

The Management of Paediatric Hospitals

Unlike the state owned French hospitals that were intended to receive all comers, the British paediatric hospitals were designed to care for the children of the 'deserving' poor. Any family enjoying a high income, or even what were then considered adequate wages, was expected in case of illness to consult a general practitioner rather than to exploit the free services provided by the voluntary hospitals. At the other end of the economic scale, families on relief, who had thus become associated with the Poor Law system, were to be denied attendance at the new paediatric hospitals on the principle that they were already the recipients of public aid. To ensure that only the deserving poor were served, a subscriber's letter of recommendation was usually required before a child could be admitted either as an outpatient or as an inpatient.

These arrangements were not novel but replicated those introduced by voluntary general hospitals established in cities and towns throughout the country since the early eighteenth century.¹ Because all these institutions relied almost entirely on charitable contributions for funding, donors and subscribers also played a leading role in management. Usually, anyone providing the minimal annual subscription (varying from 1 to 5 guineas), or a suitable donation (10 to 50 guineas) became a governor of the hospital as well as being entitled to provide letters of recommendation for a set number of out- and inpatients. From among their own members, the board of governors elected a committee of management which generally met every two weeks to review hospital affairs. The attending physicians and surgeons received no salary but usually could recommend patients and sometimes were represented on management committees. On the whole however, as indicated by Brian Abel-Smith, while the physicians ran the medical affairs of the hospital they were not formally involved in general management.² As hospitals expanded, and administration became too complex to be casually dealt with by the governors in their spare time, full time secretaries were appointed and usually paid for their onerous duties. But as the secretaries were lay and usually belonged to 'the governors' own social circle', this move tended to accentuate the separation between the administration and the medical staff.³

In general the paediatric hospitals based their systems of management on the above principles but with some differences corresponding to their small size, special aims and also reflecting their emergence during an era of hospital reform. No less than nine children's hospitals were established in Great Britain during the 1860s, during which decade an apparently increasing incidence of hospital infection had led to the government investigation not only of Poor Law institutions but also of voluntary and endowed

¹ For a discussion of the organization of voluntary general hospitals, see: John Woodward, *To Do the Sick no Harm: A Study of the British Voluntary Hospital System to 1875* (London: Routledge and Kegan Paul, 1974), pp. 23–44.

² Brian Abel-Smith, *The Hospitals 1800–1948* (London: Heinemann, 1964), pp. 33–5.

³ *Ibid.*, p. 32.

hospitals.⁴ In 1863 John Syer Bristowe and Timothy Holmes (then assistant surgeon to Great Ormond Street as well as to St. George's Hospital) produced a 281 page report for the Privy Council on the management, construction and sanitary state of 103 hospitals in the United Kingdom, including the few paediatric hospitals then extant.⁵ This inquiry was mainly concerned with hygiene and the prevention of infection, which also formed the focus of two other investigations independently launched in 1866 by the *Lancet* and by the Poor Law commissioners with reference to the care of the sick in workhouses.⁶ Deficiencies were frequently considered as due to lax management, and the multiple inquiries promoted an atmosphere conducive to the trying out of novel methods of administration, the commonest being the appointment of a full time hospital secretary. In spite of their small size, most of the children's hospitals made such an appointment at their inception. As far as the medical staff were concerned, the most important requirement was to gain representation on boards of management and the second half of the nineteenth century witnessed medical efforts to achieve this end.

Since physicians were usually deeply involved in the establishment of paediatric institutions, they were not prepared to be as servile to lay management committees as had been customary in the past when the medical staff had been perceived as employees, albeit unpaid, and not expected to interfere with hospital organization. In the middle of the nineteenth century medical officers were still excluded from the management committees of the London teaching hospitals, although they could become governors at University College, the Westminster, St. George's and St. Mary's.⁷ Governors, however, were mere figureheads, with the important exception of those elected to form the board of management. Great Ormond Street began with the usual arrangements but, by 1855, the two senior hospital physicians, William Jenner and Charles West, and the surgeon, Athol Johnson, had all been admitted to the committee of management. In addition, the attending hospital physicians and surgeons were members of a medical committee that met every two weeks to prepare a report for the committee of management. Thus the medical staff negotiated as an organized group with the management committee, whereas in older institutions this committee had usually heeded only distinguished individual physicians with special claim to attention.

Yet Great Ormond Street proved to be somewhat exceptional for most other paediatric hospitals began more traditionally with no medical representation, or only the founding physician on the board of management. The latter often wielded great influence, as in the case of Dr. Borchardt at Manchester, or of Dr. Arthur Farre at the Evelina, because of their intimate ties with the financial patrons of their respective institutions. Baron Ferdinand de

⁴ Special hospitals for children were established in Birmingham (1861); Gloucester (1867); Brighton (1868); Nottingham (1869); also the following in London: the Victoria Hospital (1866); the North Eastern (1867); the East London (1868); the Evelina (1869); and the Hospital for Hip Diseases in Childhood (1867).

⁵ *Report by Dr. John Syer Bristowe and Mr. Timothy Holmes on the Hospitals of the United Kingdom*, B.P.P. 1864, XXVIII, pp. 463–743.

⁶ *Report of the Lancet Sanitary Commission for Investigating the State of the Infirmaries of Workhouses* (London, 1866); *Report of H. B. Farnall, Esquire, Poor Law Inspector, on the Infirmary Wards of the Several Metropolitan Workhouses* . . . , B.P.P., 1866, LXI; and also, *Report of Dr. Edward Smith, Medical Officer of the PLB, on the Sufficiency of the Existing Arrangements for the Care and treatment of the Sick Poor in Forty-eight Provincial Workhouses in England and Wales*, B.P.P., 1867–8, LX.

⁷ Geoffrey Rivett, *The Development of the London Hospital System 1823–1982* (London: King Edward's Hospital Fund for London, 1986), p. 35.

Rothschild funded the Evelina but depended on Farre, who was chairman of the otherwise lay management committee for the first six years, to plan, organize, and run the hospital.⁸ More widespread medical representation on the board of management at Great Ormond Street was, at least in part, a sign that Charles West was not to be entrusted with the superintendence so often granted to medical founders.

Initially, lay hospital managers, and the select group of physicians in their confidence, did not envisage sharing control with even senior medical officers who usually obtained representation only with difficulty, after many years of struggle and sometimes only as the consequence of an upheaval that publicized existing discord between management and staff. At Birmingham officers of the hospital were excluded from belonging to the management committee even though this hospital was most progressive in its admission policy, being a free hospital not requiring patients to be furnished with governors' letters. Nevertheless, the voluntary medical staff had to wait until 1903 before being eligible for election to the management committee.⁹ The original constitution of the Edinburgh Hospital for Sick Children decreed that officers of the institution should not act as directors, which effectively excluded the physicians from the board of management since its members were selected from among the directors. However, in 1861, this ruling was rescinded, enabling ordinary physicians to be elected as directors.¹⁰ But this medical advisory role was again undermined in 1869 when the directors decided to dispense with the annually elected medical committee, as being unnecessary.¹¹ No longer an organized group and with no certainty that anyone would be elected a director, let alone a member of the committee of management, the hospital physicians were reduced to venting their opinions and feelings via personal communications with the senior hospital secretary, John Henry. This state of affairs seems to have persisted until 1890 when one of the ordinary physicians, Dr. James Carmichael, wrote to the hospital secretary in protest. As he explained at a special meeting of the directors convened to appease the medical staff: 'the physicians considered there was a want of touch between the Medical Staff and the Directorate arising from the fact that the Staff had no voice even in regard to matters directly connected with the Medical and Surgical affairs of the Hospital'. Carmichael illustrated this point by stating 'that the Staff had various suggestions to make as to the Pathological department which they should have wished to bring forward before the last election of a Pathologist took place'. They had no opportunity to do so and, as he pointed out, 'in other like institutions the Staff were represented either in the Governing Body or on the Committee of Management, or on a Medical Committee'.¹² The regulations extant at other paediatric hospitals, namely Great Ormond Street, Pendlebury, Shadwell and the Alexandra Children's Hospital at Brighton, were produced to support this contention but

⁸ H. E. Priestley, *The Evelina: The Story of a London Children's Hospital 1869–1969* (London: Guy's Hospital, 1969), pp. 7–8.

⁹ Rachel Waterhouse, *Children in Hospital: A Hundred Years of Child Care in Birmingham* (London: Hutchinson, 1962), p. 48.

¹⁰ The original constitution of the Edinburgh Hospital for Sick Children excluded the officers of the hospital from acting as directors but this rule was rescinded twelve months after the hospital was opened, because 'It has been found by experience that this is attended with disadvantage'. Edinburgh Medical Archives, Report by the Directors of the Hospital for Sick Children, 21 January, 1861.

¹¹ *Tenth Annual Report of the Royal Edinburgh Hospital for Sick Children* (Edinburgh, 1869), p. 10.

¹² Edinburgh Medical Archives, LHB 5/24/5/5, Meeting of Committee of Directors, 23 May, 1890.

the only concession finally received was that the medical staff could send a representative to a special meeting of the committee of management convened every two months.¹³

Lack of effective medical representation at the managerial level accounted for the fact that from 1880 until 1897 only very sketchy medical statistics were published in the annual reports of the Edinburgh children's hospital. The original reports had included listings of diseases suffered by inpatients, outpatients and also those visited in their own homes but after 1880 the reports were mainly dedicated to financial matters such as recording donations and contributions. In July 1890 Dr. Carmichael was again challenging the directors with the suggestion that the annual publication of a report of important cases, with some detail as to treatment and outcome, would be useful for instruction and of interest to the profession.¹⁴ Partial success was scored by co-operation with the other Edinburgh teaching hospitals and the publication of the *Edinburgh Hospital Reports*, beginning in 1893. Here the physicians could publish clinical papers but the statistics for the Children's Hospital remained scanty until 1897 when more detailed tables once more made their appearance in the hospital annual reports.

At Manchester also the senior hospital physicians had trouble with representation for decades, and a couple of well publicized 'scandals' were required to settle matters in the 1880s. According to the 1856 rules the medical officers of General Hospital and Dispensary for Children were members of the Board of Governors *ex-officio*. Furthermore they were expected to meet at least once a month to draw up a medical report to be presented at the next meeting of the board of governors. A more complete survey was required for the annual general meeting and was incorporated in the annual report. This would seem a most progressive arrangement except that in the early years only Louis Borchardt, one of the founders of the hospital, qualified for representation on the executive committee and was thus the only physician with a voice in management. However, as the hospital expanded so did the honorary medical staff and by 1873 three physicians, Dr. Borchardt, Dr. Gwyther, and Dr. W. Barlow, were on the executive committee *ex-officio*. At this point, however, the move was made from Bridge Street to the new hospital at Pendlebury some miles from the centre of town. Because voluntary medical officers could hardly be expected to spend their time and money travelling backwards and forwards between the outpatient department at Gartside Street in Manchester and the main hospital in Pendlebury, it was then decided that new appointees should be salaried, full time employees. As such they lost the privilege of being members of the board of management, which left only Borchardt and the honorary physician to the dispensary (which remained in Manchester) to act as medical advisors to the directors.

For the next few years confusion reigned especially after the resignation of Borchardt in April 1876, as honorary physician and hospital director, although he retained his seat on the board of governors. In October 1876, this board asked for Borchardt's advice as to whether Dr. Charles Rayne, an assistant physician at the then respectable salary of £300, should be retained for another year. 'Dr. Borchardt's opinion being not altogether satisfactory to the Board', according to the minutes, 'the chairman was requested to see

¹³ *Ibid.*, 26 May, 1890.

¹⁴ Edinburgh Medical Archives, LHB 5/37/9(5), Copy of Letters by the Medical Officers . . . to the Directors, 5 July, 1890.

Dr. Rayne and state that a new engagement could only be entered into for three months'.¹⁵ During this time a successor was sought while the board refused Rayne's request for an interview and explanation, so obliging him to resign early in December. In an indignant letter to the *Lancet*, published on 6 January 1877, Rayne protested that he was given no reason for being fired 'but it was rumoured that the action was taken on the representation of Dr. Borchardt that, as a medical question, it was beyond the province of the Committee to inquire into it'.¹⁶ The chairman of the board of governors sent a reply to the *Lancet* suggesting that the extension for three months was made 'out of kindness to Dr. Rayne', and ending thus: 'the allegations about Dr. Borchardt . . . are quite at variance with what occurred at the monthly meeting, and Dr. Rayne's subsequent application for an interview with the Board was unanimously refused on the ground that there was nothing to discuss'.¹⁷ Further correspondence ensued reinforcing the impression that, whatever the merits of the case, the governing board of Pendlebury Hospital felt entitled to dismiss a senior physician without explanation in part because, as the recipient of a salary, he was a mere employee. Almost exactly three years later Rayne's successor, Henry Humphreys, also quit the hospital under a heavy cloud of resentment. His case will be discussed in a subsequent chapter since it involved relations between the medical and nursing staff, but again the arbitrary influence of Dr. Borchardt on the board of management was called into question. Suffice it to say at this point that following the unwelcome publicity in medical journals and in the *Manchester Guardian* given to the 'Humphreys affair', Pendlebury Hospital returned to the original policy of including medical officers on the executive committee of governors. Now, in 1880, the influence of Borchardt, who had returned as consulting physician, was diluted by that of three other physicians and at least two surgeons, if these were prepared to attend committee meetings. Finally, and at the expense of the two individuals who had been obliged to resign, the medical officers obtained the basis for influencing, or at least being knowledgeable about, managerial decisions.

The power to make important decisions resided with the committee of management, any medical committee being merely advisory. One of the latter's functions was to interview medical candidates for staff appointments then make a recommendation to the committee of management. At Great Ormond Street both groups were usually in agreement and confirmation thus speedily obtained. In June 1868, however, the committee of management at Great Ormond Street passed over the candidate for assistant surgeon proposed by the medical committee and appointed Howard Marsh instead. The medical committee was outraged at being given no explanation for the change and also because one of its members, Charles West, had encouraged Marsh to persist with his application by directly canvassing the members of the management committee. The medical committee report of 10 July 1868, stated 'that this Committee regard as a grave impropriety the course which Mr. Marsh has taken in privately soliciting members of the Managing Committee with the object of setting aside the nomination of this Committee'.¹⁸ West was also taken to task for supporting Marsh and the full text of his letter (written on 26 June) to

¹⁵ Salford City Archives, G/HRM/AM2/3, Board Minutes, 28 October, 1876.

¹⁶ 'Letter to the Editor of the *Lancet*', *Lancet*, i (1877): 32.

¹⁷ 'J. H. Agnew, Chairman of the Board of Governors, to the Editor of the *Lancet*', *Lancet*, i (1877): 108–9.

¹⁸ Great Ormond Street Archives (hereafter G.O.S. Archives), Medical Committee Report, 10 July, 1868; these pages, 137–40, were later deleted.

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Marsh was copied into the report. Recriminations were so bitter that West attempted publicly to defend his own conduct in a letter to the *British Medical Journal*, published on 11 July 1868. Included therein was a copy of the letter he had sent to Marsh explaining the options available and containing the following advice:

It is in the power of the Managing Committee to confirm or to reverse the recommendation of the Medical Committee. It is, therefore, open to you to address to them, as a body, any letter that you think proper at their meeting on Monday, and also to each, or any, or all of them privately, and make to them such representations as may enforce your claims.¹⁹

In effect, however, the medical committee was completely outmanoeuvred for Marsh retained his appointment and the committee was prevailed upon to delete from the record its protests against West and Marsh. This was duly done on 22 July 1868. It should be added that such confrontations seem to have been extremely rare at Great Ormond Street since, as will be seen, the medical committee usually knew how to get its way without antagonizing the board of management. Appointing the senior hospital physicians as members of the management committee undoubtedly helped to facilitate intercourse, except in the above instance when the medical staff was disunited.

Since they were charity hospitals dependent on the goodwill of subscribers, most of the paediatric institutions began with a policy of admission through governors' letters of recommendation. A notable exception to this rule was the Birmingham and Midland Free Hospital for Sick Children founded in 1862. But, as indicated by Rachel Waterhouse in her history of the hospital, finding a more equitable method of selecting admissions proved difficult. As in other voluntary hospitals, the aim was to serve the deserving poor, defined as 'that class of sick persons, suffering from whatever serious ailment, who are above pauperism, and yet below the capacity of paying for a medical man'.²⁰ Originally the subscriber's ticket of recommendation was replaced by one signed by two 'respectable' householders, but this system rapidly proved unworkable since the people living close to the hospital were only too willing to provide a signature. Then the management committee decided to limit the issue of tickets to thirty a day, on a first come first served basis. This arrangement proved manifestly unfair since, as explained by Waterhouse, 'the roughest, rudest, and often the least deserving' were usually at the front of the queue.²¹ By November 1863, a new system had been introduced which proved so effective that it was retained for the rest of the century. The house surgeon or the dispenser became responsible for giving out tickets after checking on family finances, the type of illness involved, and whether the applicant was on relief. As may be imagined, all such investigations took time, and by 1864 the task of inquiring into family means had devolved to a newly appointed full time secretary. The smaller children's hospitals at Nottingham, founded in 1869, and at Bradford, founded in 1883, also instituted free terms of admission.

The more usual method of selection via a governor's letter proved unsatisfactory in that admission depended on knowing the right person rather than being critically ill, but most management committees did not attempt reform for fear of antagonizing their patrons.

¹⁹ Charles West, 'The election of assistant-surgeon to the Children's Hospital', *British Medical Journal*, ii (1868): 45–6.

²⁰ Waterhouse, *Children in Hospital*, p. 41.

²¹ *Ibid.*

Instead the system very gradually fell into disuse as it was replaced by more informal methods of admission. The parents of sick children, finding it time consuming and expensive to waylay a compliant subscriber, would simply turn up at the hospital outpatient department where the medical staff felt duty bound to treat the children and even admit them if deemed sufficiently ill, or thought to be interesting cases. During its first year Great Ormond Street had 112 inpatients, of which only 31 were provided with governors' letters of recommendation whereas the remaining 81 were admitted directly from the outpatient room. The latter group comprised 'by far the more serious cases', according to the medical committee whose members obviously much preferred to select their own cases for treatment than to depend on the whims of subscribers.²² At this point the management committee did not object to direct admission from outpatients because of fears that the new hospital would be under used. Almost any sick child was welcome in those early days.

Very soon, however, it became obvious that there would be no shortage of patients and the management committee tried to restore priority at least for patients equipped with letters of introduction. Its members protested that the outpatient department was persistently overcrowded and even included persons who could apparently afford private medical care, that children under the age of two years were being admitted contrary to hospital regulations, and that fever cases were to be found on the general wards, while bearers of subscribers' letters were being refused admission and sometimes treated most unceremoniously. In 1854 the management committee suggested that cases of measles and whooping cough should be excluded from the wards, and that patients with governors' letters, 'when their cases are in conformity with the objects of this institution, should have the preference in admission before all others, unless a case of extreme urgency should present itself'.²³ The hospital physicians promised to restrict the number of fever cases but avoided the imposition of an absolute interdiction on admission of children with measles or whooping cough on the principle that complicated cases required hospital care. They 'perfectly concurred in the importance of giving patients sent by governors a priority of admission whenever there is the least approach to a parity between their cases, and those of other patients', but then began to look for means of ensuring that only medically challenging cases would be in conformity with the objects of the institution. Wishing to exclude chronically ill children, in 1857 the medical committee suggested that the printed circular, used to justify the non-reception of patients carrying governors' letters, should include a clause explaining that:

Many cases of rickets, of hip-joint disease or of scrofulous disease of the spine, are of necessity refused: either because they are quite incurable, or because they require nothing but rest for many months, or because good diet and fresh air for months or years are essential to improvement, and the reception of such cases would convert the hospital into an asylum for sickly children, instead of a place for the treatment and cure of the diseases of childhood.²⁴

²² G.O.S. Archives, Medical Committee Report, 19 November, 1852, pp. 43–4.

²³ G.O.S. Archives, Medical Committee Report, 17 May, 1854, p. 137.

²⁴ G.O.S. Archives, Medical Committee Report, 27 May, 1857, pp. 55–6.

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Seven years later, in 1864, the rules were revised to incorporate the above proviso. (Already in the eighteenth century patients regarded as having advanced scrofula were regularly refused admission at general hospitals such as the Edinburgh Royal Infirmary and the Aberdeen Infirmary.²⁵) Officially, the outpatient officers and house surgeon were still expected to admit all patients with governors' letters unless the hospital was full or the case was one specifically prohibited by hospital regulations, such as the above. If a medical officer rejected a case, he was supposed to write down the reasons on the letter of recommendation, and hand it over to the hospital secretary who would then communicate the decision to the subscriber. But the busy, or perhaps indifferent, outpatient attendants did not always adhere to this rule as evidenced by the complaint in January 1868, that 'in patient letters of recommendation signed by governors [have] again been found by the outpatient nurse in the assistant officers *rooms*, on which letters no cause for rejection is assigned'.²⁶ The house surgeon was given the responsibility of ensuring adherence to the rules but there were to be further examples of lax attention to subscribers' letters.

Another source of tension between the administration and the medical officers was the admission of babies to the hospital. At Great Ormond Street inpatients were supposed to be over two years of age but from the very beginning this regulation was not taken too literally. In December 1852, Charles West was explaining to the hospital secretary that there were indeed two babies in the hospital at the time but that one would have died if not admitted, whereas the other, although less critically ill, could not be nursed adequately at home for lack of space.²⁷ As the years wore on the number of infants admitted tended to rise; 32 children under the age of two were admitted in 1862, only 26 in 1866, but 54 in 1876, and as many as 80 in 1881. Periodically, the board of management issued rebukes, making the moral point that babies should not be separated from their mothers and the more practical one that they absorbed a larger share of scant hospital revenues than older children since they required more individual nursing when sick, and even when recovering, because they could not feed nor entertain themselves, quite often cried all night unless carried around by a nurse and were generally disruptive. However, no active steps were taken to restrict the admission of infants, the board of management apparently remaining content for the rest of the century merely to grumble and to retain the official prohibition in the books in spite of its continued flouting.

Other management committees struggled equally inadequately to restrict the number of babies on their hospital wards. In 1881, the committee of management at the Evelina gave the medical officers 'an instruction that in future the number of such cases [infants] should be as limited as possible, owing to the great tax it entailed upon the nursing staff of the hospital'.²⁸ But the instruction was scarcely heeded, and in 1889 the house surgeon was informed that infants 'should be refused save under very exceptional circumstances'.²⁹

²⁵ See, Guenter B. Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh* (Cambridge: University Press, 1986), p. 86; and Roger French, 'Surgery and Scrophula', in Christopher Lawrence (ed.), *Medical Theory, Surgical Practice: Studies in the History of Surgery* (London: Routledge, 1992), pp. 85–100.

²⁶ G.O.S. Archives, Medical Committee Report, 23 June, 1868, p. 104.

²⁷ G.O.S. Archives, Medical Committee Report, 29 December, 1852, p. 50.

²⁸ Greater London Record Office (hereafter G.L.R.O.), H9/EV/A2/2/1, Minutes of Committee of Management, 1875–1886, 13 January, 1881.

²⁹ G.L.R.O., H9/EV/A2/3, Minutes of Committee of Management, 1887–1898, 1 February, 1889.

Then, early in 1891, the management committee gave up the struggle, rescinding the regulation forbidding the admission of children under the age of two on the principle that it was futile to retain a rule that was so constantly broken.³⁰ Similarly, the original constitution of the Edinburgh Hospital stated that hospital admissions should be limited to children between the ages of two and eight years. Again the rule was immediately flouted for, during the first year, out of 140 inpatients 3 were below and 15 above the statutory age limits. Having admitted this deviation from regulations in its report, the medical committee disarmingly commented that: 'It is at the same time gratifying to remark that the press for admissions diminishes in a marked degree as the ages of two and of eight years are approached; a circumstance', the committee hastily added, 'clearly indicating that these limits as to age are well adapted to the wants of the class seeking the benefits of the Institution'.³¹ The following year 200 children were admitted of whom 4 were below and 37 above the established age limits. Gradually the proportion increased, the admission of babies usually being justified on the premise that they were too sick to be turned away.

The compromise hardly benefited many babies who were often so ill that they survived only a few hours or days. According to William Wallis Ord, 75 per cent of children under two years of age admitted to the Victoria Hospital for Children in 1892 had died. No wonder management committees attempted to hold down annual costs and death rates by excluding the admission of infants. But Ord believed such regulations to be 'absolutely unjustifiable', and that a better solution was to dedicate a ward with specially trained nurses for the exclusive care of babies.³² A similar proposal had been made by the medical staff of Great Ormond Street in the 1880s much to the anguish of Charles West who, although by then retired and powerless, wrote in protest to Lord Aberdare, chairman of the managing committee. True to his old form, West produced statistics from continental hospitals demonstrating the high mortality of babies in such institutions. Twenty-six hospitals for acutely ill children (as opposed to foundling hospitals) returned an average mortality of 41.5 per cent for children under the age of two years, whereas for older children the mortality was 13 per cent. Even at the St. Elizabeth, St. Petersburg, and the Leopoldstadt, Vienna, where infants were admitted with their mothers, or had wet nurses, the mortality was 40.3 per cent and 47 per cent respectively. As West indicated, 'the mere collection of a number of infants within the walls of an institution is in itself a source of danger'.³³ He was willing to accept that babies failed to thrive for no obvious reason when confined to institutions, whereas most of his medical contemporaries believed that modern methods, in the form of expert care and good food and hygiene, could perform wonders so long as the infants were not moribund on admission. Management committees, however, remained unenthusiastic about admitting babies except at the East London, which was the only British paediatric hospital to open a ward exclusively for infants during the nineteenth century. Of 1,533 patients admitted to the East London during 1893, 498 were under the age of two and no less than 221 of these infants died mainly due to various forms of tuberculosis, atrophy, bronchopneumonia and gastroenteritis.³⁴

³⁰ *Ibid.*, 30 January, 1891.

³¹ Edinburgh Children's Hospital Archives, Medical Report, 1 January 1861.

³² William Wallis Ord, 'The Utility, Peculiarities, and Special Needs of Hospitals for Children', in John S. Billings and Henry M. Hurd (eds), *Hospitals, Dispensaries and Nursing* (Baltimore: Johns Hopkins Press, 1894), pp. 363–79.

³³ Charles West, *A Letter to the Rt. Honble. Lord Aberdare* (London: H. Sotheran, 1887), p. 5.

³⁴ *The Twenty-seventh Annual Report of the East London Hospital for Children* (London, 1894) pp. 17–19.

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The management of all voluntary hospitals was complicated by uncertainty in funding. Ancient institutions such as St. Bartholomew's and St. Thomas's wielded hefty endowments but the rest had mostly to make do with whatever charitable donations they could coax from the public. Some years were leaner than others, following unfavourable publicity or economic downturns nationally or even locally. During the early 1860s the Lancashire 'cotton famine', induced by civil war in the United States, created a considerable increase in demand for care at the Dispensary of the Manchester Children's Hospital, from 2,080 outpatient admissions in 1860 to 4,636 in 1861 and 5,444 in 1862. The hospital coped but only just, in that the funds received hardly covered expenses. Dr. James Whitehead, one of the founders of the Clinical Hospital for Diseases of Children, Stevenson Square, Manchester, who was also having a hard time keeping his outpatient department afloat, complained in the pages of the *Manchester Guardian* that the Hospital and Dispensary for Sick Children was exaggerating the local infant mortality rate in its appeals for public support.³⁵ The two hospitals were competing for donations at a time of blighted economy for the whole Manchester region. But, even when the economy was more or less normal, new hospitals were often seen as a threat to older institutions. When the East London Hospital for Children, established in 1868 by Dr. and Mrs. Heckford, was desperately short of funds in 1874 and pleading for financial help, a medical man made the comment 'that there is no want in such a place as that, when the older hospitals need funds to carry them on; much better give the money to them and send the children to Great Ormond Street, or any other hospital'.³⁶

Under the existing system, or rather lack of system, voluntary hospitals were launched piecemeal as acts of faith that the communities they served would support them. Since the paediatric hospitals were designed to care for poor children they could not expect funding from their patients' families but turned instead to the local gentry and tradespeople. Continuous exhortation seems to have been necessary to maintain a flow of funds, and management committees frequently understated their assets in annual reports so that their pleas for financial assistance would not appear unjustified. Income usually exceeded expenditure and the surplus was invested to form a reserve fund which was frequently glossed over, or even unmentioned, in the annual report. Managers were probably wise in using this subterfuge since the reserve fund was the only immediate source of cash in an emergency and also served as a reservoir to be tapped when expansion was contemplated. In 1872 Great Ormond Street seemed well off with an income from subscriptions and donations of £12,590, plus £19,000 in invested funds, and a running expenditure of only £7,715. However, a new hospital was then under construction which, according to the management committee, required the expenditure of about £1,000 per month from invested capital in addition to slightly over £3,000 donated in 1872 to the special 'building fund'.³⁷ As anticipated by the hospital managers, the public contributed generously to this special fund without which the total cost of the new hospital, £31,611, could not have been met.

³⁵ *Manchester Guardian* (1864), 6 January, p. 4.

³⁶ *Seventh Annual Report of the East London Hospital for Children* (London, 1874), p. 22; the quotation was from an article extracted from the *Pall Mall Gazette* (1870), 7 April, where it was pointed out that people in the neighbourhood of the financially ailing East London might not think it 'much better' to give the money to Great Ormond Street.

³⁷ *Twenty-first Annual Report of the Hospital for Sick Children* (London, 1873), pp. 6–9.

In 1872 Great Ormond Street was only one, albeit the largest with 127 beds, of five paediatric hospitals in London with inpatient facilities. The next largest, the Evelina, opening in 1869 with 100 beds, was apparently more secure financially than the rest since its founder, Baron Ferdinand de Rothschild, and his family, then covered all expenses. Yet the financier was not prepared to shoulder the whole burden indefinitely, so, in 1871, appeals for public support were made to collect sufficient extra money to balance the books and facilitate expansion. The response was so meagre that only a portion of the 100 or so available beds were in use at any one time, 40 in 1872, 56 in 1874, 66 in 1882 and, according to H. E. Priestley, not until 1903 did the number exceed 70.³⁸ Since the Evelina accepted children of all religious denominations and had one ward set aside for Jewish patients, the lack of generous donations, particularly on the part of the local Jewish community, may seem surprising. In part, however, parsimony was due to the Evelina being perceived not as a public charity but as the private preserve of the Rothschilds, with the baron as permanent president of the hospital and his friends in control of the management committee. By 1892, during which year stock amounting to £1,500 had to be sold to cover expenditure, the baron decided 'to withdraw those restrictions which hitherto existed owing to its private character, and to give the public the control in its management'.³⁹ Meaning that henceforth his wishes would be replaced by a constitution and that ordinary subscribers would no longer be passive donors but would elect, from their own group, members to a now enlarged management committee, as was the norm elsewhere. Now the Evelina would have the best of both worlds for, in spite of relinquishing much authority, the baron continued his support of the institution and left it well endowed, with a bequest of £100,000, at his death in 1898.⁴⁰ At the turn of the century the Evelina was declaring a slight excess of ordinary income, £6,150, over an expenditure of £6,003, while the other London paediatric hospitals, including the Hospital for Sick Children, were then apparently operating in the red or close to it.⁴¹

As we have seen, the plea of financial stress was used by management committees as a means of attracting further subscriptions and donations. But the technique could also have unwanted repercussions, in that the concerned and contributing public began to want to know how the money was being spent, whether wisely or wastefully. Considerable sums were involved (see Table 2). According to an article in the *Westminster Review*, the income for 1872 of the seventy-eight voluntary hospitals and thirty-six charitable dispensaries then extant in London was about £600,000. If income was assumed to equal expenditure, then 'an amount equal to three shillings per head of the whole population [of London, then just under four million] is spent annually in the voluntary gratuitous medical relief of patients not afflicted with mental disease'.⁴² However, since over 58,382 inpatients, 830,000 hospital outpatients, and 253,665 dispensary patients had benefited, presumably, from this largesse, the modern reader is left wondering how so much could be accomplished for so little. But to the 1874 reviewer the sum seemed enormous particularly since 'in Manchester, where wealth abounds in a maximum degree, the cost of voluntary

³⁸ Priestley, *The Evelina*, p. 10.

³⁹ *Evelina Hospital for Sick Children, Annual Report for 1892* (London, 1893), p. 4.

⁴⁰ Priestley, *The Evelina*, p. 14.

⁴¹ Henry Burdett, *Hospitals and Charities 1901* (London: Scientific Press, 1901), pp. 263–4.

⁴² 'Medical Charity: Its Extent and Abuses', *The Westminster Review*, 45 (1874): 174–224 (182).

medical charity is, in proportion to the population, far less than it is in London'.⁴³ Expenses in Manchester worked out at less than half of the three shillings attributed to each person living in the London area, for not only did a smaller proportion of the Manchester population benefit from medical charity, but also on average each recipient cost less to be treated. The appended 'List of the Principal Children's Hospitals in 1900' (Table 1), suggests that Londoners used their paediatric outpatient departments more extensively than did provincial city dwellers, presumably because the metropolitan hospitals were prepared to spend greater sums of money on the required facilities. During 1900, Great Ormond Street coped with nearly 24,000 new outpatients whereas the Manchester Children's Hospital had just under 15,000 'admissions' to its Gartside Street Dispensary. All the paediatric hospitals in London had large numbers of outpatients relative to their bed size. Thus the Evelina, with only 66 beds in use, cared for 19,489 outpatients in 1900, and the even smaller Paddington Green Children's Hospital (46 beds) dealt with nearly 14,000 outpatients. Overall the provincial paediatric hospitals provided for far fewer new dispensary patients either because the local parents were not so trusting of hospital care or because they were more satisfied than their London counterparts with the general practitioner services available to them. The metropolis was also favoured in that it was the haven for aspiring specialists, by far the best part of the country in which to make a name and then be successful in private practice. So the London special hospitals were partially constrained to provide patients and experience for their ever enlarging medical staff, while their provincial counterparts could practise greater thrift.

Nevertheless, comparing costs from hospital to hospital and from region to region was an obvious, and deceptively easy, way to challenge the management of the more expensive institutions. No account need be taken of diversity between regional labour costs or of the differing services, and therefore requirements, of the various classes of hospitals. In April 1868, *The Times* ran a leading article criticizing the managing committee of the Hospital for Sick Children for its extravagance.⁴⁴ Since, according to this editorial, the London Ophthalmic Hospital annually relieved nearly the same number of in- and outpatients as Great Ormond Street for about half the costs, it would appear that funds were being wasted in the latter institution. 'It is probably not difficult to ascertain pretty closely what is the average cost of a patient in a Hospital', *The Times* stated, 'and if this average be, as we believe, largely exceeded in this instance, it is certain there must be something amiss, and the Committee ought to institute a close examination'. Ever watchful over the interests of Great Ormond Street, Charles West immediately wrote to *The Times* indicating that its editorial was based on fallacious arguments.⁴⁵ In the first place, to compare costs on the basis of the annual total of inpatients was misleading. The critical figure was the number of beds occupied at any one time, a maximum of 75 at the Hospital for Sick Children versus only 40 at the Ophthalmic Hospital. On this criterion the difference in costs per bed between hospitals fell appreciably and was, according to West, £60 for Great Ormond Street versus £45 for the eye hospital. Secondly, a larger number of nurses and supporting staff were required at the former hospital not only because of the greater bed occupancy but also because children needed more constant attention than adults. Unimpressed by West's

⁴³ *Ibid.*, p. 183.

⁴⁴ Editorial, *The Times* (1868), 17 April, p. 9.

⁴⁵ *The Times* (1868), 21 April, p. 5.

explanatory letter, the editor continued to doubt 'whether an expenditure of £60 a head per annum is necessary for the treatment of sick children'.⁴⁶ His censure of the management of Great Ormond Street did not, however, result in any obvious pecuniary loss to the hospital, since receipts for 1868 showed an increase of nearly £100 in annual subscriptions and of more than £300 in donations over the previous year.⁴⁷ Perhaps West's logic had proved more persuasive to any potential contributors than had *The Times*'.

Financing the voluntary hospitals continued to be a growing source of contention. During the late 1860s, the concept of hospitals being used, or rather 'abused', by patients able to pay for health care came to the forefront. To a large extent the discussion was one-sided in that nearly all the commentators took for granted the reality of extensive 'hospital abuse' and assumed that, if opportunistic patients could be excluded from the voluntary hospital system, all would be well. Many critics condemned the specialized hospitals as being particularly wasteful of funds because they duplicated services that could be provided by the larger, and therefore presumably more cost effective, general hospitals. Struggling medical practitioners also resented the special hospitals for providing free care at their expense. One wrote to the *Lancet* in 1869 to complain that since the establishment of Great Ormond Street, 'my practice of giving advice in my surgery for 1s. or 1s. 6d. a time, has fallen off to the extent of 30s. per week, a sum which I can ill afford to lose'.⁴⁸ Apparently reasonably prosperous people, who would not think of going to a general hospital, did not hesitate to apply to a special one in the belief that there they would receive the best possible advice.⁴⁹ Such a reputation was exactly what was desired by West and others for the paediatric hospitals, but without the accompanying censure from people critical of the multiplicity of hospitals in the London region.

One such adversary contributed a lengthy article on London hospitals and dispensaries which was published in *The Times* early in 1869.⁵⁰ The author, a physician judging from the style and content of the essay, considered the whole system inefficient, wasteful, and unfair to all parties involved, that is to patients, subscribers, physicians and medical students. Because the large general hospitals had failed to establish special departments and retained only a small and exclusive medical staff, frustrated and ambitious physicians had looked elsewhere to establish fields of practice. The consequence was a plethora of small specialized institutions, far more expensive to run, and contributing little, if anything, to medical education, since 'the majority of men being educated for the Medical Profession cannot or will not attend'. Incidentally, this criticism was applicable to Great Ormond Street, which had instituted lecture courses in 1859 but had great difficulty in attracting a reasonably sized audience.⁵¹ As far as the writer in *The Times* was concerned, the children's hospitals achieved nothing that could not be done as well, or better, in the wards of the established general hospitals.

⁴⁶ Ibid.

⁴⁷ *Seventeenth Annual Report of the Hospital for Sick Children* (London, 1869), p. 9.

⁴⁸ 'Abuse of Hospital Relief', *Lancet*, i (1869): 212.

⁴⁹ William Fairlie Clarke, 'The Medical Charities of London', *Quarterly Review*, 136 (1874): 371–94 (378).

⁵⁰ 'London Hospitals and Dispensaries', *The Times* (1869), 30 January, p. 4.

⁵¹ G.O.S. Archives, Medical Committee Minute Books, vol. 3, 14 January, 1863, 'The committee considered the question of continuing the lectures:- Mr. Holmes reported the small attendance this day and it was determined that if the attendance on the next occasion should be less than six no further advertisements should be inserted'. Clinical lecture courses were continued because of the importance of teaching for the reputation of the hospital.

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Four hospitals for children, one hospital for women, and two for women and children, make up a total of 285 beds between them, and thus seven buildings, seven committees, seven sets of paid house-surgeons, secretaries, clerks, collectors, matrons, and other officials, seven sets of advertisements, seven repetitions of expenses for printing, stationery, and postage, are caused by institutions that, if all put together, would still form an aggregate far smaller than many of the great London hospitals. The reason why seven have been founded is probably that there were seven medical men who wished to gain experience in the treatment of such patients; while the regulations of previously existing hospitals, whether general or special, afforded no room for the gratification of their laudable ambition.

One can conclude that the writer preferred the Parisian hospital system, with three children's hospitals of over 500 beds each then extant, although he might have balked at the revolution which had enabled the French completely to revise their system of health care. In England, in contrast, change occurred only piecemeal as dictated by individual need and enterprise. As pointed out by numerous critics, the consequence for London was a veritable hodgepodge of small, medium and large institutions mainly concentrated in the more affluent northern and western city districts. Thus an unwieldy, disorganized and expensive system had emerged which did little to supply the health requirements of the more needy centres of population in east and south London.

On balance the children's hospitals provoked less discontent than did those specialized in dealing with specific disease categories. The former could be considered as general hospitals for a specific age group, receiving acutely ill children who could not usually be nursed at home, whereas eye, skin and orthopaedic hospitals were attracting mainly chronically sick patients who formed the pecuniary mainstay of general practice. The *Lancet* and the *British Medical Journal* seem to have been favourably disposed to the paediatric hospitals even though both journals took pride in representing the interests of ordinary doctors so bitterly opposed to the growing number of special institutions. In 1869, when the *Lancet* investigated the administration of outpatient departments of London hospitals, Great Ormond Street's peculiar problems received thoughtful consideration. To quote from the *Lancet* report:

With respect to the social standing of the patients, the physicians remark that occasionally ladies present themselves who are elegantly dressed, but that by far the majority belong to a lower class. We saw none of the former [during one week, with 1510 patients attending], and believe that it would be impossible to commit the power of refusal to any officer. Complaints are indeed made by the local practitioners of the injury inflicted on them by this facility in obtaining gratuitous advice and help; but it is right to state that the [management] Committee are evidently alive to the difficulty of discrimination. With every desire to extend over as wide an area as possible the benefits of the hospital, they cannot and do not shut their eyes to the fact that great vigilance is required to prevent the benefits of an institution intended for the relief of the really poor from being diverted to a class in very far better circumstances.⁵²

In 1869 over 15,000 new patients were brought to the outpatient department at Great Ormond Street where the facilities were described by the *Lancet* investigators as 'totally

⁵² 'The Lancet Investigation into the Administration of the Out-Patient Department of the London Hospitals. No I. The Hospital for Sick Children, Great Ormond Street', *Lancet*, ii (1869): 553-4.

insufficient' for carrying out the work. The same year the management committee attempted to restrain the flow by ruling that no patient would be prescribed to for a second time except on the production of a letter signed by a subscriber, minister of religion, or a doctor. The idea was to continue with the relatively free reception of new patients, but to discourage trivial cases from returning. This new system, or perhaps the overcrowding and long waiting period to which all patients, except the most sick, were subject, had an effect for attendance figures fell slightly in the next few years. During this time a larger hospital was being erected and in June 1875 the new outpatient department was opened. It rapidly became all too popular with even 'persons in a superior position availing themselves of its benefits'.⁵³ To remedy this evil, the management committee sought help from the Charity Organization Society. Now, to be eligible for a second visit, parents must take a form, furnished by the hospital, to be approved and signed by an officer of the Charity Organization Society. No family with an income of more than 30s. per week need apply for the officers of the Society were dedicated to eradicating unjustified claims to charity. In 1876 the number of outpatients was 3,841 less than in 1875, but the management committee of Great Ormond Street estimated this gain of dubious value since it had been obtained at the expense of much friction with parents, with subscribers, and even with the hospital physicians who considered the utility of the hospital as a centre for the treatment of severe cases to have been diminished.⁵⁴ In 1887 the limiting family income level was raised to 40s. per week and, to pacify subscribers, parents with governors's letters no longer needed to be investigated by the Charity Organization Society before a second visit to the hospital. The numbers of patients refused treatment became insignificant, being 134 in 1887, 109 in 1888, 218 in 1889 and 118 in 1890.⁵⁵ At this point the regulations were abandoned with investigations into income made only in flagrantly suspicious cases. Instead of trying to enforce unpopular restrictions, the hospital again enlarged its outpatient facilities. Attendance figures grew steadily. 12,990 new patients had sought care in 1882, 17,156 in 1888, and by 1894 the figure was 27,334 (with a total of 69,896 outpatient visits for the year). During 1899 there were only 23,892 new patients but the total number of outpatient visits had risen to 94,156.

This increasing activity in the outpatient department at Great Ormond Street was paralleled in the other London children's hospitals in spite of complaints from local doctors. In evidence given to the Select Committee on Metropolitan Hospitals, 1890–1893, Horatio Nelson Hardy, a general practitioner, made the age old claim that children's hospitals were not necessary because 'every general hospital, if properly organized, ought to be able to treat children's diseases as well as any other disease'.⁵⁶ Another general practitioner, Frederick Henry Corbyn, accepted the need for inpatient facilities for children but, with considerable justification, condemned the outpatient departments as 'hotbeds of infection'.⁵⁷ He was particularly indignant that practitioners like himself were penalized, under the Notification of Diseases Act, if they did not report

⁵³ *Twenty-Fourth Annual Report of the Hospital for Sick Children* (London, 1876), p. 5.

⁵⁴ *Twenty-Fifth Annual Report of the Hospital for Sick Children* (London, 1877), p. 7.

⁵⁵ *Second Report from the Select Committee of the House of Lords on Metropolitan Hospitals*, B.P.P., 1890–91, XIII, para. 20207, evidence of Arthur Lucas, vice-chairman of the Hospital for Sick Children.

⁵⁶ *First Report from the Select Committee of the House of Lords on Metropolitan Hospitals, 1890–3*, B.P.P., 1890, XVI, para. 1068.

⁵⁷ *Ibid.*, para. 3644–61.



Figure 3: New Year's Day at the North Eastern Hospital for Children, c. 1872, wood engraving by H. Haral after M.E.E.
(The Wellcome Institute Library, London.)

cases of infectious disease under their care within twenty-four hours, while nothing was done to regulate outpatient departments where sick children would sit around for several hours, spreading infection, before being seen by a hospital doctor. Indeed, the only medical practitioner called to give evidence who was entirely in favour of paediatric hospitals was Robert Barnes. He did 'not think those hospitals [for children] could be done without; there is the greatest possible use in them. The East London, for example, is a great institution'.⁵⁸ But Barnes was not dispassionate since Dr. Heckford, who had founded the East London Hospital for Children, had been first his pupil, then his friend.

Generally speaking the management committees were not over concerned by accusations that their hospital services were being abused. By 1894 the British Medical Association, under pressure from discontented general practitioners, had formed a Medical Charities Committee that, together with the ever persistent Charity Organization Society, sought to ensure that hospitals and dispensaries were not used by the more prosperous. Members of the Medical Charities Committee called upon hospital officials with suggestions for reform only to receive noncommittal answers. So the committee printed a list of recommendations and sent these to all the hospitals in the London metropolitan district together with a poster, to be exhibited in the outpatient waiting-rooms, stating that patients would be 'required to give information as to their means and circumstances with a view to prevent the abuse of this charity by persons who are well able to pay'.⁵⁹ Favourable replies were received from the Alexandra Hospital for Children with Hip Disease and from Paddington Green Children's Hospital. The secretary of the Belgrave Hospital for Children politely replied that the suggested objectives had already been attained under current arrangements at his hospital. Less politely, the secretary of the Evelina wrote that his hospital committee 'are quite satisfied that there is no appreciable abuse of this charity. They therefore do not see their way to adopt the Recommendations of the Association'.⁶⁰ The Victoria Hospital for Children and the East London Hospital for Children did not commit themselves to any specific measures and no reply at all was received from Great Ormond Street.

The religious affiliation of members of the hospital staff was a matter of unusual concern to committees of management. Many of the difficulties Charles West encountered in his final years at Great Ormond Street were, in his opinion, due to his having become a Roman Catholic in 1874.⁶¹ The committee of management at Great Ormond Street protested that his new religious affiliation was not the cause of friction, but other evidence suggests that being or becoming a Roman Catholic was often viewed with suspicion by Victorian hospital authorities.⁶² Nor was it only Catholics that were feared as potential

⁵⁸ *Ibid.*, para. 13750.

⁵⁹ 'Report of the Medical Charities Committee', *British Medical Journal*, ii (1894): 193–7.

⁶⁰ *Ibid.*, p. 196. When a deputation from the B.M.A. had called on the Evelina in April, 1894, to urge that the hospital should employ an officer to inquire into the financial state of all applicants to the outpatient department, the management committee had decided there was no need for such a measure; G.L.R.O., H9/EV/A2/3, Minutes of Committee of Management, 1887–1898, 25 April, 1894.

⁶¹ Charles West, *A Letter to the Governors of the Hospital for Sick Children* (London, 1877). In this published letter West wrote that he was withdrawing 'from even nominal connection' with Great Ormond Street because of two divisive questions: his religious opinions and the, in his view, despotic powers assumed by the committee of management in recent years.

⁶² *A Statement by the Committee of Management of the Hospital for Sick Children . . . in Reply to a Letter Addressed by Dr. West to the Governors of the Hospital* (London, 1878).

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trouble makers; converts to any religion were perceived as conscience bound to proselytize other members of the staff and patients. At the Evelina, officially run as an absolutely undenominational institution, trouble arose when Miss Alice Cross, lady superintendent since 1879, informed the management committee in 1894 that she had decided to join the Roman Catholic church.⁶³ The committee at first accepted the situation on condition Miss Cross undertook not to influence any of the nurses or patients. Then the committee members changed their minds, finding Miss Cross' letter acceding to their conditions unsatisfactory, and also because they discovered that a ward sister had also converted to Roman Catholicism.⁶⁴ At this point both women were asked to resign. Miss Cross managed to placate the committee with a second letter complying with the requirements, but the ward sister's forced resignation was accepted even though she had worked at the hospital for four years.⁶⁵ Undoubtedly, the committee were reluctant to lose the services of an efficient lady superintendent, who would remain at her post until 1903, and instead vented their displeasure on an underling.

At the Hospital for Sick Children, Nottingham (opened in 1869) the management committee was initially quite determined to entrust nursing, housekeeping and dispensing to members of a religious sisterhood. (The emergence of religious nursing sisterhoods and some of their contributions to nursing reform will be discussed in a later chapter). Originally these responsibilities were undertaken by the sisters of St. Lucy's Home and Charity at Gloucester but this arrangement did not last for long. In the summer of 1870 the Sister Superior replaced Sister Millicent, who had charge of the hospital, with a Sister Edith without informing the committee of management which was understandably disturbed particularly since the latter began her term of service by absenting herself from the hospital for four days without notice to the committee.⁶⁶ At a meeting where the Sister Superior and Sister Millicent were both present, the hospital secretary demanded to know whether 'the Sisterhood was to be the subordinate to the Committee, or the Committee simply nonentities in the Hospital'.⁶⁷ He also made the contentious suggestion that the unsatisfactory level of public financial support for the institution might be due to nursing being in the hands of the sisterhood. Matters went from bad to worse and, two months later, the sisters simply walked out of the hospital leaving it without any kind of superintendence at all.⁶⁸ In spite of this experience enough committee members remained in favour of nursing by a sisterhood for the Sisters of St. John's House, London, to be requested to take over at this point. This arrangement lasted for about two and a half years and seems to have been reasonably satisfactory for the annual report for 1872 stated that it was 'impossible to speak in sufficiently high terms of the admirable care and conscientiousness with which the Sister and Nurses have conducted the maintenance, the nursing, and dispensing which have been committed to them'. However, the Council of St. John's House withdrew its services to the Children's Hospital in November, 1873,

⁶³ G.L.R.O., H9/EV/A2/3, Minutes of Committee of Management, 1887–1898, 28 March, 1894.

⁶⁴ *Ibid.*, 7 April, 1894.

⁶⁵ *Ibid.*, 25 April, 1894.

⁶⁶ Nottingham Children's Hospital Archives, Manuscript Department, University of Nottingham Library, Board of Management Committee Minute Book I, 1869–1876, 9 August, 1870 and 6 September, 1870.

⁶⁷ *Ibid.*, 1 November, 1870.

⁶⁸ *Ibid.*, 7 February, 1871.

ostensibly for lack of sufficient staff to continue the contract.⁶⁹ No other sisterhood was willing or able to take charge so Miss Townson, an associate of St. John's House, was taken on as temporary lady superintendent. One year later she was elected 'lady matron' and all connections with St. John's House were then discontinued. From then on the hospital managed, quite adequately it would seem, with lay nurses only.

The early records for the management committee of Nottingham's Children's Hospital reveal the difficulties encountered in attempting to reconcile spiritual and temporal interests in a hospital setting. Originally the institution possessed a room fitted as a chapel but this was dismantled in 1871 to placate subscribers who objected to the type of religious service thought to be conducted therein. Objections to the Oxford or Tractarian movement within the Church of England were strong at the time and some people suspected that high church services were taking place in the hospital chapel under the influence of the Anglo-Catholic sisterhood of St. Lucy. If closure of the chapel allayed fears that patients were being forcibly exposed to high church ritualism, it also became an impediment when the management committee sought to find another sisterhood to nurse the children, since most orders expected their members to attend religious services daily. As early as 1870, the hospital secretary had hinted that lack of contributions to hospital funds might be due to the nursing being in the hands of a sisterhood but, at the time, his interpretation was not the general one.⁷⁰ Certainly, however, religious nursing orders expected to regulate the behaviour of their members with a minimum of interference from management committees, an attitude which was bound to cause friction sooner or later.

On the whole, the management committees of paediatric hospitals could be more flexible and experimental than those of other larger hospitals working under the weight of longer tradition and more rigidly formalized regulations. Also contributing to a more relaxed atmosphere was the greater ease in collecting funds for, although the management committees of children's hospitals were for ever pleading poverty, it was easier to get material aid for sick children than for adults. At best the paediatric hospitals seem to have been run with compassion and generosity not only for patients but also for members of the staff. This was not always so; the institutions at both Manchester and Liverpool suffered from unpleasant relations between staff and management during the early years. But, in general, management committees seem to have been open to the relaxation of regulations, or to the bending of rules, when circumstances so required. Thus, the Evelina Hospital retained the services of Miss Cross, as discussed above, even though the regulations required the resignation of any member of the nursing staff upon change of religious affiliation. Most of the paediatric hospitals paid the minimum of attention to the strictures of the Charity Organization Society, concerning abuses of their outpatient departments. When, in 1878, the management committee at Birmingham Children's Hospital was advised by the secretary of the newly established Birmingham Provident Dispensary that hospital administration should be reformed to give the provident dispensary a chance to fulfil its purpose, meaning that patients should be more carefully screened for ability to pay, the hospital committee decided that it had no need to consider this question until the

⁶⁹ *Ibid.*, 3 June, 1873.

⁷⁰ Nottingham Children's Hospital Archives, Manuscript Department, University of Nottingham Library, Board of Management Committee Minutes, I, 1869–1876, 1 November, 1870.

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provident dispensary proved its own effectiveness.⁷¹ A month later the hospital committee of management decided that 'the data furnished by the Charity Organization Society [on the extent of hospital abuse] are not sufficient to form definite and important conclusions upon', so disagreeing with its own medical committee which supported the allegations of the Charity Organization Society.⁷² Management committees disliked outside interference and, at the children's hospitals, were usually able to retain their independence.

Internally some redistribution of power and influence had taken place by the end of the century. By this time, the medical staff had representatives on almost every hospital board of management as well as their own advisory committees and, as will be seen, nursing was also independently represented in the person of a lady superintendent or matron. Growth in size, and increased professionalism among doctors and nurses, induced these changes. Running a children's hospital had become a time consuming affair for, as will be seen, most hospitals now had much enlarged medical and especially surgical departments, new services such as dentistry and radiology, full time pathologists, anaesthesiologists and ophthalmologists, nurses in a ratio of about one to each four inpatients, and their own convalescent homes. To supervise such an enterprise, and obtain the required funds, management had become dependent upon the professional services of at least one full-time secretary and usually also a treasurer. The mostly benevolent paternalism which had been the hallmark of most original administrations was modified in the direction of greater efficiency and accountability.

⁷¹ Birmingham Children's Hospital Archives, Committee of Management Minutes 1877–1885, May 13, 1878.

⁷² *Ibid.*, June 17, 1878.