trusts dealt with many commissioners, particularly in the case of large multispecialty trusts, in effect a group of specialist hospitals which in central London what might draw only a minority of its work from local districts. In theory there should be strong purchasers and strong sellers, but frequently the competence of the purchasers was questionable, whereas trust chief executives had lengthy experience. Purchasers tended to have little leverage and few options open to them. Weak commissioning persisted over many years. Although a key lever in achieving change, some might say that commissioning had failed.

London Reports

Change in London is often preceded by a major study and a report. There were two such planning exercises in early 1992, one by the King's Fund led by Virginia Beardshaw and one later that year initiated by government (Tomlinson 3). Generally such exercises achieve far less than the proponents hope, and more than the opposition would wish to see. 'You might get 20%,' said Robert Creighton, a chief executive.²²

1991 - The King's Fund Commission 16

The King's Fund appointed a Commission in 1991 to develop a London-wide vision of services that would make sense in the early years of the next century. Financial reallocation under RAWP was having a detrimental effect on London, the RHAs were not taking a London-wide view, and there were fears that the newly introduced internal market would disadvantage the hospitals. It spent £500,000 commissioning 12 research reports and the final document analysed the interlocking set of problems posed by health services, medical education and research in London. It said that Londoners received a poor deal and warned that health care in the inner-city might become inappropriate unless there was the political will to back a strategy of fundamental reform. The report accepted the case for a reduction in acute services with a complementary build-up of primary health care. It

did not consider the paucity of back-up beds in nursing and residential homes, which barely existed in the metropolis. It reported that at least 5,000 beds must be closed if the capital were to be guaranteed a good standard of health into the next century. 'Costs in London are not just expensive, they are extremely expensive . . . change is inevitable . . . Inner London hospitals are top-heavy with doctors and the rate of patients going through is slower.' While the report indicated the direction of the changes needed, it did not suggest the choices that had to be made or which sites might be closed. Substantial attacks were mounted on its findings because of a belief that it was working towards a pre-determined conclusion and that some of its members had little sympathy for London or for specialists. Virginia Bottomley, Secretary of State from April 1992 to July 1995, would have liked support for decisions she needed to take, and did not get it.

1991-2 Tomlinson 3

The Conservatives, committed to market solutions but faced with clear problems requiring decisions at a governmental level, embarked on strategic planning. At the 1991 Conservative Party conference William Waldegrave, then Secretary of State for Health, announced a review by Sir Bernard Tomlinson, Chairman of the Northern RHA. A safe pair of hands, he would ensure that the King's Fund did not 'run away with the ball.' Big building projects were imminent at UCLH and St Mary's and there was no logical basis for making decisions. *The Times* said that Mr Waldegrave was 'wringing his hands' over what should be done in London and needed to be convinced that major decisions were intellectually based. There was an election coming up and it was not the time for big decisions. UCLH/Middlesex, strongly supported by the scientific community because of the quality of its work, wanted a new building and this might mean the closure of other hospitals. Already expansion had been approved at Guy's, the Chelsea and Westminster was established and St Mary's was being developed. The effects of RAWP on central hospitals, which in the event were over-estimated, and of the internal market, were key to the commissioning of the inquiry. However, William Waldegrave had delayed the need to take action before the election. Those working on the two reviews cooperated, and data was exchanged.

Tomlinson reported in October 1992. 3 He emphasized the need to improve primary and community care to national standards and provide services for people with special needs such as the homeless.

An idea that had emerged at a Nuffield-sponsored meeting was a 'free-fire' zone where normal health service rules could be modified to facilitate the development of primary health care. Tomlinson adopted this and the government provided £170 million over six years in a 'London Initiatives Zone' covering about 4 million people, where needs were great and an innovative approach was required. Educational and management effort would be strengthened. Most people underestimated the complexities of building new and better facilities for GPs and primary health care teams. Neither was it easy to turn a theoretically attractive plan for the teaching hospitals and medical schools into schemes on the ground. The money helped new projects and encouraged the study of long-standing problems of inner London practice but the pace of change was slow and the effect on acute hospital services minimal. The changes to the hospitals and to primary health care were unpopular and not politically easy to fight.

The Tomlinson Report, well summarised by the *Independent* on 24 October 1992, foresaw a surplus of 4-5,000 beds because of the withdrawal of inpatient flows from outside central London and the increasing efficiency with which beds were used. The report suggested reducing the number of medical students in London by 150. Whole hospitals should be taken out of use and the resources redeployed to develop primary care and community services. Tomlinson revived earlier proposals for rationalisation. They involved change at UCLH/Middlesex that had become a single, powerful and scientifically important organisation. There would be a single management unit for St Bartholomew's and The Royal London; the loss of one hospital from among the south London hospitals of Guys', King's, St Thomas' and Lewisham, and Guy's and St Thomas's should merge on one site. The report proposed linking 8 of the 9 London medical schools into four and associating them with four multi-faculty colleges of the university.

The Homerton in Hackney should take most Hackney patients currently treated at Bart's. The Middlesex site of the combined University College/Middlesex hospitals should close and its services relocated on the University College Hospital site. The London Hospital for Tropical Diseases, and the Royal National Throat, Nose and Ear, at Gray's Inn Road, would shut, and move to the redeveloped University College Hospital. Guy's, by London Bridge station, and St Thomas's, a mile away opposite the Palace of Westminster should merge on one site under a joint trust board. St Mark's Hospital, in Islington, which specialised in the treatment of bowel diseases, would become part of

the Northwick Park district hospital complex in Harrow, Middlesex.

Charing Cross, in Hammersmith, which had the greatest excess costs, must close. The Royal Brompton hospitals, dealing with heart and lung complaints, and the Royal Marsden cancer hospital should be brought together on the vacated Charing Cross site. If not, the site should be sold. St Mary's, Paddington, needed to reduce the number of its beds, and Queen Charlotte's maternity hospital should shut and its services moved to the Hammersmith. The capital's postgraduate research institutions should consider ways to concentrate the single specialty research institutes on fewer sites.

Sir Bernard estimated that cuts in acute services and rationalisation could yield £54m a year. There were four broad responses: the optimistic that primary and community care could be brought up to the standards elsewhere; the realistic accepting the recipe but gloomy about the money and the difficulties; the despairing who doubted whether anything would be accomplished; and the reaction at St Bartholomew's that was to indulge in old-style emotional campaigning against the proposals. St Bartholomew's had come to believe its own rhetoric and dismissed any proposal not to its liking, however well founded. Its campaign was given a voice by the *Evening Standard* in probably the most ferocious media war ever waged against health service managers and NHS policy, unparalleled in its unstinting aggression and partiality.

After the unexpected Conservative victory in April 1992, Virginia Bottomley, the new Secretary of State, began to take decisions although eminent men tried to bully her. "I had all these great-uncles who died in the first war, we were taught that when the whistle blows you get out of the trench and you walk towards the guns. That is what I was brought up to do, to get out of the trench and walk towards the guns."³ She redefined the NHS as the provision of care on the basis of clinical need, regardless of the ability to pay, not by who provided the service. This idea was not accepted by her Labour successor Frank Dobson when the Conservatives lost power in 1997, but was by his - Alan Milburn.

In February 1993 the Department of Health's response *Making London Better*, 3, accepted the general thrust of the recommendations, and the need to develop primary health care. It provided a comprehensive blueprint for further development. Specifically government announced

a review of six specialty services.

UNIVERSITY COLLEGE/MIDDLESEX: The hospitals should merge on one site and absorb two of the smaller specialist hospitals, the Royal National Throat, Nose and Ear, and the Hospital for Tropical Diseases.

ST BARTHOLOMEW'S: appraise three options - closure, merger with the Royal London and the London Chest; or retention as a smaller specialist hospital, subject to the outcome of the speciality reviews.

ST THOMAS'S and GUY'S: Merger consolidating services on one site

CHARING CROSS: A&E workload to transfer to the new Westminster and Chelsea hospital. The long-term future to depend on the outcome of the speciality reviews.

ROYAL BROMPTON and ROYAL MARSDEN: consider merger. Perhaps their institutes, could form part of a new Chelsea Health Sciences Centre

QUEEN ELIZABETH: merge with the nearby Homerton.

ROYAL NATIONAL EAR, NOSE & THROAT: merge with UCH/ Middlesex.

ST MARK'S: to Northwick Park

HOSPITAL FOR TROPICAL DISEASES: merge and relocate to UCH/ Middlesex.

To drive the implementation of the Tomlinson proposals, a London Implementation Group (LIG) was formed, chaired by Tim Chessells, Chairman of North East Thames RHA, who had direct access to Ministers. Six specialty reviews were established to examine clinical requirements; the clinicians in the specialty under consideration came from outside London and could be brutal when faced with the pretensions they sometimes encountered. The reviews (1993) proposed that the best centres should be developed, the smaller ones should be closed or merged, and new ones established where they were needed as at St George's where there was a long-standing need

for renal replacement therapy. Many of the recommendations were implemented but not all; too much was expected too fast. Some were revised as a result of wider considerations; in the south east neurosurgery was not moved to Guy's but remained at the Maudsley near the Institute of Psychiatry. Several initiatives now came together making change possible. A research review of the London postgraduate hospitals pointed to the need for a wide range of skills including biophysics and molecular biology, and association with general hospitals and university facilities. Medical school deans had to play a difficult hand; most were privately supportive of the need for change and prepared to work for it, but in public they had to take their colleagues with them as far as possible. Trust chairmen had been appointed knowing there was a job to be done. They and their chief executives were heavyweights who did not fool around, and transitional funds were available to sugar the pills of change and mergers. Ministers were far more involved than they had been in the work of the LHPC. The Higher Education Funding Council (HEFCE), as a member of the London Implementation Group, was involved in medical school mergers and amalgamations, as well as through its direct links with the institutions. The London Implementation Group closed down in April 1995, and the then two Thames RHAs north and south of the river became responsible for co-ordinating change, though they too were facing demise.

Guy's was in a difficult position. It had been lauded as a "Flagship" NHS Trust, but in 1991 a black hole appeared in its finances damaging its record. Tomlinson had suggested a merger on one site with St Thomas's, but which site? A vicious feud broke out, the Chairman and Chief Executive of Guy's were replaced, and their successors argued successfully for managerial integration but a two-site solution. Guy's increasingly became the major academic location with regional specialty work, and St Thomas's the acute hospital with accident and emergency. In parallel, the United Medical and Dental schools battled with academic integration.

'During the past twenty years,' wrote Lord Flowers in *The Times*, 'with a few honourable exceptions every attempt to reform London medicine has been defeated by vigorous rear-guard action on behalf of any hospital or medical school adversely affected. The result has been that the standing of teaching and research in London's famed medical schools has been steadily slipping. The time has come for the government to stand firm.' In *Making London Better 3*, Virginia

Bottomley took decisions that her predecessors had been canny enough to defer and for which her successors would be forever in her debt; she was prepared to bell the cat, as the *BMJ* had put it. She narrowly escaped defeat in Parliament and a rebellion of some senior London Tory MPs. Her reward was the Department of National Heritage. Robert Maxwell, Secretary of the King's Fund, said that the creation of big medical centres across London, the main tertiary centres of service, research and education for the future, had been talked about for 50 years. Now it looked set to happen and would be Mrs Bottomley's best legacy.

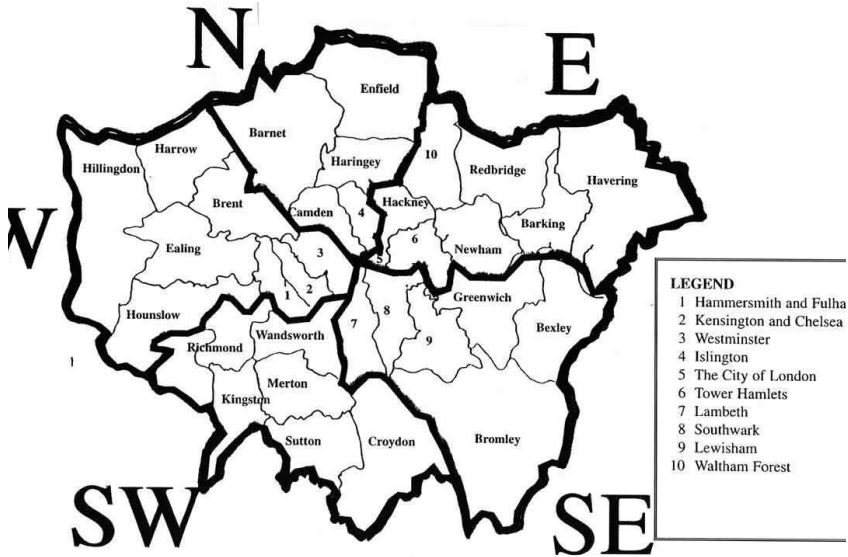
Industry had been removing middle management, 'downsizing' and producing 'flatter' organisations, but few foresaw that regions might be abolished. A review in 1993 of the relationship of the 14 RHAs with the centre recommended that regions should be amalgamated in April 1994 into eight. London was subsequently divided in 1996 into two regions, north and south of the river. Finally regions were abolished in favour of eight regional offices of the Department of Health. Later 'regions' returned in the shape of Strategic Health Authorities, albeit with slightly different functions.

1997 - The Labour government. *The new NHS - Modern, Dependable 9.*

Labour took power in 1997 and Frank Dobson, the new Secretary of State, set out Labour's initial vision in *The New NHS - Modern, Dependable*. The harder edges of the internal market were softened. Fund-holding went, co-operation replacing more extreme forms of competition. The interdependence of health and social care, and joint programmes, were stressed.

In June 1998 Frank Dobson, decided that London would form a single NHS region and a single London Regional Office of the NHS Executive was established in January 1999. The arguments against such a pattern, vetoed by Bevan in 1946 and again rejected at the time of the 1974 NHS reorganisation, were now weaker. A London region had been proposed by Tomlinson. Change had therefore been expected and affected the boundaries of the surrounding areas.

Hospital trusts became accountable to regional offices for their statutory duties, then to health authorities and later primary care trusts for the services they delivered. The separation of planning from



From the Turnberg Report showing the five sector scheme

provision and decentralization of hospital management was maintained.

1997 – Turnberg 4 The NHS and University Medical Schools

Until the mid-1990s it was believed that London's hospitals provided too many acute beds and it was right to reduce their number. As London came under ever increasing financial pressure following the Resource Allocation Working Party Report (1976) and clinical developments speeded earlier discharge, hospitals were closed against substantial opposition and bed numbers continued to fall. 'Every workhouse I tried to close,' said Kenneth Clarke, 'was regarded as a centre of clinical excellence by all the staff who worked there and all its patrons. The most extraordinary dumps were defended by banner-waving demonstrators.'²⁵ Ultimately the belief that there were too many beds became untenable. After the election Labour had faced problems with commitments such as 'no hospital closures', an end to a postcode lottery, and the salvation of St Bartholomew's - Frank Dobson had made scurrilous remarks about Virginia Bottomley's decisions on St Bartholomew's. Labour saw that health services

needed to be coordinated with medical education and, perhaps to get himself off the hook, Frank Dobson commissioned a strategic review of inner London, increasing uncertainty. Led by Professor Sir Lesley Turnberg, it reported within months.⁴ Turnberg focussed on wider strategy, recommending large-scale planning for major change, greater involvement of the public in the development of proposals and a future focus on primary and community care. It made specific recommendations in relation to several hospital sites. It was clear that there was great pressure on London services, workload was rising and the number of GPs was falling. Hospital bed numbers had reduced substantially; between 1990/1 and 1995/6 1130 acute inpatient beds had disappeared from inner London, and when geriatric, maternity and psychiatric beds were included the loss across London as a whole had been 9,271. Turnberg concluded that there was now no evidence that there were more acute beds available to Londoners than the English average, taking into account the use of London beds by non-Londoners. The subsequent *NHS Plan (2000)*¹⁰ accepted that a substantial increase in capacity was needed if waiting lists were ever to be reduced. Improvements in primary care had not substituted for reductions in secondary care. The campaigning by St Bartholomew's gave the impression that its fate was the key decision but the Royal London Hospital was planning a massive rebuild and other important issues included mental illness, primary care and community services, and the medical school mergers that had health service consequences. Queen Mary's Roehampton was also scheduled for closure.

Turnberg felt that a five sector scheme would assist planning. Health authorities should work together at sectoral level. These sectors were not unlike the inner parts of the old Regional Health Authorities (for the shire counties had been separated) and reflected a five sector scheme Tomlinson had liked. Radial organisation had been referred to in the sixties as a "starfish" pattern. The more egalitarian term of Pizza slices was now used and within the slices PCTs, Trusts and the educational authorities had a commonality of interest that led them to work with each other, rather than with other pizza slices and the Turnberg sectors were used for many years to come.

Reconfiguration

A new imperative was now emerging - rationalising/reconfiguring the hospital system. The need to provide specialised expertise 24/7,

medical staffing problems and the restriction of the hours worked

under EC legislation had changed the criteria for defining the size a safe hospital. The progressive increase of sub-specialties meant that rotas of consultants in most of them could be accommodated in a large hospital but not in smaller District General Hospitals (DGHs).

Now that far more specialties were involved in care, there had to be full cover of each to provide a 24 hour service. It was rational to plan for fewer major hospitals, strategically placed. These might be supported by more local facilities. National Service Frameworks developed for clinical specialties outlined clinical networks of hospitals varying in their sophistication. Reports of the BMA, Royal College of Physicians (RCP) and Royal College of Surgeons of England echoed the earlier thinking of the Bonham-Carter Report (1969), suggesting that a single general hospital now should serve populations of not less 500,000.¹⁴

Under pressure to improve the volume and quality of services without higher costs, some trusts, for example the Central Middlesex, introduced process re-engineering. If the stages in the delivery of care were examined, was there a better way of designing the system? Given better drugs and anaesthetics allowing more speedy recovery, state-of-the-art diagnostics and imaging, minimum intervention techniques and better information systems, could any stages be omitted, or be arranged more economically to save the time and money of both patients and staff? The development of treatment centres, many in the private sector, became a priority in government thinking. In London few were developed, other than that at the Central Middlesex which itself operated under capacity.

A related problem was the provision of effective emergency care when most consultants were super-specialists and out of their depth. The RCP said half of the hospitals it surveyed had adopted an emergency admission ward, perhaps of 20 beds, with a system of assigning patients to specialist units. The RCP suggested that Acute Medicine was a separate specialty, required by each hospital taking acute admissions.

Hospital Development in five London sectors

New hospitals planned in the 1970s had opened in the 1980s, for

example the Newham Hospital (1983) and the Homerton in Hackney (1986). Development was often supported by the Private Finance Initiative (PFI), and major changes took place in each of the five 'Turnberg' sectors adopted as the boundaries for managerial bodies. The problems with PFI were the inflexibility once the building had been opened and the nightmare financial costs that stretched way into the future.

Until 2012 London had a single special health authority, NHS London, with an overview of the metropolis and an effective record of clinical improvements in the care of, for example, stroke and trauma care. Subsequently while there was a London branch of NHS England, changes were driven, if at all, by the the Clinical Commissioning Groups (CCGs) that had been established by the Lansley reforms. Strategic planning was near impossible.

North East London

In the North East were The Royal London and St Bartholomew's, Queen Mary College and the medical schools of the two hospitals. One of the greatest conflicts involved Barts and The London. These two hospitals and their staff had long standing divergences of view and a deep distrust of each other. As part of the Conservatives' NHS reforms (1990) the idea of self-governing hospital trusts within the NHS was introduced and Bart's was planning to set up such a Trust when its independent future was called into question by the Tomlinson Report. This did not see Bart's as a viable hospital and recommended its closure. The Government's response in 1993 supporting Tomlinson gave three options for Bart's: closure, retention as a small specialist hospital, or merger with the Royal London Hospital and the London Chest Hospital. This sparked an intense public debate and a campaign to save the hospital on its Smithfield site. In April 1994 the Royal Hospitals NHS Trust was formed, incorporating the three hospitals. Turnberg had supported the case for redevelopment of a 900 bed secondary and tertiary care hospital in Whitechapel, while maintaining some tertiary services at Smithfield, mainly cardiac and cancer services. A billion pound PFI development began, the financial cost of which overhung the trust and prevented it achieving foundation trust status. Later, mergers were encouraged culminating in 2012 in the creation of a huge trust, Barts Health, uniting St Bartholomew's, The Royal London, Newham and Whipps Cross hospitals. Its management insisted that major savings could be made but they proved illusory. An

agreement was made with UCLH to exchange cardiac services for cancer, leaving Barts to concentrate on the former. By 2015 there was an annual deficit of £93 million, a CQC report revealed poor nursing standards particularly at Whipps, and the trust was put into special measures. New building had been undertaken at Whipps Cross and Newham General (an Ambulatory Care and Diagnostics Unit and an adult mental illness unit).

The new Queen's Hospital in Romford brought together the services previously run at Oldchurch and Harold Wood hospitals; built under the Private Finance Initiative, it opened in 2006, complementing the rebuilt King George's Hospital Ilford where lower risk and midwife led maternity care was provided. It was the second of two huge hospitals in north east London.

North Central London

The Department of Health had supported merger between the medical schools and hospitals of UCH and the Middlesex Hospital, two organisations with a similar ethos, and the boundary between North East Thames and North West Thames was moved so that the districts containing these hospitals could be united in 1982 as 'Bloomsbury.' Of the other hospitals relating to UCL, the Eastman Dental Hospital had special health authority status but in 1996 joined UCLH. The Elizabeth Garrett Anderson Hospital (1888) became part of the same Trust in 1994. The National Heart Hospital's services went to the Brompton and in 1994 the hospital was re-opened as a *private* heart hospital. Falling into debt, the hospital re-joined the NHS in 2001, when it was bought with central funds by UCLH to become the home for the trust's cardiac services, adding capacity and reducing long waiting lists for heart surgery. The Hospital for Tropical Diseases became the home for the London School of Tropical Medicine and moved to a building in the grounds of the St Pancras Hospital becoming part of the UCLH. The National Hospital for Neurology and Neurosurgery, Queen Square joined UCLH Trust in 1996, the Institute of Neurology affiliating to UCL. The Royal London Homeopathic Hospital joined forces with UCLH in April 2002.

Turnberg supported the proposal for capital development at UCLH and ground was broken in 1999 for a £422 million private finance initiative that opened in 2005 uniting most of the University College London Hospitals on a single site and providing a diagnostic and treatment

centre. Being a foundation trust, UCLH sold off profitably the old Middlesex Hospital site for flats, gaining the Trust £175 million. With its new development commissioned, and its financial situation sound, the Trust rebuilt its obstetric hospital (the EGA wing) and cancer unit and looked at the possibility of bringing other hospitals, including postgraduate teaching hospitals, onto its site, for example the transfer of the Royal National Throat Nose and Ear Hospital from The Royal Free to UCLH.

Substantial development was also taking place elsewhere. The first phase of a new Barnet General Hospital opened in 1997. A major development took place at the Whittington. At Chase Farm Hospital, a new surgical wing and Treatment Centre was built, and the North Middlesex was redeveloped with a new A&E department, critical care unit, outpatients department, imaging centre, eight operating theatres and five inpatient wards, opening in 2010.

A world-class medical science centre for London was developed by a partnership of Britain's biggest funders of clinical research, the Medical Research Council (MRC) National Institute for Medical Research, the Wellcome Trust, Cancer Research UK and University College, London (UCL). A £350 million scheme went forward on a 3½ acre site near the British Library and St Pancras station. The Francis Crick Institute was the largest laboratory of its kind in the world, accommodating 1,500 leading researchers in different fields and in 2011 Kings College and Imperial signalled their intention to associate with it.

North West London

Centrally the sector contained the Hammersmith, Queen Charlotte's, Chelsea Hospital for Women, Charing Cross and, in close proximity, St Mary's, the Chelsea and Westminster and two specialist hospitals, the Royal Marsden and the Royal Brompton. It came to be dominated by Imperial College. In 1984 the medical schools of Charing Cross and Westminster hospitals united, and in the next year the districts in which they were situated were merged into one authority, Riverside District Health Authority, with plans to rebuild and reduce the number of hospitals to two. Brent and Paddington District Health Authorities 'huddled together for strength and warmth', in the words of the district manager. In 1988 Parkside Health Authority was created, uniting St Mary's and the Central Middlesex, leaving St Charles' as a non-acute community hospital. Hospital planning involved the part-rebuilding of

St Mary's and rebuilding the Central Middlesex, the first phase being a pioneering ambulatory care centre. The new Chelsea and Westminster Hospital, which enabled the closure of five separate hospitals, opened in 1993.

The Turnberg report called for more rational distribution of specialist services in North West London. The outcome was the Paddington Health Campus project, a variant of the proposals in the Pickering Report of the 1960s to be funded by PFI. It would bring together Royal Brompton & Harefield NHS Trust, St. Mary's NHS Trust, Imperial College's National Heart and Lung Institute and North West London's specialist children's services to one site in Paddington. The Business Case was approved by the Department of Health in 2001, but the cost steadily escalated until it was clear that it was not viable. It was cancelled in 2005. The Hammersmith/Queen Charlotte's new maternity facility opened in 2003.

In the early 1990s the Medical Research Council (MRC), under financial pressure, decided to pull out of its Northwick Park Clinical Research Centre and concentrate at the Hammersmith Hospital. Northwick Park had been bought by Charing Cross Hospital in 1944 to allow it to relocate from the centre. Ultimately it became a colocation of research with a district general hospital that had a "normal" case-mix. Perhaps the idea of this association was flawed; science grafted into an unreceptive environment at a district general hospital where there were suspicions that patents would be "experimented upon". Perhaps that decision was partly the result of forceful personalities and power politics.

This withdrawal freed modern accommodation and research space. A small specialist hospital concerned with coloproctology, St Mark's, needed to move from its poor accommodation in City Road. St Mark's had the foresight to realise that it had more to lose than gain from a merger with Barts and grasped the alternative, Northwick Park, with enthusiasm. Relocation in 1995 provided immediate access to intensive care, theatres and state-of-the art imaging and service departments. St Mark's had its own front door, clinical directorate and all the advantages of association with a busy district general hospital. Organisationally there was amalgamation within the North West London Hospitals NHS Trust incorporating Northwick Park & St Mark's and the Hospitals in Harrow, the Central Middlesex covering Wembley, Willesden, Edgware, Harlesden and Stanmore.

The Royal Brompton & Harefield NHS Trust was established in April 1998 based on two sites, one in central London and one in Middlesex. The Trust provided services for all age groups from infancy to old age and associated with its multi-faculty university partner Imperial College School of Medicine within which was the National Heart and Lung Institute.

Turnberg supported the approach to collaboration in the rationalization of services that was being undertaken by the hospital trusts and Imperial College. In 2007 under the aegis of Imperial College, it was proposed to bond the Hammersmith Hospital and St Mary's to create an Academic Health Sciences Centre, merging units such as renal medicine, and making it easier to bring cutting edge research earlier into clinical practice. This was accredited in March 2009.

In a collaborative exercise the eight CCGs took forward an earlier Darzi era exercise, '*Shaping a healthier future*' (2012) that aimed to provide better care in the community, although its proposals to downgrade some A & E Departments including Hammersmith and Charing Cross aroused opposition.

South West London

In south west London the position of St George's was secure, and the plans to relocate the Atkinson Morley Hospital to the St George's site, and further developments there were supported by Turnberg. The neuroscience and cardiac centre, the Atkinson Morley Wing, opened in October 2003

South East London

In southeast London there was protracted discussion and much infighting about the future of Guy's and St Thomas', whether one or the other site should close, where the accident and emergency department should be situated, and where specialised services should be concentrated. If these two hospitals agreed on anything, it was that King's College Hospital was subordinate. Ultimately the A & E Department went to St. Thomas' because ambulance access was far better. Turnberg said that the merger of the two Trusts had allowed the development of proposals for rationalizing services across the two

sites. There had also been discussion about the distribution of specialised services between St Thomas', Guy's and King's College Hospital. A new wing at King's College Hospital opened in 2003 and a new children's unit was planned but the special trustees at St Thomas' funded children's care there. Turnberg examined redevelopment of acute services in Bexley and Greenwich, and supported the redevelopment of Queen Elizabeth Hospital to replace services at Greenwich, built under PFI at a cost of £93M. This involved the redevelopment of the former Military hospital including the design, construction and financing of new buildings, the refurbishment of existing ones and the maintenance and operation of the entire hospital. Both it and Bromley soon had large deficits because of the irreducible costs of their whole hospital PFI schemes.

University decisions and the London medical schools

Since the time of the Royal Commission on Medical Education (1968) academic mergers had been proposed. The earlier Todd pairs differed substantially from the pattern later implemented.

Todd pairs

St Bartholomew's Medical College and The London Hospital Medical College;
University College Hospital Medical School with the Royal Free Hospital School of Medicine;
St Mary's Hospital Medical School with the Middlesex Hospital Medical School;
Guy's Hospital Medical School with King's College Hospital Medical School;
Westminster Medical School with Charing Cross Hospital Medical School;
St Thomas's Hospital Medical School with St George's Hospital Medical School.

Final Mergers

Imperial

Westminster Medical School
Charing Cross Hospital Medical School
St Mary's Hospital Medical School

Queen Mary College

St Bartholomew's Medical College
The London Hospital Medical School;

Kings College

Guy's Hospital Medical School
St Thomas's Hospital Medical School
King's College Hospital Medical School

University College London Hospitals

University College Medical School
Royal Free Hospital School of Medicine
Middlesex Hospital Medical School

St Georges

Imperial College

Imperial College gained a medical school by merger with St Mary's Medical School in 1988. Its Faculty of Medicine was formed in 1997 by the merger of St Mary's Medical School with Charing Cross and Westminster Medical School, the Royal Postgraduate Medical School and the National Heart and Lung Institute. Secure in its prestige and size, Imperial took a firm line with the medical schools that were now an intrinsic part of it, and with the hospitals to which they related. In 2007 St Mary's Hospital Trust, The Hammersmith Hospitals Trust and Imperial College united to become the Imperial College Health Care Trust and this was selected as one of five multispecialty Biomedical Research Centres. In 2003 it was given the power to award its own degrees but did not immediately use it.

Imperial thought that globally there was only room for 5-6 major biomedical research and teaching centres, perhaps two in the USA, one in the Far East and two in Europe. Imperial considered itself the natural premier league centre in the UK; others did not agree. The

Medical Faculty ethos was that of Imperial College, scientific based and of the highest standard. There was a thorough reorganization to develop an integrated Faculty, one organisation using the same letterheads. In 1988 the Royal Postgraduate Medical School merged with the Institute of Obstetrics & Gynaecology and also became part of the Imperial College School of Medicine. The National Heart and Lung Institute situated next to the Royal Brompton Hospital became part of Imperial College in 1995, and part of Imperial College School of Medicine in 1997. The attempt to bring the NHS and the academic side together as a single body did not work well. The huge problems of old buildings and financial deficits proved an excessive burden on top management.

Queen Mary's wished for a medical faculty, but was in a financially weak situation, as were the two medical schools involved, St Bartholomew's and The Royal London. There were substantial objections to amalgamation from both the medical schools, and the merger in 1995 as Bart's and The London School of Medicine and Dentistry, the medical faculty of Queen Mary University of London, was not a happy one. Bart's and the Royal London had everything one could desire in terms of a local population, but the association with QMC, comparatively weak as a research institution, did them no favours and the QMC and the two medical schools associated with UCL Partners.

King's College

The United Medical and Dental Schools (UMDS) of Guy's and St Thomas' was formed in 1982 & King's College London School of Medicine at Guy's, King's and St Thomas' Hospital (earlier the GKT School) in April 1998. KCL, associated with such powerful hospitals, gave UMDS room for manoeuvre. Internally there were power struggles on both the service and the academic sides to determine the future pattern of service. From 2007 students registered with King's were awarded a King's degree, rather than one from the University of London. In March 2009 King's Partners was accredited an Academic Health Sciences Centre and made rapid progress to become a major player.

University College London

University College/Middlesex schools merged in 1987. The Institute of

Child Health became part of UCL in 1996 & the Royal Free and University College Medical School was formed in 1998. University College London Hospitals while having only small local catchments had substantial financial assets and an ideal academic location next to UCL, perhaps the strongest research base in London. As UCL Partners, it was selected as a Biomedical Research Centre in 2008 comprising UCL with Great Ormond Street, Moorfields Eye Hospital, The Royal Free and University College London Hospitals. New "partners" steadily joined. As "London's leading health research powerhouse" it focussed on areas of research which posed a major health challenge, e.g. neurosciences, children's health and cancer. Though the medical schools merged, the Royal Free Hospital Trust remained under separate NHS management and with a new Chair and Chief Executive steadily became a stronger organisation..

Imperial and UCL discussed a merger, but decided it was in the interests of neither side. However, the discussions divided the London medical schools into two camps, Imperial College and UCL neither of which were supportive of the concept of London University, and the other three. In 2005 UCL gained independent degree awarding powers from the Privy Council. Students registering after 2007 had a UCL degree. Such moves, covering all subjects and not solely medicine, tended to undermine London University.

St George's

St George's, far from the centre of London and with no substantial university link, was not in the same league. It maintained an independent position within the University of London but later established links with Kingston University.

There were now four university centres, each related to a multi-faculty college, plus St George's. The postgraduate institutes were finally brought within the fold, as proposed by Sir George Pickering in 1962.¹⁸ Within this structure, once the colleges became directly funded by the Higher Education Funding Council for England (the successor in 1993 to the University Funding Council) the University of London had to accept the realities of local ambitions, including the individual right to grant degrees. The colleges had gained financial and managerial autonomy, UCL, Queen Mary, Kings and Imperial being separately identified from 1993/4 and St George's two years later. The University maintained a coordinating group of the medical

faculties to discuss strategy for mutual benefit but each college took a different approach to the integration of medical schools within their fief.

Nationally the large teaching trusts, Newcastle, Manchester, Sheffield, Birmingham, Oxford, Cambridge, UCLH, King's, Guy's/Thomas' and Imperial established a group, the Shelford Group, to discuss and forward their interests. They enjoyed access to the highest political levels. Other teaching trusts that were smaller were in a different league.

2000 Labour's second wave, changing structures and policies.

The replacement of Frank Dobson in 1999 as Secretary of State for Health by Alan Milburn heralded further change. Milburn wished it to be fast and over a broad front. Labour's second major health policy document, the *NHS Plan*, was issued in July 2000 with four main themes, increasing capacity, setting standards and targets, supervision of the way the NHS delivered services, and 'partnership'. There was no specific London agenda. Substantial progress was achieved in terms of waiting times and waiting lists. Milburn's policies involved a greater role for the private sector, for example in the private finance initiative and independent treatment centres, radical changes in funding with the introduction of tariffs and Payment by Results, and Foundation Hospital Trusts with greater freedoms.

Trusts and Foundation trusts (FTs)

In July 2002 it was proposed that acute hospital trusts that had performed well could apply to be "NHS Foundation Trusts". These would have greater freedom in terms of management, closer links to their community and greater local financial control. Authorisation as a FT was hard to obtain as the trust had to meet high standards of financial security and governance excellence. Nevertheless three London hospitals appeared in the first wave in 2004, Moorfields, the Royal Marsden, the Homerton and soon after UCLH. Later King's College Hospital, the Royal Brompton and Harefield, and Guy's/St Thomas' also became FTs. The Royal Free became one in 2011 and Kingston in 2012. The trusts of the West Middlesex and Barnet/Chase Farm sought association with existing FTs. Compared with the rest of England fewer London hospitals became FTs. In some cases there were financial problems, often relating to a debt overhang from developments under PFI as in the case of the Royal London Hospital

and hospitals in South London. The cost of PFI capital could be three times as large as that of historic assets, and not all trusts managed the transition to higher payments satisfactorily.

NHS Foundation Trusts differed from existing NHS Trusts in key ways for they had the freedom to decide at a local level how to meet their obligations; they were not under the supervision of the special health authority; they had an individual constitution that made them accountable to local people, who could become members; and governors who could hold the board to account and, indeed, appoint and sack the Chair.

They were authorised and regulated by Monitor which kept a careful eye on financial risks and issues of quality. FTs could provide new services and develop their facilities from their own resources as they wished. For example the Homerton successfully bid to provide community nursing services to its area. If an FT sold land, it could keep the proceeds for re-development. Thus UCLH sold the site of the old Middlesex Hospital keeping £175 million, in the teeth of opposition, which with the sale of other assets greatly assisted redevelopment.

New patterns of hospital medicine in London.

The *NHS Plan's* structural reorganisation took place on 1 April 2002, "devolution day". At that point there were 28 Strategic Health Authorities, with five for London. New factors began to drive changes in hospital medicine in London, far more than elsewhere. Increasingly services were planned across and between hospitals and trusts, not merely within them. Services might be provided more effectively in larger units, perhaps by hospital mergers reflecting changes in the pattern of London medical schools, and there was a drive to reconfigure services on the basis of clinical outcomes as in heart disease, trauma and stroke. Organisational change continued and in 2004 Ministers said 'the unique nature and scale of health service issues facing the capital might point to a single organisation to oversee service development.' Following the Government report *Commissioning a Patient-led NHS* (Department of Health, 2005), a single SHA was established in London, though the PCTs that were largely coterminous with boroughs were left unchanged.

NHS London (SHA) and the Darzi Reports

NHS London covered an area coterminous with the local government office region and was established in July 2006. It was closed as a result of the Health and Social Care Act 2012 on 31 March 2013. It had brought together 5 SHAs, North West London, North Central London, North East London, South East London, and South West London. It was therefore the nearest that London had ever had to a "Central Hospital Board for London," providing strategic leadership for all of health services in the capital and with responsibility for the performance of 31 primary care trusts. NHS London had responsibility for those trusts that were not Foundation Trusts, for example south London hospitals and Barts and the London, which involved substantial fire fighting, but also the formation of a more strategic view of London health services. It had less responsibility for 16 self-governing foundation trusts. NHS London was chaired in turn by George Greener, and after his resignation in September 2008 by Sir Richard Sykes, previously chief executive of GlaxoSmith-Kline. Sykes resigned as Chair in May 2010.

Trouble shooting

At the time of its establishment, financial growth had never been greater but this ended with an economic downturn. Trusts in south east London had long-standing financial problems, recording annual deficits every year since 2004/2005 from the unaffordable and irreducible costs of its whole hospital PFI schemes, 16% of their income. Cost-improvement schemes could not restore financial health without risking the quality and capacity of services. In 2005 a major review taking 5 years was established (*A Picture of Health*), covering Queen Elizabeth, Woolwich and Bromley Hospitals, Queen Mary Sidcup and Lewisham. The SHA would have liked to have examined all services in south east London simultaneously but this proved politically too difficult. The final proposal was for a large reduction in medical and acute bed capacity at the Queen Mary's Sidcup site with the closure of 284 acute beds and the cessation of emergency admissions. To facilitate service changes a single merged trust was established in 2009 to cover three hospitals, with a total combined debt of £149m. The merger was a financial failure and the Care Quality Commission found the trust was not complying with some standards of safety and quality.

Strategy

Perhaps the SHA's most important action was, while Sir David Nicholson was chief executive, to commission a clinician, Professor Sir Ara Darzi, to review London's health care system. Darzi, intelligent, hard working and alert to trends, had extensive support both in back office terms and from senior clinicians. He got quality far more to the forefront of people's minds, at a time when targets were the mantra. Among trust chief executives there was a consensus of support. Legitimacy was established through the clinical leadership with an extensive consultation programme, and by selecting a few priorities to be tackled properly rather than trying to do everything. The three priorities were stroke, trauma and the polyclinic programme. The course and outcome of this programme was subsequently reviewed by its key officers.^{22b} Darzi's first report *The Case for Change* (March 2007) argued that the current system was wrong, because it could not handle health inequalities, patients' expectations, the need to centralise specialised care, the relationship with academic medicine or give value for money.¹⁹ *A Framework for Action* was published in July 2007, days after Darzi's ennoblement and his appointment by Gordon Brown as a junior health minister in the Lords. ¹⁹

Darzi was one of the "goats" in Brown's "government of all talents" and he came to believe that his appointment as a Labour Minister turned people against his report, although it was the product of many hands including McKinsey's.²⁵ It recommended 5 principles, an individual focus on patients' needs, services local where possible and centralised where necessary, focus on health inequalities, prevention rather than cure and truly integrated care. Technical groups had looked at population trends, e.g. the population expansion in the "Thames gateway", and the likely health problems in London over the coming years. Clinical working groups considered appropriate policies for care and the care pathways best suited to differing groups of patients. Hospitals might be classified as local hospitals, elective centres with high throughput, major acute hospitals handling complex work, specialist hospitals and academic health science centres.

Brilliant in conception, but according to the *Guardian* a recipe for turbulence, it was a blueprint for a radically different NHS. Darzi believed that chronic disease would be better managed by larger units, 150 polyclinics handling much work previously undertaken in hospitals. Some large practices already provided extensive facilities but the

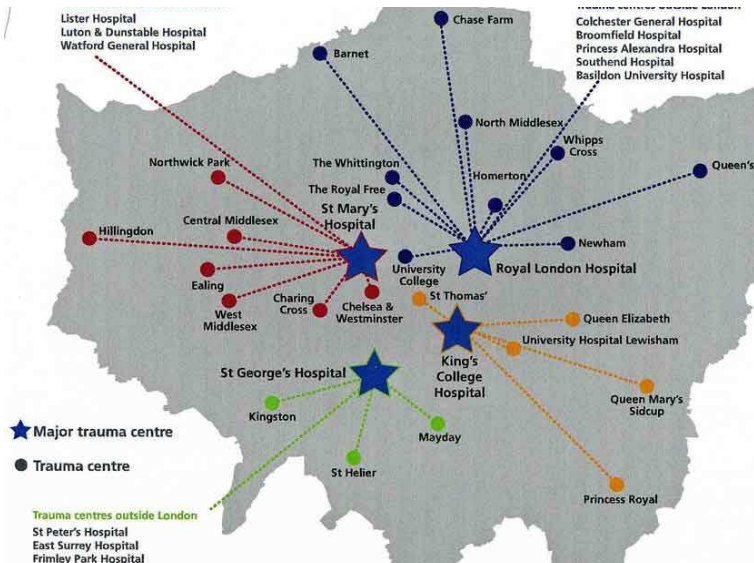
inclusion of imaging, consultant outpatient sessions and minor surgery would require much investment. The proposals for polyclinics found little favour with GPs. The number of major acute hospitals would be cut by more than a half, some being restricted largely to cold surgery. There might be some 12 specialist hospitals and 8-16 major acute hospitals. Patients in emergencies would be admitted to the hospital best suited to their needs; near or far. Services for the mentally ill and long term conditions needed improvement and the report was fleshed out with reports of working parties, for example on maternity services.

For maternity a tiered system was proposed according to clinical and social need of home delivery, midwife-run maternity units, some on a hospital campus, and full scale obstetrician round the clock hospital units. Darzi seemed to believe that the health service could be rebuilt starting from scratch. The costings provided by McKinsey's attracted significant criticism. Major savings depended on the ability to transfer services into the community, but some polyclinic schemes seemed lavish and were likely to cost, and not to save, money. Darzi accepted that the plan had a long timescale and was confident that he could take others with him but this was only partly true. He wished his concepts to influence national thinking particularly on quality, but he offended some by offering instant solutions to problems with which people had wrestled for years. The SHA went to public consultation and a bare majority accepted most of the proposals. A joint committee of primary care trusts (PCTs) accepted the proposals in June 2008.

Reconfiguring clinical services.

Trauma and Stroke reconfiguration

NHS London hosted *Healthcare for London*, a transient organisation paid for by the 31 PCTs to encourage planning of the more complex services London wide. Already heart attacks had been centred on four key hospitals. From 2006 NHS London consulted on and implemented reconfiguration of major trauma and acute stroke units. Against much political opposition but usually with strong clinical support specialist care was centralised. The Prime Minister himself was lobbied and Andrew Lansley was against the stroke proposals.^{22a} The SHA sponsored the work that established a 'case for change'; usually led by a clinician from the field and a steering group reviewing the evidence. This was not always hard or absolute but in general suggested that the more a centre did, the better they were at it. Economic arguments



The concentration of major trauma services at The Royal London, St Mary's, St George's and King's College Hospital

were not paramount. The decision about how many centres there would be lay largely with NHS London and the expert group and might be contentious. Similarly, the expert group decided on the criteria by which applicant trusts would be judged for centre status. Trusts submitted their bids, NHS London evaluated them and once decided, the commissioning process was used to cement arrangements. Many opponents of the proposals were ultimately converted. In February 2009 eight hyperacute stroke units (HASUs) and four trauma units were established. As a result of stroke reconfiguration virtually all patients who would benefit from thrombolysis got it (18%), three times more than in the country as a whole, saving some 400 lives a year. The HASUs were The Royal London Hospital, St George's Hospital, King's College Hospital, Northwick Park Hospital, Charing Cross Hospital, University College Hospital, The Princess Royal University Hospital and Queen's Hospital Romford supported by 24 stroke units where patients would continue their recovery.

Post Darzi Reconfiguration in London

To aid reconfiguration, in 2009 the Primary Care Trusts created five subgroups, three north and two south of the Thames later followed by more formal merger of the PCTs. Reconfiguration proposals were developed in North East London and North Central London (*the Barnet, Enfield and Haringey Clinical Strategy*) but stalled for a time. The strategy for the south west, *Healthcare for South West London, Better Services Better Value* was abandoned. To aid reconfiguration, in 2009 the Primary Care Trusts created five subgroups, three north and two south of the Thames later followed by more formal merger of the PCTs. Reconfiguration proposals were developed in North East London and North West London (the Barnet, Enfield and Haringey Clinical Strategy) but stalled. So did the strategy for the south west, Healthcare for South West London. A major reconfiguration in North West London, *Shaping a Healthier Future*, was approved, enabling the closure of A and E at Charing Cross, Central Middlesex Hospital and Ealing in October 2013.

A delay imposed by Andrew Lansley on taking office as Secretary of State for Health provided opponents of local change with ammunition. The polyclinic programme, itself largely based on proposals already in hand, was ended but the primary care trusts and their successor clinical commissioning groups pressed on with rational developments under the banner of integrated care to improve services for the frail elderly. Evaluation showed little evidence that the polyclinic programme had improved service development, access, quality of care and patient experience, and it had not generated significant cost savings. Clinical pressure continued to ensure service transformation in cardiovascular, cancer, mental health, maternity and neonatal intensive care and paediatric services.

Biomedical Research Centres (BRCs) and Academic Health Science Centres (AHSCs)

Since the time of William Osler and the Flexner report a century previously there had been recognition that service, teaching and research were mutually supportive. Driven from a research standpoint by Dame Sally Davies, the UK government recognised the economic, financial and clinical advantages of backing medical developments, research leading to better treatment. The example of major

biomedical research centres in the USA, which had spearheaded clinical development, led to the establishment of the National Institute for Health Research (NIHR) and consideration of which centres should be supported to encourage "translational research". A panel of international experts chose centres in open competition as world class in research. In December 2006 Patricia Hewitt, the Secretary of State, announced five multispecialty trusts that would be supported, three in London (Kings, UCLH and Imperial) plus Oxford and Cambridge, and a further six in particular clinical fields. NHS research moneys went preferentially to these power houses of translational research.

Subsequently, following the Department of Health's paper on *Innovation Health and Wealth* (December 2011), sponsored elsewhere in the Department and strongly supported by the PM Tony Blair, Alan Johnson, announced in March 2009 that five academic health science centres would be created in England, after a separate peer review of the final applicants by an international panel of experts. The keynote would be collaboration between a trust or trusts and a university. The successful centres were Cambridge University Health Partners, Imperial College, King's Health Partners, Manchester AHSC, and University College London Partners. From the outset the AHSCs behaved differently. Imperial behaved imperially, centring power on the university with a single chief executive for the NHS and university sides. Equality between the partner trusts and the university was the ethos at UCL Partners. These large centres began to play a major role in structuring local and specialist health services. While having no managerial authority over the NHS, their influence was considerable. Hospitals in a relationship with universities not selected began to consider their own future. Designation as a AHSN brought additional money to the organisation.

2010: The Coalition and the Health and Social Care Act (2012)

Labour was defeated in the 2010 election and the new Secretary of State, Andrew Lansley, arrived with further proposals for reorganisation that he had published while in opposition. Lansley was distrustful of central planning. He immediately moved to embargo proposed reconfigurations, imposing new criteria such as local support from the public and general practitioners. Because the London SHA had been in advance of other authorities, it was particularly affected by this decision and important strategic plans were placed at risk. The Chair, Sir Richard Sykes, previously chief executive of GlaxoSmith-

Kline, resigned believing that the delay was driven politically and not by logic. So did 4 non-executive directors. Many of the reconfiguration proposals such as those in North East London had emerged from a long process of clinical involvement and public consultation. Others, as at Chase Farm, were necessary and had been delayed for years by political and public dissent. While some could be criticised, such as the belief that polyclinics would move up to half acute care into the community saving money, to delay restructuring at a time of financial crisis was questionable. Many of the trusts where restructuring was planned had financial problems and were also at risk of providing poor care. NHS London considered how mergers might improve matters.

The White Paper, Equity & Excellence, Liberating the NHS was followed by compromises within the coalition, fierce political battles and following the Health and Social Welfare Act (2012), major organisational change.²⁰ In 2013 the London SHA and Primary Care Trusts were abolished, to be replaced by a London regional branch of NHS England with three area groups, two north and one south of the Thames. Pan-London planning and hospital reconfiguration became more difficult. Commissioning functions were transferred to clinical commissioning consortia, and lines of accountability were confused. Within a year nobody could be found willing to defend the changes that were generally held to be mistaken. When appointed as Chief Executive of NHS England in 2014, Simon Stevens was left to try to sort out the mess without resorting to further legislation, against a worsening economic background.

Financial problems

Because of the global economic crisis of 2007/8, Kinsey were commissioned by the Department of Health to examine NHS finances. Its report in March 2009 suggested the need for swingeing economies. The NHS Chief Executive, David Nicholson, said that efficiency improvements of £15-20 billion would be required in the three years between 2011 and 2014. In 2011, tariff payments were cut and some activity was restrained, most acute trusts in London projecting an in-year deficit of 6-9%. Monitor found that most trusts not yet of foundation status were financially at risk. Some such as the Royal London were burdened by major PFI commitments (10% of the national hospital PFI programme) that debarred it from meeting tests of financial stability. Others had historic debts. NHS London

confirmed that Newham, Whipps Cross, North West London Hospitals, West Middlesex, Barnet and Chase Farm, St George's Healthcare, South London Healthcare, and Barking, Havering and Redbridge Hospitals would all remain in deficit in the medium term. In April 2011 Imperial College Health Care Trust, budget £910 million, had a deficit of £40 million, and the Chief Executive and Finance Officer resigned. The SHA rightly believed that if acute trusts were left with their levels of deficits, London would end up with failing trusts with significant debt, which would result in performance failure, not only financially, but in patient care. The Francis Report (2012) following the problems at Mid-Staffs had made clear that good care depended on safe nurse staff levels. Pressure to recruit added to financial problems, and conversely several trusts with poor staffing and bad Care Quality Commission reports went into 'special measures'.

In 2011 NHS London examined the financial viability and clinical sustainability of the 18 acute NHS Trusts in London yet to achieve Foundation Trust status. (Safe and Financially Effective - SaFE). Even assuming major improvements in productivity, only a third would be in a viable long-term financial position by 2014/15. In 2013 NHS London was abolished and responsibility for strategy passed to the new Clinical Commissioning Groups (CCGs) which formed a London wide Clinical Commissioning Council, to the London regional office of NHS England, to Monitor for foundation trusts, and the Trust Development Authority (TDA) for other trusts. (Monitor and the TDA merged in 2016).

Merger, at least for the Southeast London Healthcare Trust, was not a panacea.²⁴ In 2012 the Secretary of State placed the trust into administration. Faced with a rising deficit an administrator was appointed by the Secretary of State in 2012 who later approved his recommendations. Among them was the closure of the A and E department at Lewisham, but this went to Court and was ruled outside the remit of the SOS. In October 2013 the Trust was dissolved, and in its place a new trust (Lewisham and Greenwich) managed QE Woolwich and Lewisham hospitals; King's College Hospital FT took the Princess Royal Bromley; and Oxleas FT Queen Mary's Sidcup. The DoH paid the excess costs of the PFI buildings and wrote off debts so that the new organisations were not saddled with historic deficits. Time had been lost and local staff traumatised.

Seeking solutions led to other risky decisions. The merger of Barts, the Royal London, Whipps Cross and Newham as Bart's Health was agreed by the Secretary of State (2012). Within a year the merged trust was in "financial turnaround" and in 2015 the Chair, Chief Executive and Chief Nurse resigned. The hospital went into "Special Measures" because of its continuing deficit and poor CQC reports.

In North West London McKinsey's were asked to examine the configuration of services between Imperial College Healthcare Trust and West Middlesex University Hospital Trust, which led to consultation on *'Shaping a healthier future'* in 2012 that proposed a reduction in A & E units coupled with attempts to improve services in the community.

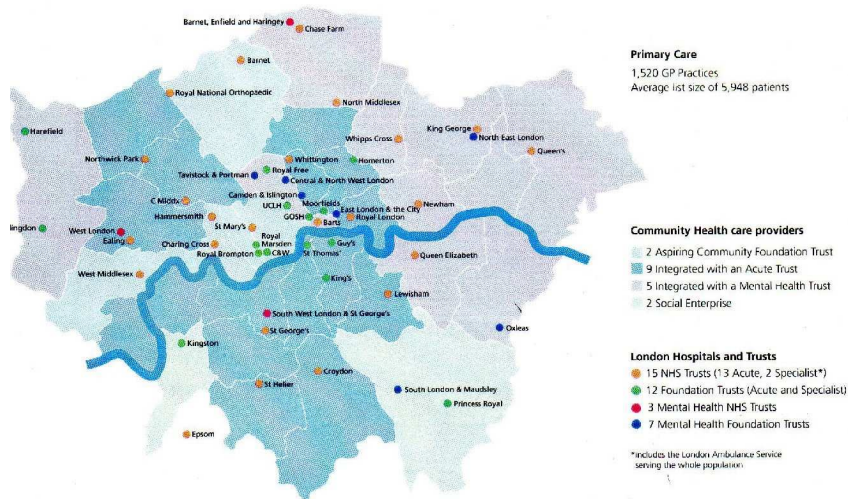
Improving health and health care in London

In December 2011 the King's Fund also took stock of the financial and policy landscape, the successes and unfinished business of *Healthcare for London*, and the loss of momentum through the decision to abolish the SHAs. Its assessment was updated in 2013, listing significant reconfiguration proposals. A common theme was the aspiration, never shown to save money, to develop more integrated care and to deliver it increasingly in primary and community settings.

21

The financial situation, though dismal, was at least clear. It was policy that was uncertain. The Fund thought that London, with a greater concentration of problems and financial difficulties than elsewhere, faced a strategic vacuum with no clear lead to coordinate services and drive through necessary changes. Much had been accomplished in heart disease, stroke and trauma by having a central focus. Only 16 of 42 London trusts were currently foundation trusts, with around half of the remainder unlikely to be financially viable in the medium term. The Fund saw a reduction in the number of hospitals and the resultant political conflicts as inevitable.

NHS England London Region published *London - A call to action* in 2013, which like the Darzi reports aimed to stimulate debate about the challenges faced by the NHS in London and the case for "transformation" 26. A useful guide with a helpful map, the challenges were presented better than solutions.



Map from *London, a call to Action*. NHS England, London Region, 2013

The Academic Health Science Centres now played a role in reconfiguration for it might be their staff who identified better ways of providing clinical care at a world leading level. For example it was agreed that specialist cardiac services move from UCLH to Barts, while specialist urological cancer surgery would transfer to University College London Hospitals and the Royal Free. Purchasers and providers were collaborating on reconfiguration. UCL Partners described the move as a “once-in-a-lifetime opportunity” to create world class cancer and cardiac care for 6 million people in London and beyond, on a scale similar to the reconfiguration of stroke care across London. UCLH said there were only two things it could do at world-class standard, neuroscience and cancer. “It’s not possible anymore for everyone to do everything.” Concentration of expertise would allow Barts to compete with international cardiac centres, such as the Cleveland Clinic, while UCLH competed with the equivalents for cancer, for example the Memorial Sloan-Kettering cancer centre in the US.

Inner London Trusts and Foundation Trusts as of 2016

Structurally, the financial climate had encouraged organisational mergers. Larger Trust groupings appeared in four of the five Turnberg sectors

North East London

Barts Health NHS Trust (Trust created 2012)
The Royal London Hospital, St Bartholomew's Hospital,
Newham University Hospital (2012),
Whipps Cross University Hospital (2012)
Homerton University Hospital Foundation Trust (2004 FT Status)

North Central London

Royal Free Hospital London NHS Foundation Trust (2012 FT Status)
Royal Free Hospital, Barnet Hospital (2014), Chase Farm Hospital (2014)

University College London Hospital NHS Foundation Trust (1994/2004 FT Status)

University College Hospital & Middlesex Hospital (1982), National Hospital for Neurology and Neurosurgery (1996), Royal National Throat, Nose and Ear Hospital (2012), Eastman Dental Hospital (1996), Royal London Hospital for Integrated Medicine (2002)

Great Ormond Street Hospital for Children NHS Foundation Trust (2012 FT Status)

The Whittington Hospital NHS Trust

North Middlesex University Hospital NHS Trust

The Hillingdon Hospitals NHS Foundation Trust (2011)

Hillingdon Hospital, Mount Vernon Hospital

Royal National Orthopaedic Hospital Trust, (Stanmore & Bolsover Street)

Moorfields Eye Hospital Foundation Trust (2004 FT Status)

Moorfields has many satellite units embedded in other hospitals in London and the Home Counties

North West London

Imperial College NHS Healthcare Trust
Charing Cross Hospital (2007), Hammersmith Hospital (2007), Queen Charlotte's Maternity Hospital (2007), St Mary's Hospital (2007), Westminster Eye Hospital (2007)

Chelsea and Westminster Hospital NHS Foundation Trust (2006 FT Status)

Chelsea and Westminster Hospital (Built on site of St Stephens and opened 2003), West Middlesex University Hospital (2015)

London North West Healthcare Trust (2014)

Central Middlesex Hospital, Ealing Hospital, Northwick Park Hospital, St Mark's Hospital

Royal Brompton and Harefield NHS Foundation Trust (2009 FT Status)

Brompton Hospital, Harefield Hospital

South West London

St George's University Hospitals NHS Foundation Trust (2015 FT Status)

(Incorporating the Atkinson Morely Hospital)

Kingston Hospital NHS Foundation Trust (2013 FT Status)

Royal Marsden NHS Foundation Trust (2004 FT Status)

Royal Marsden (Chelsea), Royal Marsden (Sutton), Royal Marsden day unit in Kingston Hospital.

South East London

Guy's and St Thomas' NHS Foundation Trust (2004 FT Status)

Guy's Hospital, St Thomas' Hospital

King's College Hospital NHS Foundation Trust (2006 FT Status)

King's College Hospital, Princess Royal University Hospital, Farnborough Common (2013), Orpington Hospital

Lewisham and Greenwich NHS Trust

Queen Elizabeth Hospital Greenwich, University Hospital Lewisham

The UK general election in December 2019, that saw the return of a Conservative government with a majority of 80, provided a mandate for the UK to leave the European Community, and a new Secretary of

State for Health and Social Care, Matt Hancock. He was soon to be at the centre of a crisis.

Covid-19 (Coronavirus) 2020

In January 2020, reports were received from Wuhan province in China of the outbreak of a new viral respiratory disease. It was spreading rapidly, and while the majority of cases were mild, if not asymptomatic, after a few days a minority developed a severe respiratory illness requiring intensive care and often ventilation. Other organ failures, such as renal failure, also occurred. Among these, a substantial and increasing number died. The spread of the disease to many other countries, aided by air transport, was rapid. By March 2020, it was recognised as a major threat, indeed an international pandemic, with many UK cases, particularly in London, cases in the thousands and daily deaths in the hundreds.

The government acted, pledging additional resources and writing off many historical hospital debts. The Prime Minister, Boris Johnson, contracted the disease and was admitted for a few days to intensive care at St Thomas', and nationwide social isolation was instituted. The Chief Medical Officer, Professor Chris Whitty, rapidly became a media personality in daily briefings and his Gresham Lecture. The effect on London's hospitals was dramatic. Elective admissions ceased while wards and theatres were re-purposed as intensive care units. A new hospital was constructed within days at the Excell exhibition centre (The Nightingale Hospital) in case hundreds or thousands of intensive beds were needed although, in the event, a massive increase in the intensive care facilities of all London hospitals just managed to cope with the demands. The use of public transport fell by 95% as only key workers, NHS and Food chains, remained at work. Some types of care, for example, cancer care, were centralised at the Royal Marsden to avoid infection, while other hospitals became temporarily single specialty. NHS workers, although provided with a level of personal protecting clothing, died in their dozens. Residents of residential care homes were badly hit. A massive increase in testing for the virus was instituted, as it became clear that localised contact tracing was ineffective. A rapid search for a vaccine began, and for existing drugs that might affect the disease.

The re-emergence of planning

The Andrew Lansley reforms had dealt a blow to the concept of strategic planning, but under Simon Stevens the concept began to re-emerge. NHS England established "footprints" within which authorities were encouraged to cooperate, and to develop service transformation plans (STPs). In London the footprints resembled the areas of five earlier planning areas, along the lines suggested by Turnberg. Statutory bodies, CCGs and Local Authorities, were instructed to develop plans for the future to improve the quality of services within the budgets available. These STPs were reviewed by the King's Fund and Nuffield Trust in 2017 that felt that the money available to achieve desirable change was not likely to be available, and the authority to achieve change was lacking. 28

The State of Play, 2020

Summarising the position over the 30 years from NHS restructuring to the Health and Social Care Act 2012, London's hospitals started under the management of four regional health authorities and individual teaching districts. They were bound into a planning system where the aspirations and the money did not match. They had little control over their destiny; there was infighting between the medical schools and no effective strategic planning. Thirty years later the Department of Health was stepping back from involvement and briefly there was a single strategic authority, and from 2013 a regional branch of NHS England, for London. The medical schools had sorted out their problems and academic health science centres were the new big beasts. Issues of quality, competition and the private sector were taking an increasing role and planning for services such as heart and stroke was taking place across the metropolis, rather than within individual hospitals, with substantial clinical involvement, and driven by commissioning. Increasingly the burden of the care of the elderly and those with multiple problems was leading to 'Integrated care' with attempts to unite the work of general practitioners and hospital services.

The problems of developing, and where necessary remodelling, London in matters of health administration "is admittedly one of unending difficulty." So said *The Lancet* in 1920, and when this book was first published in 1986 few could have predicted the pattern of

London health services and hospitals thirty years later.

For those attempting to improve London's hospital system, however the complexity of the changes in 2013, and the processes now to be gone through, seemed massive according to most observers, the King's Fund and Ruth Carnall, retiring chief executive of NHS London. 22a. The organisational complexity was horrendous. Planning services across the capital had been made more difficult by the abolition of the Strategic Health Authority, NHS London in April 2013, and the fragmentation of commissioning into 32 Clinical Commissioning Groups (CCGs), while NHS England retained centralised – and largely unaccountable – control over primary care and specialist services. The Health & Social Care Act 2012 had effectively increased the numbers of commissioners, while in practice imposing greater centralised control.²⁷ Progress was coming from success in working with clinicians, whether consultants or GPs. The trend to look at clinical services for quality and cost across hospitals and trusts is encouraging. London remains, however, with its hospitals, universities and academic health science centres a powerhouse of talent. Long may it remain so, but for two centuries it has been a wild problem, difficult to define and mutating under one's gaze like Lewis' Carol's Cheshire Cat. In the words of *The Lancet* on 18th January 1873, the hospitals of London are "a service doing on the whole an enormous amount of good and necessarily doing also a certain amount of mischief."

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This book has traced the way in which a multitude of hospitals, which differed in their aims, their finance and their management have, progressively become associated in a system that, as Lord Lawson has wryly suggested, is the closest thing the English have to a religion. From Sir Henry Burdett in the 19th Century to the managers and the ministers of the day, competent, intelligent and devoted people have struggled with this Sisyphean task. We have not reached perfection but much good has come from their efforts. In the 19th Century the great voluntary teaching hospitals, and the specialist hospitals, were developmental points. Today is it Academic Medical Science Centres.

A complex system and a wild problem

London medicine is an incredibly complex system that few if any really understand. Developing a mental model of it takes time. London presents a wild problem, difficult to define, ever changing and just as a solution is apparently in sight, the problem alters. Often the law of unintended consequences seems to prevail.

Hospitals and the NHS form part of the wider economy. With the NHS spending some 8% of the gross national product, the political view that a vibrant health service depends on a vibrant economy must be correct. The health service has over a million staff so that merely as an employer it is a substantial component of our society. In some localities health care is the dominant employment. At one time the number of doctors who were to be trained in the UK was geared to the likely speed of economic growth, not the need for their services. In the 19th century an agricultural depression devastated voluntary hospital finances, and hard times increased the strain on the workhouses. Our current economic problems are at the root of many issues in the NHS. Kenneth Clarke maintains that there are positive advantages in stringency, forcing as it does reappraisal of how the system is managed.¹ Not everyone would see matters in this way.

The desire to mitigate the effect of social inequality on health, also a near impossible task, adds to the complexity. From Charles Booth to Brian Jarman and Sir Michael Marmot, managers have been reminded of its importance. Voluntary hospitals, for example The London, attempted to shoulder the burden of the care of the impoverished.

Awareness that social services play a key role in health care lay behind the drive for coterminosity of health and social care in the 1974 reorganisation, and remains on today's political agenda. The Resource Allocation Working Party (1976) 2 redistributed money partly with this in mind, London losing money to the north, to the shire counties and to long stay specialties that were previously grossly under resourced.

Clinical care is ever changing. Old killers, the fevers and tuberculosis, do not dominate health services as they once did. New methods of diagnosis and imaging have changed the shape of hospitals, altering the balance of inpatient and ambulatory care, modifying the functional content of hospitals and leading to an increase in the number of patients. Fifty years ago Sir Max Rosenheim at UCH joked that a health person was someone who had been inadequately investigated. Joint replacement, transplantation, minimally invasive surgery and better anaesthesia have changed the business of the hospitals. Genetic medicine doubtless will do so in the future, and most advances modify the site of health care delivery between the community and the hospital in one direction or another.

Research is the life blood of a developing service. A hundred years ago in his rather arcane style, Sir William Osler talked about what was essentially translational medicine when he said that 'the hospital [specialist] units mint, for current use in the community, the gold wrought by the miners of science. This is their first function.' Today we have the academic health science centres that 'make the most of the synergies between research, education and health services to translate research into better care and increase the speed at which research is taken from bench to bedside and back again'.

Additionally there has always been an international angle, from the time that Florence Nightingale studied continental hospitals and nursing systems, to today's world-wide clinical trials. No country's hospital system stands alone. Its staff, their knowledge and their skills move between countries. London is part of an international network.

The modification of health systems

Changes in systems are seldom radical and are usually firmly based on what has previously existed. They are evolutionary, not revolutionary. Whether one looks at leaders such as Bevan or Obama, the systems they have influenced are founded on what went before. The 'appointed day' when the NHS began, 5th July 1948, brought not one extra doctor or nurse. The unfolding story in the book is one of evolutionary change, although a major upheaval such as the 1939-1945 war makes a new and radical departure easier. 'Never waste a good crisis' has become a management doctrine. Some saw in the Darzi proposals of 2006-2008 an attempt to tear up primary care and the hospital service and start again. 'Brilliant in conception, clinical in slant, but a recipe for turbulence,' said the Guardian; it was a blueprint for radically different NHS. In the event it was merely a blip in the history of the London hospital system although some useful change did occur.

Centralisation and devolution

For two hundred years there has been a continual strain between centralisation and devolution. Governance and management have always been contentious issues. Initially decentralisation dominated. Hospitals were managed either by ad hoc bodies, established specially for that purpose such as the committees of the voluntary hospitals, or by elected authorities and their committees. The result was confusion, gaps, overlaps and chaos.

When the pressure for centralisation arrived, for example with the need for poor law hospital reform and the creation of a system of fever hospitals, or for removing London hospitals to the places where the poor had come to live, the trouble started. The argument for devolution has always rested upon the need for hospitals to be sensitive to local opinion and local needs and to allow staff to feel that they have a measure of control. The centralist argument was expressed by the Royal Commission on smallpox hospitals, commenting on the Metropolitan Asylums Board in 1882.⁴

'It will bring to a focus, and will be able to give instant and extended effect, to all the experience which will otherwise be scattered with various results, among a variety of bodies not always actuated by broad or accurate views. It will also be able to make the different parts

of a large system work into each other, not only for the advancement of practical efficiency, but also for the careful observation, collection and publication of facts systematically observed over the large field which their operations cover. Finally, it will probably be able, from its dignity and importance, to command a higher class of administrators. The Board, if it is one, will be the picked men of the metropolis, instead of the picked men of a parish.¹

An uneven and incoherent hospital service had developed in London. The voluntaries could not raise enough money, either individually or jointly, to expand to meet the increasing demand for hospital care as medical science developed. So the rate-supported hospitals moved into acute care, compounding the problem of competitive and overlapping services.

The confusion led to repeated calls for economy and efficiency, for cooperation and rationalisation by, among others the Select Committee of the House of Lords (1892),⁵ the King's Fund (1897), the Cave Committee (1920), Neville Chamberlain as Minister of Health, the Sankey Commission (1937)⁶, and the Nuffield Provincial Hospitals Trust (1941). Unfortunately, because of the multitude of authorities with different perspectives, agreement on issues of a fundamental character could seldom be reached.

The NHS ultimately provided a broader framework for planning, but it was also structured to function with many independent authorities, each separately accountable to the Minister. Planning within a single organisation is always simpler than coordinating the planning of separate bodies. The creation of 'joint planning' and 'liaison' committees is frequently a sign of a basic organisational fault. Progressive reorganisations sometimes tried to mould the London authorities into a pattern which would make major change possible. The establishment of a single region for London (2002) had this aim and the 2013 reforms weaken this.

Ara Darzi (2008) believed that one should centralise when essential, for example to improve outcomes, and decentralise where possible to improve access.³ Whatever the advantages and disadvantages are for centralisation in clinical and management terms, the situation differs in research and development. From the special hospitals or the 19th century, through the postgraduate teaching hospitals in the 20th to our new Academic Health Science Centres, the need for local

autonomy is clear. London's three AHSCs will almost certainly develop an accent on different medical problems, playing to the strengths of their staff. They have to if they are to fulfil their function.

Merger and Reconfiguration

Hospital buildings have a limited life span. Services need to change. Reconfiguration is continually needed. In 1948 the local hospital management committees began the process of reshaping the local hospital provision, a process that has continued ever since. Hospital rebuilding with associated hospital closures have taken place but amalgamation as a method of rationalisation has always been favoured. It is less drastic than closure and therefore more acceptable. It preserves valuable strengths and traditions and a role can be found for supporters in the new organisation. It is argued with little evidence that larger units may be more economical to run, and more convincingly that they will provide a better basis for medical education and research. Finally the merger can be combined, if desirable, with a judicious reduction in bed numbers. The early efforts of the King's Fund to achieve amalgamation of small hospitals have been followed ever since by mergers, a continuing process fuelled by budget cuts, the migration of population, the falling duration of inpatient stay and the need to create larger units to ensure clinical effectiveness.

Sadly while in the business world a merger almost always has a clear objective, obtaining a brand name, reducing over capacity or developing a new product, recently in the NHS this has not always been the case. Merger has sometimes been seen, in the face of the evidence of failed past mergers, as the way to resolve a managerial problem. However, as the Americans say, three turkeys do not make a hawk - as has recently been evident in south London (2013).

Management styles

Whether it was the King's Fund, the LCC, Lord Dawson's Interim report in 1920 or in the NHS, the wish to provide an equitable service at a reasonable cost has always been there. The King's Fund relied on friendly persuasion, the LCC on a clear management hierarchy, but recently it has been hard to see how decisions come to be taken within NHS management. The clash of the populist, the political, the professional and managerial is only too evident. Lack of organisational clarity is a problem with the 2013 changes. It is an axiom that in a 'wild

problem' those whose duty it is to find a solution are frequently themselves part of the problem. This seems to be the case in London. It is hardly surprising that initiatives such as the London Health Planning Consortium, Tomlinson 7, Turnburg 8, and Darzi 3 seldom achieve more than 20% of their potential.

Lead time to change

As a result, the time taken to achieve necessary changes is protracted. Sometimes it seems as if there is a rule that from the perception that change is necessary to its implementation is about thirty years. Whether it is the relocation of hospitals, the merger of medical schools or the development of clinical networks coordinating services across hospitals rather than within them, this delay seems only too frequent. To make it even worse, time after time, a group has become knowledgeable, expert and effective but before the full results of their efforts are harvested, it has been dismantled. This happened after the London Health Planning Consortium, Tomlinson and Turnberg. A central hospital board for London was suggested 150 years ago. Only recently was one achieved in NHS London and it too has gone. If there is any lesson to be drawn from the history of London's hospital and health system it is that nobody gains in the long run from the absence of a central focus for handling London's health problems, although it needs to operate openly and transparently.

An institutional history is not the place to predict the future, or even to identify the key issues for solution. However some the problems of the past are past are still with us, primary care, 'hospital abuse' with patients coming to hospital that could be cared for in the community, rivalries between institutions, lack of capacity where and when it is needed, and planning services to meet the needs of our patients.

There remain great strengths in London hospital medicine and its research base, which by any standard should be preserved as foundations for the future. Working in London's hospitals, and managing them, has never been easy, nor will it be in the future. It is a certainly memorable experience.

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Ministers of Health from 1948

Bevan Aneurin	Labour	August 1945 - January 1951
Marquand	Labour	January 1951 - November 1951
Crookshank	Conservative	November 1951 - May 1952
Macleod	Conservative	May 1952 - December 1955
Turton	Conservative	December 1955 - January 1957
Vosper	Conservative	January 1957 - September 1957
Walker-Smith	Conservative	September 1957 - July 1960
Powell Enoch	Conservative	July 1960 - October 1963
Barber Anthony	Conservative	October 1963 - October 1964
Robinson Kenneth	Labour	October 1964 - October 1968

Secretaries of State for Social Services

Crossman Richard	Labour	November 1968 - June 1970
Joseph Keith	Conservative	June 1970 - March 1974
Castle Barbara	Labour	March 1974 - April 1976
Ennals David	Labour	April 1976 - May 1979
Jenkin Patrick	Conservative	May 1979 - September 1981
Fowler Norman	Conservative	September 1981 - June 1987
Moore John	Conservative	June 1987 - July 1988

Secretaries of State for Health

Clarke Kenneth	Conservative	July 1988 - November 1990
Waldegrave William	Conservative	November 1990 - April 1992
Bottomley Virginia	Conservative	April 1992 - July 1995
Dorrell Stephen	Conservative	July 1995-May 1997
Dobson Frank	Labour	May 1997- October 1999
Milburn Alan	Labour	October 1999 – June 2003
Reid John	Labour	June 2003- May 2005
Hewitt Patricia	Labour	May 2005- June 2007
Johnson Alan	Labour	June 2007- June 2009
Burnham Andy	Labour	June 2009 - May 2010
Lansley Andrew	Coalition	May 2010 - September 2012
Hunt Jeremy	Coalition	September 2012 December 2019
Hancock Matthew	Conservative	December 2019 -



Biographical notes on Sir Henry Burdett, 1847-1920

A man of many parts with boundless energy, Burdett began his working life in a bank, but at the early age of twenty-one he was appointed hospital superintendent to the Queen's Hospital, Birmingham. He came to be well known to Joseph Chamberlain (Mayor of Birmingham 1873-5) who was notable for combining effective social reform with sound business principles. Having virtually doubled the income of Queen's Hospital in six years, he became house governor to the Seamen's Hospital, Greenwich, where he again revitalised the hospital, attracted new funds and trained a number of young but rising administrators. Though lacking the time to take finals, he entered himself as a medical student at Guy's and so impressed those he met that he was appointed secretary to the Shares and Loan Department of the London Stock Exchange in 1881, leaving Greenwich.

His book, *Prince, Princess and People*, a sketch of social progress exemplified by the work of the Prince of Wales (later Edward VII) attracted influential attention. An active participant in the Social Science Association, his organisation of the first hospital conference led to the establishment of the Hospitals Association in 1884. He founded, in conjunction with the Hospitals Association, a weekly journal, *The Hospital*, which

became his personal platform. He was one of the earliest workers in the cause of Hospital Sunday, was the author of a four volume classic *Hospitals and Asylums of the World* (1893), and launched Burdett's *Hospitals and Charities - the Year Book of Philanthropy*. This became the leading annual reference book on hospitals and it appeared until the 1990s as the *Health Services Year Book*.

As his reputation and influence grew, he took the precaution of taking a shorthand writer to meetings with him, for his blunt comments were sometimes misquoted. A governor of many hospitals, his long and wide ranging experience of hospital administration and finance made him a formidable adversary. He was interested in the development of the nursing profession, writing a book to help girls wishing to enter nursing, and establishing the Royal National Pension Fund for Nurses. He, and his journal, supported the establishment view of his day that a register for nurses would be disadvantageous, siding with Miss Nightingale and Miss Liickes against Mrs Bedford Fenwick. His obituary in *The Lancet* describes him as a kindly hospitable man whose mind moved on large lines towards large objectives, but who could never subdue the instinct for oratorical effect, the dramatic pause and gesture. His writings and criticisms were robust, and those who did not measure up to his high standards would find a caustic comment in *The Hospital*. He therefore made enemies as well as friends. Active in visiting hospitals and always sympathetic to appeals for advice, he had no patience with inefficiency. While he believed that more men of accomplishment were needed on hospital boards, those devoting themselves to the noble cause of the hospitals had to give their all, as he did himself. For his services he received first the KCB and later the KCVO.

Burdett recognised that hospitals must demonstrate soundness and economy of management if they were to survive, but he viewed them with something approaching reverence. 'The concept of the voluntary hospitals of this country constitutes one of the noblest monuments of our Christian civilisation. We believe and hope that the day is far distant when any serious attempt will be made to substitute State hospitals for the noble medical charities scattered throughout England, charities which are at one and the same time the wonder of foreigners and the just glory and pride of the British nation.'

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Sir Henry Burdett. *The Hospital*, 1920, ii, pp 129-147

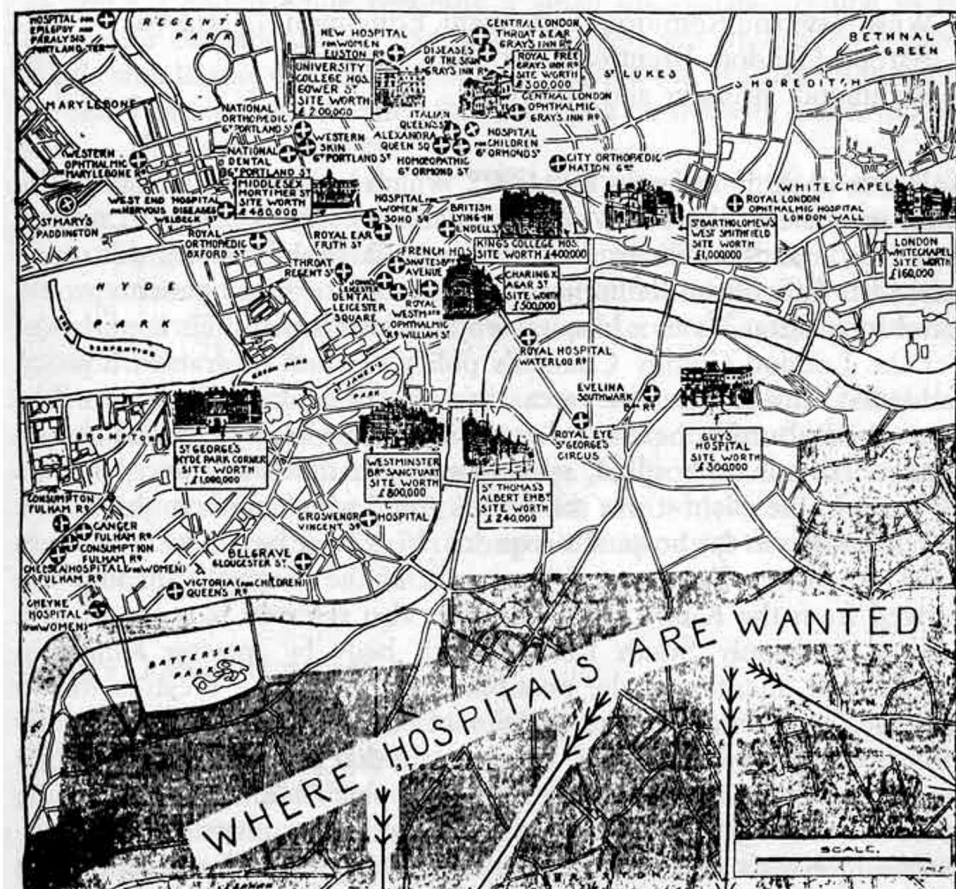
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Besides tracing the development of the system from the year that saw the foundation of the Lancet, this book considers the major influences on the hospitals such as specialisation, medical education, developments in nursing and the frequent financial crises with which the hospitals had to deal. The hospitals were more remarkable for their individuality than their common sense of purpose.

Comments on the First Edition

"a welcome perspective of today's debate over London"

"an invaluable history of London's healthcare system"

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