

**The Cottage Hospital Movement in
England & Wales 1850–1914: Origins,
Growth and Contribution to the
Healthcare of the Poor**

Keith Atkins

**This thesis is submitted in partial fulfilment of the requirements of
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Abstract

This thesis makes a significant contribution to the understanding of healthcare provision for the poor in the second half of the 19th century in England and Wales. It explores the origins behind a new type of hospital which began to emerge in the mid-nineteenth century, the cottage hospital, and attempts to fill a gap in the historiography of the rise of the hospital in the nineteenth century. It compares six cottage hospitals, three based in villages and three based in towns, and reveals marked differences (especially in comparative analyses of admissions by gender) as well as similarities. It highlights the impact of industrialisation and mechanisation on workers revealing work place accidents as the most frequent cause of admission for men. The thesis uses the writings of the founder, and his supporters, of what became known as the Cottage Hospital Movement, studying contemporary arguments, for and against, such an enterprise. It provides in depth insight into the role of the church and philanthropy and the importance of local community in the success of the hospitals, but most importantly highlights the role of the medical men as prime movers. It also exposes how local medical men were not only able to improve their standing in their local communities, but were able to improve their own knowledge and practice through the presence of the hospital.

As Steven Cherry has shown, many of these hospitals survived and continue in the NHS today still offering local, in the community care. Now, as then, they are in the firing line of the ongoing debate between the desirability of small/local/familiar institutions versus the specialist/ technical but distant 'super hospitals'. This thesis adds significantly to the historical cannon of nineteenth century medical care for the working poor, and the databases created as part of this research offer future historians the opportunity to explore the subject further.

Dr Sue Hawkins, First Supervisor, 22 March 2019

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Preface

This thesis was submitted for a posthumous award of PhD. Its author, Keith Atkins, sadly passed away, as he was entering his writing-up period. It is therefore incomplete. It was examined in its incomplete form (as presented here) by an external and internal examiner who both agreed that, despite being incomplete the thesis makes a significant contribution to our knowledge of early cottage hospitals in England and the individuals who were key to the development of the cottage hospital movement. They agreed that Keith's work was 'original ... packed with detail ... and showed clear evidence of thought and analysis'.

As his supervisor, I have pulled Keith's work together and tidied it up to present here, but all the work presented is Keith's own. The only exception is this preface, which I have written, in an attempt to explain how far Keith had got and where there were areas which we had both agreed needed further refinement. I explain where these lacunae are in this Preface.

In my opinion the thesis is 75-80% complete. The first three chapters required some minor editing (especially in relation to referencing), whilst the final chapter was still in draft format, requiring some more thought about the structure and the conclusions to be drawn from it. All archival research was complete. Some updating of secondary literature was required.

Keith's aim was to study an aspect of pre-NHS healthcare in England and Wales which has been neglected by medical historians to date, the cottage hospital movement of the mid-late nineteenth century. There has been a small number of articles on cottage hospitals which focus on specific geographic areas (particularly Steven Cherry's study of cottage hospitals in East Anglia), but no attempt has been made to survey the Movement as whole, which in the second half of the 19th century brought affordable healthcare to the rural poor. Using records from his selected hospitals (annual reports and committee minutes), the writings of some of the main players in the Cottage Hospital Movement (including Henry Burdett), and the lively discourse on the subject in

the contemporary medical press, Keith's research provides detailed insight into the Cottage Hospital Movement. It sheds light on how and why the Movement flourished in the late 19th century, the individuals who were behind it and their motives. Further, as Keith has been able to locate and use patient records from a selection of hospitals, he has also been able to study the health challenges facing the rural poor (and a lesser extent, that of industrial workers in small towns) at a time when the rural economy was undergoing as dramatic a revolution as was seen in the towns and cities. When much historical focus in this period has been on challenges to public health in the urban populations, this research offers new insights into the health of the rural population.

Keith took a quantitative approach to his research, collecting data on cottage hospitals from a wide array of sources and compiling databases from which he was able to plot the geographic development of the Cottage Hospital Movement, revealing an uneven development of hospitals around the country and enabling him to ponder on why this might be? In addition to a study of rural health (or ill-health) and to a lesser extent, that of the industrial workforce, Keith's research also encompasses subjects such as the role of philanthropy and the Poor Law in rural healthcare, and the role of women in the provision of rural healthcare services.

Primary research took place at archives around the country, in Keith's search for information on cottage hospitals. He had two objectives in mind: firstly to create a comprehensive directory of cottage hospitals in England and Wales which could be used to study the development of these institutions; secondly to identify a number of hospitals with extant annual reports and patient records which could be used to study both the work of the cottage hospitals and the health of rural (and to a lesser extent, town-based) poor.

As a result of this work, he identified six hospitals (three town-based and three rural) which form the basis of this thesis. They all had extant patient records with a long enough continuous and overlapping chronology to enable meaningful comparisons to be made. Keith's research methodology is discussed in detail in Appendix 5. He was also able to identify 600 cottage hospitals across

England and Wales and details of these were entered into his Cottage Hospital Database. A brief summary of these findings is provided in Appendix 2 and maps of hospital openings by decades are presented in Appendix 4. This is the most comprehensive list of such hospitals in existence and provides the basis for further research into this overlooked aspect of pre-NHS healthcare in England & Wales.

Status of the Thesis

Two of the four main chapters: 'The Origins of the Cottage Hospital Movement' and 'The Cottage Hospital Movement: Consolidation, Expansion and Growth, 1871 – 1914' were in final stages of completion, needing only minor enhancements. The third chapter 'Governance and Financial Management of Cottage Hospitals; Medical and Nursing Staff and the Contribution of Upper- and Middle-Class Women' was a little behind the first two, but was also in need of only minor revision. The fourth chapter which focusses on the patients and makes use of the patient record databases was at an earlier stage. Analyses of the data were complete (with one or two exceptions) and are presented in the bound thesis, but more work was needed to develop these findings into an argument about the nature of cottage hospital treatment, what the data can tell us regarding health of the poor and to tease out the trends. This chapter in particular needed further secondary reading to support the research findings. A more detailed description of the status of each chapter is provide below.

The main missing elements in the thesis are the Introduction and the Conclusion. We had agreed that the Introduction would consist of a number of elements, including a literature review of the key themes (cottage hospitals, the medical marketplace, the Poor Law, philanthropy), a methodology section and a general introduction to the aims and objectives of the thesis. Keith had completed the Methodology section (which in the absence of an Introduction is presented in this thesis as Appendix 5) and had written separate literature reviews on the topics listed, but these had yet to be woven into the Introduction proper. There is no Conclusion. This would have been one of the last tasks during the writing up period, but unfortunately, Keith was taken seriously ill so suddenly we had no time to discuss this.

The Thesis is completed by the addition of several Appendices which in the main are complete. The brief biographies of key characters required some expansion.

There is a bibliography.

The six patient databases and the Cottage Hospital Database have been made available with the thesis in the form of Excel spreadsheets. It is also hoped to make them available online, probably via the UK Data Archive Service at the University of Essex.

Description of the thesis chapter by chapter

Chapter 1 Origins of the Cottage Hospital Movement – 1850-1870.

The purpose of this chapter is to investigate the beginnings of what became called the Cottage Hospital Movement, by looking at the emergence of such hospitals in the 1860s. It considers the origins of the idea and the individuals instrumental in developing this new system of healthcare for rural populations. It draws extensively on the writings of contemporary observers and the men who were directly involved, published in pamphlets, books and medical journals of the time. It addresses questions as to motivations for the foundation of the movement and how these hospitals sat alongside other provision for the poor such as general hospitals and workhouse infirmaries. Key individuals whose ideas are explored include Albert Napper, acknowledged founder of the cottage hospital and the 'Movement', and Henry Burdett, an influential figure in hospital administration in the UK in the second half of the 19th century.

The chapter is in Final draft stage. It had one or two outstanding queries to be resolved and needed a strengthened conclusion. As it stands it is too long, and it was planned to move some of the text into the Introduction.

Chapter 2 The Cottage Hospital Movement: Consolidation, Expansion and Growth, 1871 – 1914

Chapter 2 considers the growth (in number and the geographic spread of cottage hospitals) during the 1870s to 1914. It identifies the spread of the idea as a solution to health problems among the rural poor into some towns where industrialisation was taking hold. The main source for this chapter is the database of cottage hospitals created a result of extensive research in the literature of the second half of the nineteenth century during which every instance of cottage hospitals was noted, along with any other information available on dates of opening, bed numbers, nursing arrangements etc. This resource has enabled the production of a series of maps showing the gradual geographic spread of the hospitals around England and Wales. The chapter discusses how, as the idea spread, Napper's original idea slowly evolved into something he himself was not happy about, but was clearly meeting a need in populations not well served by the voluntary hospital network.

The chapter is in a similar condition to Chapter 1. There were minor queries to resolve, referencing needed to be strengthened and some rationalisation with other chapters was required.

Chapter 3 Governance and Financial Management of Cottage Hospitals; Medical and Nursing Staff; the Contribution of Upper- and Middle-Class Women
Chapter 3 considers the workings of these hospitals; particularly how they were financed and managed. In this chapter the six hospitals (3 rural and 3 town-based) take centre stage and act as case studies for a comparison of management systems and financial arrangements, using extensive collections of annual reports which have survived for these hospitals (the reason for their selection). This chapter brings in discussion of various themes which resonate with other social histories of the late 19th century: philanthropy, the role of the church and the increasingly public role of women.

The chapter needed a little more work than first two. Some sections needed strengthening, especially on nursing and role of women, and more reference to other historians' work was in progress but not included. There were a few

outstanding queries and some checking for duplication with other chapters was required.

Chapter 4 The Patients: Admission Process; Socio-Economic Status; Gender, Age, Disease or Illness; Medical or Surgical Treatment

This chapter was in most need of more work. It attempts to investigate questions regarding the causes of admission to the six hospitals, looking for similarities and differences between all six and between town vs rural institutions; and also to analyse admissions by gender, social status (occupation), age, and cause of admission. A number of analyses are presented, based on these themes, but need more in-depth treatment, to shed light on questions relating to health in rural communities, and the danger to health of industrialisation which was taking place at the end of 19th century. It needed more thought about structure, especially how to give more prominence to the comparisons being made, and to emphasise the significant findings the analyses had identified. The conclusion, that admissions were mainly due to industrial accidents and poor diet, would have been strengthened, while comparison with voluntary hospitals would also have been added using other historians work on these hospitals. In particular, on the sections relating to child patients, useful comparisons would have been included with admissions to children's hospitals in the period, using the Hospital admission Records Project (HHARP) which studies admissions to several such hospitals in the same period as this thesis. Generally, this chapter needed more support from other historians' work also, particularly the discussion regarding TB-related conditions.

Appendices

Most of the appendices are complete. The Biographies are at an early stage and would have been expanded.

Bibliography

The bibliography reflects what is in this version of the thesis, but would have been expanded further as part of the writing-up period. It should not therefore be read as a definitive bibliography on the subject.

Databases

The following access databases, which were used in the construction of this thesis, are presented digitally with the thesis in Excel format.

Cottage Hospital Database (1836-1939; 600 records)

Patient Records

Bourton Cottage Hospital Patient Database (1860-1893, 672 records)

Cranleigh Village Hospital Patient Database (1860-1905, 1096 records)

Moreton Cottage Hospital Patient Database (1883-1889, 808 records)

Braintree Cottage Hospital Patient Database (1886-1907, 760 records)

Chorley Cottage Hospital Patient Database (1893-1903, 845 records)

Lydney Cottage Hospital Patient Database (1897-1904, 235 records)

In Summary

This thesis, although incomplete, is still makes an important contribution to our knowledge of the development of a network of hospitals often overlooked when historians discuss the rise of the hospital in the nineteenth century. It uses a number of unique datasets created by Keith as a basis for analysis and a detailed study of the writings of influential individuals in the development of cottage hospitals. The thesis, and the accompanying databases, will be of interest and great use to any researchers focussing on health of the poor and the healthcare available to them. It was Keith's wish that his work should form the basis of further research and he was determined that his databases should be made available to other researchers for this purpose. It is my intention to find a home for them where they can be accessed easily by future researchers.

Dr Sue Hawkins, Kingston University, 20 March 2019.

First Supervisor.

Chapter 1: The Beginning of the Cottage Hospital Movement in England and Wales, 1850 - 1870.

Introduction

In November 1859 the first recognised cottage hospital was opened in Cranleigh, Surrey, by established local surgeon Albert Napper.¹ By the end of the nineteenth century about 450 cottage hospitals had been established in England and Wales, providing between 3,000 and 4,000 beds, and these small institutions had become the main providers of accessible medical and surgical services to the rural poor who were remote from the voluntary hospitals in larger towns and cities.²

This Chapter examines the historical, social and medical influences which contributed to the development of what became known as the Cottage Hospital Movement, which provided the third constituent of in-patient treatment for the poor alongside voluntary hospitals and workhouse infirmaries.³ The arguments draw upon the Annual Reports and digitised patient records of three early cottage hospitals at Cranleigh (Surrey), Bourton-on-the Water and Moreton-in-Marsh (Gloucestershire); three town-based institutions, Braintree (Essex), Lydney (Gloucestershire) and Chorley (Lancashire); and the Cottage Hospital Database, developed as part of this research.⁴

It has been argued that the birth of the cottage hospital movement can be explained by examining developments in the professional status of medicine in the mid-nineteenth century. The increasing professionalisation of medicine, and in particular, the newly regulated profession of surgeon, raised confidence generally in the ability of surgeons to provide reliable care. This increased respectability of the profession enabled them to be more ambitious in establishing practices and opening specialist hospitals, which they sometimes took to such extremes as to be described by contemporaries as 'vanity hospitals', established purely to reinforce their reputations or to take money off gullible patients.⁵ It is argued though that this new-found confidence also enabled some (especially in rural communities) to use their improving status to

raise support for institutions in which to treat the rural poor, a longstanding problem which was becoming more acute as industrialisation moved to the countryside with the mechanisation of agriculture.

The example set by some professionally registered medical practitioners to demonstrate and advertise specialist skills and thereby acquire fee paying patients no doubt raised awareness amongst rural surgeons that it was both possible and practical to establish and run a small rural hospital, illustrated by the rapidity with which cottage hospitals started to emerge. By the end of 1861, one year after Cranleigh had opened, six more cottage hospitals had opened in England and Wales: Bourton-on-the-Water (Gloucestershire), Woodbridge (Suffolk), Fowey (Cornwall), Teignmouth (Devon), Cleveland (Yorkshire), Dinorwig (Caernovshire) and one on Jersey (Channel Islands).⁶

However, this argument linking over-supply of doctors with the emergence of cottage of hospitals is not necessarily supported by the evidence gathered as part of this study. Many early cottage hospitals were founded by well-established financially secure local surgeons able to give their services free for many years.⁷ Albert Napper, for instance, had practised in Cranleigh since 1854, John Moore (the founder of Bourton Cottage Hospital) qualified in 1845 and George Moore, co-founder of Moreton Cottage Hospital, qualified in 1830, while Drs Ackland and Leman at Teignmouth qualified respectively in 1847 and 1828. All had established successful local practices, and no substantive evidence have been found that a surplus of medical practitioners in the first half of the nineteenth century influenced the foundation of cottage hospitals. Cottage hospitals were not jealously guarded 'vanity' hospitals, rather they provided benefit to all local practitioners, allowing them to admit, treat and care for their patients in the hospital, if they chose to, unlike the restrictions imposed by voluntary and municipal hospitals.

Early cottage hospitals

In the 1850s, the lack of medical services in rural communities and the expansion of industrial towns was beginning to be recognised. In 1854, the *British Medical Journal* published a letter from Spencer Thomson MD, a practitioner in Burton-on-Trent who was concerned by the lack of facilities

available to treat cases of infectious diseases in the rural poor. He proposed that

‘the evil of the sick poor being treated in their over-crowded dwellings [...] might be alleviated by having [...] a sort of “Cottage Hospital”, that is a small house [...] devoted to the reception of the sick [...] others might be received into them under certain conditions of payment, and might of course choose their own medical attendant.’⁸

Thomson suggested that such an establishment, ‘if it can be called such’ should be placed under the care of ‘the most trustworthy and intelligent among the permanent recipients of parish pay.’⁹ His suggestion showed that the concept of a small local hospital was beginning to be discussed but, surprisingly, it did not result in further correspondence. In 1875, the obituary of George Ross MD, one-time editor of the *Medical Circular*, noted that he had ‘ventilated the idea of a system of cottage hospitals in [...] 1858’. It continued, ‘the general acceptance which this plan of suburban cottage hospitals has obtained is now well-known in the profession, although it is not so generally known in whose fertile brain it originated.’¹⁰

Medical historians have identified cottage hospital-like establishments which pre-dated Cranleigh. Steven Cherry named a number of small hospitals which had opened in the late eighteenth and early nineteenth centuries in East Anglia and the West Country such as Shottesham (Norfolk) which existed in 1754, and referred to a small number of dispensaries which had added emergency and in-patient beds such as at Wiveliscombe (Somerset) in 1804.¹¹ Barry Doyle has described a cottage hospital established in Middlesbrough in 1858 run by the Anglican Order of Holyrood which had laid claim to be the first cottage hospital, an assertion he described as erroneous, giving credit to Cranleigh.¹² John Hall, in his work on hospitals in Oxfordshire, listed a small number of ‘cottage’ or ‘rural’ hospitals and dispensaries with in-patient beds which had opened before 1859.¹³ Two other works have provided histories of the ‘the cottage hospital’, both claiming to have identified earlier examples than that of Cranleigh. Richard McConaghey, editor until 1971 of the *Journal of the College of General Practitioners* and contributor to *Medical History*, published ‘The Evolution of the Cottage Hospital’, in which he referred to Teignmouth Dispensary, Devon,

which by 1849 had expanded by the addition of six beds.¹⁴ Meyrick Emrys-Roberts identified a cottage dispensary with four beds which opened in 1818 in Southam, Warwickshire¹⁵ and, in Wellow, Nottinghamshire, a six-bed cottage hospital which had opened in 1842.¹⁶

To understand the origins of the cottage hospital it is necessary to refer to contemporary writers, of which there is a wealth of material. Commentators (and staunch supporters of the cottage hospital) such as Horace Swete, Edward Waring and Albert Napper described how these institutions differed from existing providers of health care in pamphlets and articles and letters in medical journals and in so doing, provided context for the questions at the centre of this research: what prompted the emergence and rapid expansion of the Cottage Hospital Movement from 1860, why were they mostly in rural areas and why did they cater, almost exclusively, only for the 'deserving poor'?¹⁷

These nineteenth-century writers (and others) agreed that, despite the prior existence of the small hospitals mentioned above, the first true cottage hospital opened in Cranleigh, Surrey in November 1859, 'designed for the accommodation of the Poor when suffering from sickness, or from accident.'¹⁸ Local surgeon, Albert Napper had leased a cottage from the village rector, John Sapte, which he had converted and furnished at a cost of £92. He acted as sole Medical Officer at Cranleigh Village Hospital from its opening until his retirement in 1881 when his son, Arthur Napper, took over the practice and the hospital.¹⁹ Napper was an active and influential supporter of the south-eastern branch of the British Medical Association (BMA), which had formed only three years earlier, and had helped to organise its national system of districts within branches. He used this platform shamelessly to promote his concept and the benefit of village hospitals to medical colleagues.

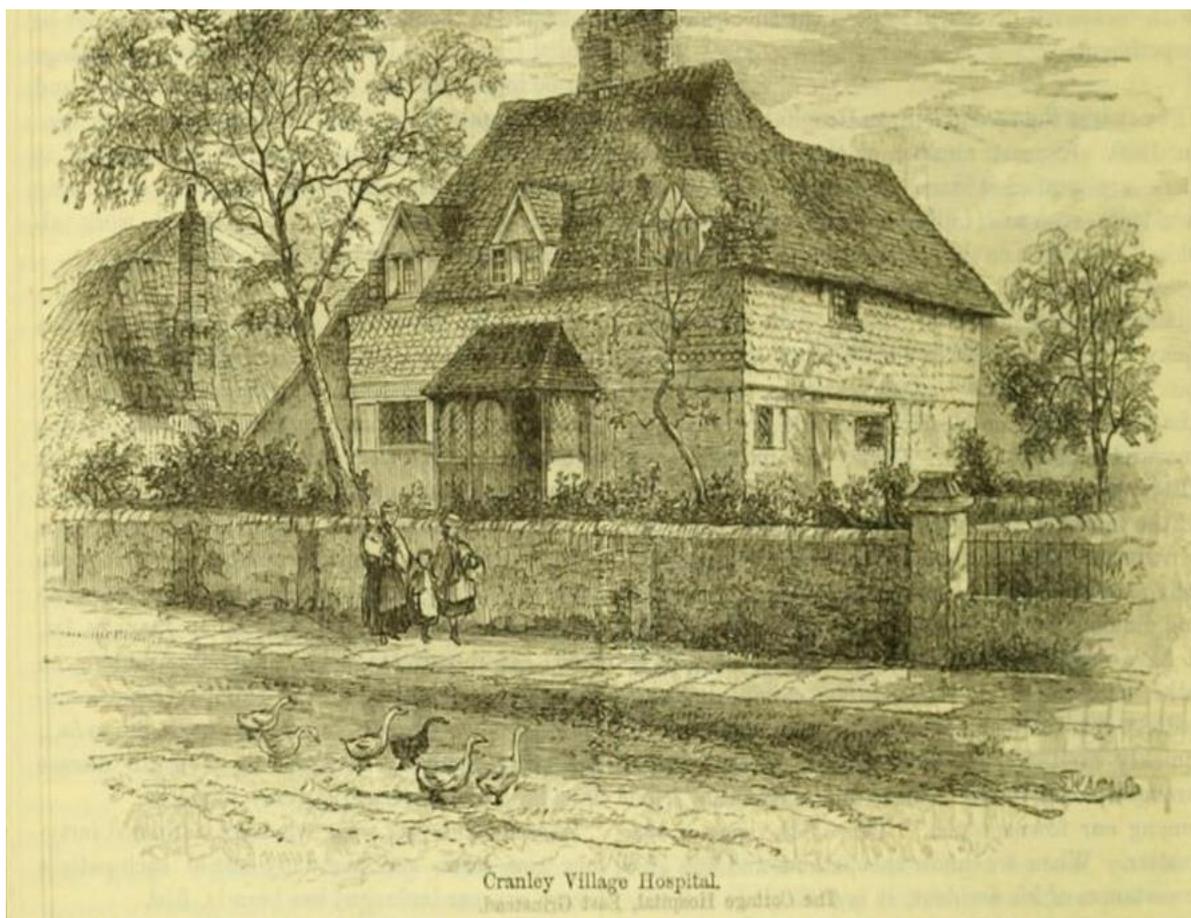
In 1859, Cranleigh was a small agricultural Surrey village, nine miles from the closest market town of Guildford, over poor toll roads, often impassable in winter. Until 1866, Guildford itself had no hospital; Cranleigh's sick were treated in their own homes as was normal practice, obtained remedies and prescribed medicines from the village's 'pharmaceutical chemist' (recorded in the 1861

census) or, occasionally, were taken to one of the London hospitals. A dispensary for the 'sick poor' had opened in Guildford in 1860 but it only provided home care to patients who lived within a two-mile radius of Guildford Town Hall, excluding Cranleigh's inhabitants, and the Cranleigh workhouse had closed in 1836 when the Hambledon Poor Law Union was formed, as a result of the Poor Law Amendment Act of 1834.²⁰ There were no hospitals in the other nearby towns of Godalming and Horsham.

On its opening, the Cranleigh hospital was managed by three trustees: John Sapte, who acted as Visitor and Manager, and John Bradshaw and James Elmes, both major local landowners.²¹ Its Secretary and Treasurer was Ellen Pocklington, daughter of a clergyman, and Annie Crewdson, the daughter of local tradesman, was Collector of Subscriptions.²² The cottage, located on the edge of the village has survived, is Grade II listed and continues to provide out-patient services. Napper and his family occupied an adjacent house, which facilitated quick access to the hospital. The illustration in Figure 1.1 shows Cranleigh Village Hospital as it appeared in 1866, not long after it opened.

The new hospital opened with just six beds. Its rules allowed for patients of both genders and all ages who could not be treated at home to be admitted, but excluded those with infectious or tubercular diseases, those deemed incurable and pregnancy cases. Limiting access for patients with such conditions minimised the impact on hospital finances of potentially long-stay cases, as little could be done for the incurable and those suffering from tubercular diseases. It also helped to reduce the number of deaths which would be shown in the Annual Report, which might otherwise cast doubt on the hospital's efficiency.²³ Despite this the patient records, discussed in detail in Chapter 4, show that these rules were not adhered to rigidly; some patients diagnosed with tubercular diseases of the joints and a small number of post-natal cases were admitted.²⁴

Figure 1.1: Cranleigh Village Hospital, c1866.²⁵



The hospital had just one nurse and there were two other staff: a handyman, who also acted as hospital porter and a woman for the 'necessary work of the house'. Domestic arrangements were under the management and supervision of 'some of the ladies of the parish.'²⁶ This simple form of organisation, with the local gentry and clergy in charge, and middle and upper-class women undertaking various roles such as fund raising and domestic management became the standard model and was quickly adopted by other early cottage hospitals.²⁷ The Movement was given extra weight when Henry Burdett, an influential hospital administrator, announced his strong advocacy of cottage hospitals, describing Napper as the 'Founder of Village Hospitals' and 'a skilled surgeon, an enthusiastic sportsman, and a good man [...] a worthy example of the fine old English gentleman, of whose merits so much has been said and sung in the past.'²⁸ Burdett's advocacy of cottage hospitals, discussed below, showed that he and Napper were well acquainted.²⁹

Running costs of Cranleigh Hospital were met from annual subscriptions, which rarely totalled more than ten guineas; individual donations, usually a few shillings; church collections, door-to-door fund-raising and, later, from bazaars, concerts and readings. National fund-raising initiatives, implemented at local level, such as Hospital Saturday, Hospital Sunday and Pound Days also became a valuable source of income.³⁰ The hospital generated a small financial surplus each year. A distinguishing feature of cottage hospitals was the insistence that patients (or their families or employers) should make a small weekly payment of a few shillings, for the duration of their stay.³¹ This differentiated cottage hospitals from their voluntary counterparts (which on whole did not charge fees), but they continued the practice common in voluntary hospitals of subscriber tickets, a system under which subscribers were entitled to recommend a number of candidates for admission. At Cranleigh Napper, in conjunction with Sapte, determined who among ticket holders should be admitted; except for accidents and emergencies which Napper alone authorised. The patients listed in the early Cranleigh records were either seriously ill, chronically sick or had suffered an accident and their sponsors were well known village residents, so it is unlikely that this dual admission process gave rise to conflict. The early records named the person proposing admission: nearly forty per cent were recommended by Sapte or the vicar of a nearby parish, about one third were accidents, and the remainder were sponsored by one of the trustees, or a local landowner, tenant farmer, member of the local gentry, or their wives.³²

In 1861 local surgeon John Moore, also supported by his local rector (Rev C W Payne Crawford), opened a cottage hospital at Bourton-on-the Water, Gloucestershire. Bourton's rules and operating principles were very similar to those published by Napper and reproduced in the *BMJ*, suggesting that Moore had been influenced by the experience at Cranleigh and was encouraged to attempt a similar experiment, by the success and relatively low start-up cost of Cranleigh.³³

Moore's initiative was not without difficulty, as he recalled in the Bourton Annual Report for 1871:

'When the establishment of the Bourton-on-the-Water and Cotswold Village Hospital was first mooted, we well recollect how (although the Cranleigh Hospital was entering upon its second year), some ridiculed our efforts to bring Hospital assistance to the doors, as it were, of our poorer neighbours – how some, while wishing us God-speed, warned us that the attempt must end in failure – still more gratefully do we remember how some, while doubting the possibility of success, cheered us with more substantial aid and good wishes also [...] and through good report and evil report, we have struggled successfully to the end of our first decade.'³⁴

No doubt other early cottage hospital pioneers experienced similar difficulties. A pamphlet written by WC Coles, Bourton's honorary consulting surgeon for many years, described the first sixteen years of the hospital. He referred to Napper as the founder of cottage hospitals, observing that 'village or cottage hospitals had sprung up in many directions, almost all based upon the principles of the Cranleigh and Bourton Hospitals.'³⁵ By 1892, thirty years after its foundation, the Bourton Annual Report observed that for several years it was 'the sole public refuge for the sick and injured between Oxford, Cheltenham and Worcester [...] bringing to the village-labourers' doors, hospital aid, only previously attainable after a long-suffering ride of at least 16 miles', but now it was one of eight similar Cotswold institutions providing in total eighty beds, equivalent in size to a small county hospital.³⁶

While historians Cherry, Hall and McConaghey all acknowledge Cranleigh Village Hospital as the first cottage hospital, their studies of the emergence of cottage hospitals have been approached from different perspectives. Steven Cherry examined the role and expansion of a selection of cottage hospitals in Norfolk and Suffolk, some of which developed from earlier dispensaries (commencing with Ditchingham founded in 1865), and followed their development and subsequent rationalisation or closure after the establishment of the National Health Service (NHS) in 1948.³⁷ He identified some cottage hospitals which were founded to meet specific local requirements such as the

Rous Memorial Hospital in Newmarket which opened mainly to serve the Jockey Club, an indication that even in the early days, cottage hospitals were starting to diverge from the simple Cranleigh model. Cherry has suggested several reasons for cottage hospital growth, arguing that 'professional interests [of doctors] and the desire to achieve low-cost care largely determined their characteristics.'³⁸ He maintains that cottage hospitals provided several distinct advantages, besides speed of treatment in cases of accident or emergency. They obviated the need for patients to experience hazardous journeys over inadequate roads to County hospitals; and enabled doctors to see their patients in one place, providing better and more regular treatment, minimising travel time (especially in poor winter conditions), yet enabled the patient to be removed from their unsuitable homes, a point particularly emphasised by Napper. Modest weekly payments by the patient, which conformed to the Victorian ethos of self-help, contributed to the low cost of treatment and the hospital fulfilled a further role by acting as a repository (accessible to local practitioners) of surgical instruments, medicines and dietary supplements.³⁹

Cherry has also suggested that the cottage hospital brought its Medical Officer the prospect of additional income from paying patients, an interesting observation as no evidence of 'private patients' has been found in any of the early hospital reports accessed in this research. The opposite was the case: the majority of patients encountered in the six hospitals studied were paupers or the 'deserving poor'. It was not until the mid-1890s that 'pay beds' began to appear. It is possible that Cherry was suggesting that the presence of a hospital improved the status of the doctor, and as a result, those who were able may be persuaded to consult him instead of a town-based consultant. Later, Burdett recognised that the growth of a middle class with disposable income had led to 'private patients' being admitted to cottage hospitals. His revised model for cottage hospital rules, first published in 1896, acknowledged the potential for private patients, recommending that: 'Any suitable patient desirous of having the comforts and nursing of the hospital may, on the certificate of one of the medical officers, and subject to there being room, have the privilege of being admitted on payment in advance of not less than 20s per week in the ordinary wards, or 30s per week in a private ward.'⁴⁰ It is important to note his

caveat here, 'subject to there being room', which emphasises that the original purpose of the hospital should not be lost sight of.

John Hall has proposed that cottage hospitals began to emerge where access to a general hospital was limited or non-existent. Additional factors in the appearance of cottage hospitals could include a new confidence in local practitioners, and the presence of local charitable and philanthropic capacity sufficient to maintain a hospital. He observed that as a result, where cottage hospitals were established was geographically random, a theme explored in depth by Gorsky, Mohan and Powell who demonstrated that local voluntary sector provision tended to produce a geographically uneven service.⁴¹ This study suggests this may not be entirely the case for cottage hospitals, and the geographic spread of these institutions will be discussed in more detail in Chapter 2.

While McConaghey also agreed that passing of the 1858 Medical Registration Act, was important in giving doctors a legal recognition and status, thereby facilitating their ability to establish institutions, he also believed advances in medical technology were having a similar influence. The introduction of ether and chloroform in the mid-1840s extended the scope and ease of surgery and the new hospitals provided facilities to carry out surgical procedures, some of an advanced nature using anaesthetics. Such new technologies enabled the rural doctor to demonstrate his skills and impress potential local fee-payers to use his services, rather than the inconvenience of a London-based consultant.⁴² Napper, not slow to see the wider implications for his practice, was keen to advertise his own successful use of this new technology, reporting in his annual reports on successful operations undertaken under anaesthesia.⁴³ The patient was admitted with 'strumous disease of the elbow joint and was about six months pregnant [...] I amputated the arm at the middle of the humerus having previously placed her under chloroform,' he reported in the 1864 Annual Report. He was pleased to report that he saw the woman again some months later, and although she lost her child, was herself well, and learning to cope with only one arm.⁴⁴

Before Cranleigh Village Hospital opened, there were small, local institutions already established; dispensaries with two or three beds and a few small hospitals which had been founded by a local surgeon, churchman, religious order or an enlightened employer. Some of these institutions did not survive the death or retirement of their founder or were unable to attract sufficient funds to remain in business.⁴⁵ Others such as the hospitals at Stroud and Fowey quickly evolved into larger voluntary, general or district hospitals. As an active member of the BMA, Napper would have known of the existence of such dispensaries with in-patient beds and it is likely that this awareness contributed to his growing desire to establish his own local hospital. Cherry has argued that the prospect of a village hospital brought the possibility of additional income from paying patients, although it should be noted that the financial accounts of the early cottage hospitals do not show 'private patients' contributions were a significant income source for the hospital. Nevertheless, it provided the rural doctor with the opportunity to demonstrate his surgical proficiency, and it is highly likely that Napper (and other doctors associated with the early hospitals) were able to supplement their private incomes as a result of this boost to their local reputations.⁴⁶

Evidence for Napper's motivation to establish his own hospital was provided by Horace Swete, author of an early handbook on cottage hospitals and founder of Wrington Cottage Hospital (which opened in 1864 in Weston-Super-Mare, Somerset). He asserted that for some time prior to the establishment of the Cranleigh Hospital Napper had campaigned locally for access to a quiet room in which a severe case of accident or disease could be accommodated and nursed. His case was finally made when the local rector, John Sapte, hearing that Napper was performing a leg amputation in a local cottage, aided by his dispenser, a policeman and an elderly woman, attended the scene and was so appalled by what he saw that he immediately offered a church-owned cottage to house a village hospital.⁴⁷

Confirming Swete's account, Napper, in correspondence with Sapte during their dispute over who was the founder of cottage hospitals wrote:

'In the autumn of the year 1859 I one day met with the Vicar [...] of Rudgwick, [...], who asked me if I could undertake at his expense the treatment of a poor woman suffering severely from disease of the ankle joint. I told him that she had long been under my treatment, and that at a distance of four miles, I found it impossible to effect a cure. [...] On the following day I met with [Sapte] and repeated to him what had passed [...]. I had long wished for some place in which to treat them, were it only a small cottage, provided with a nurse, good food, and the necessary appliances.'⁴⁸

Napper was faced with fundraising for conversion of the cottage which the Rector had provided. Funds were acquired surprisingly quickly, as the hospital admitted its first patient on 28th November 1859.⁴⁹ Local subscriptions and donations (none exceeding £5), a church collection, a benefit concert and a lecture had raised £165, which ensured the hospital also had adequate funds remaining for its first year of operation, achieving a surplus of £34.⁵⁰ The initial renovation could not have been much more than cleaning and whitewashing and by the time of the 1st Annual Report in October, two more beds had been provided, increasing the number to six. The trustees report, probably written by Napper, observed that many of the patients could not have been treated in their own homes, 'medical treatment being of little avail in the absence of efficient diet, nursing, and comfort'. He went on to state:

'The institution of the CRANLEY VILLAGE HOSPITAL [sic] resulted from the absolute necessity of providing better accommodation for the poor, in cases of sickness or accident, than that afforded by their own cottages. The distance of the London Hospitals preventing them from being of much use to the poor in country districts, and the change also to the atmosphere of London, being oftentimes in itself prejudicial to the health of country patients.'⁵¹

The importance of this new type of hospital was recognised immediately. In March 1860, the *BMJ* considered it worthy of an editorial. It noted that the hospital was designed to fulfil a long-needed requirement in rural districts which were remote from larger hospitals and, after describing its operating principles and financing, concluded by stating: 'We commend this to the notice of our associates in rural districts [...] the experiment is worthy of extensive trial [...]. The principle is excellent; the only modification required will be in details.'⁵²

As Cranleigh Village Hospital had only opened the previous November, it is significant that the *BMJ* was so quick to promote its benefits. Through his close association with the BMA, Napper probably knew the *BMJ* editor, Robert Streeten, a Worcester-based MD, and could have used that friendship to gain publicity for his new hospital.⁵³ The editorial immediately elicited many enquiries of Napper, leading the *BMJ* to publish, three weeks later, the Rules of Cranleigh Hospital.⁵⁴ Napper wasted no time in distributing the 1st Annual Report. In October 1860, the *BMJ* once more praised Cranleigh Hospital, drawing attention to the benefits it provided to its patients by avoiding the detrimental effects of long distance travel to a county hospital and to the medical practitioner by 'exercising and maintaining his manipulative skill.'⁵⁵

The *BMJ*'s advocacy of cottage hospitals was particularly directed towards the benefits which would accrue to medical practitioners based outside the metropolis and large cities. The article observed that, 'There are doubtless many practitioners who had never had the opportunity of assisting or witnessing a first-rate operation since their student days in consequence of the lack of some institution in which they could be performed with due care and safety' and went on to comment that this lack of opportunity carried a financial penalty. '[W]here there is lack of practice', the article continued, 'there must be a want of skill; hence the higher classes are led to call in the aid of metropolitan celebrities on very slight occasions'.⁵⁶ In November 1861, the *BMJ* returned again to the topic, writing that 'the benefits derived from such village hospitals is manifest [...] it gives the provincial surgeon [...] the means of making himself equal to all emergencies'.⁵⁷

These leading articles gave primacy to the benefits the hospital would confer upon the local, mainly rural, surgeon. The 1858 Medical Act had enhanced the status and authority of registered practitioners by establishing the principle that medicine was a profession with recognised regulated qualifications. Although it would take time for these changes to permeate society it is clear why the *BMJ* was keen to take every opportunity to promote developments, such as the emergence of cottage hospitals, which demonstrated and reinforced the skills of the local practitioner.

The Lancet not to be outdone by the *BMJ* also praised the development of the cottage hospital at Cranleigh for similar reasons:

‘The management of cases of accident and severe illness among the poor in rural districts constantly offers the most serious difficulties to the surgeon [...]. A well devised effort made in the village of Cranley, successfully meets these shortcomings, and may serve as a model to be copied elsewhere. It is a sensible and useful development of local philanthropy for which we desire permanence and a rich fruition of useful works.’⁵⁸

The reference to ‘permanence’ in this quote might be a veiled warning that such experiments should not fall victim to the fate of many ‘specialist’ or ‘vanity’ hospitals, which attracted support only for as long as the cause was ‘fashionable’, and then disappeared without trace. Napper suggested in a letter published in the *BMJ* that the establishment of a cottage hospital, ‘will do more to elevate the position of the provincial general practitioner, both socially and professionally, than anything that has been done since the passing of the Apothecaries Act of 1815’, an indication that he was well aware that one of the benefits of founding the hospital was an improvement in his own personal standing among the elite in his local community, and hence his income.⁵⁹

At the end of 1862, in conjunction with the publication of the second Annual Report, Napper published a pamphlet entitled a *Statement of the Medical Officer of Cranley Village Hospital*. He stated he had decided to publish the statement, ‘in anticipation of the numerous communications which have on each previous occasion attended its issue’.⁶⁰ Clearly, news of his work was arousing

great interest and generating many calls on him for advice on establishing similar institutions in other places; the pamphlet was his way of anticipating the demand that coverage of the second annual report would generate. He gave two reasons for establishing a cottage hospital: the difficulties faced by a country surgeon in providing essential treatment ‘in the cottages of the poor [which terminates] very frequently in permanent disorganisation or death’; and the benefits to local general practitioners ‘as a means of promoting a more generous and friendly feeling, by bringing us together in consultation on cases of difficulty, and in rendering assistance in severe operations.’⁶¹

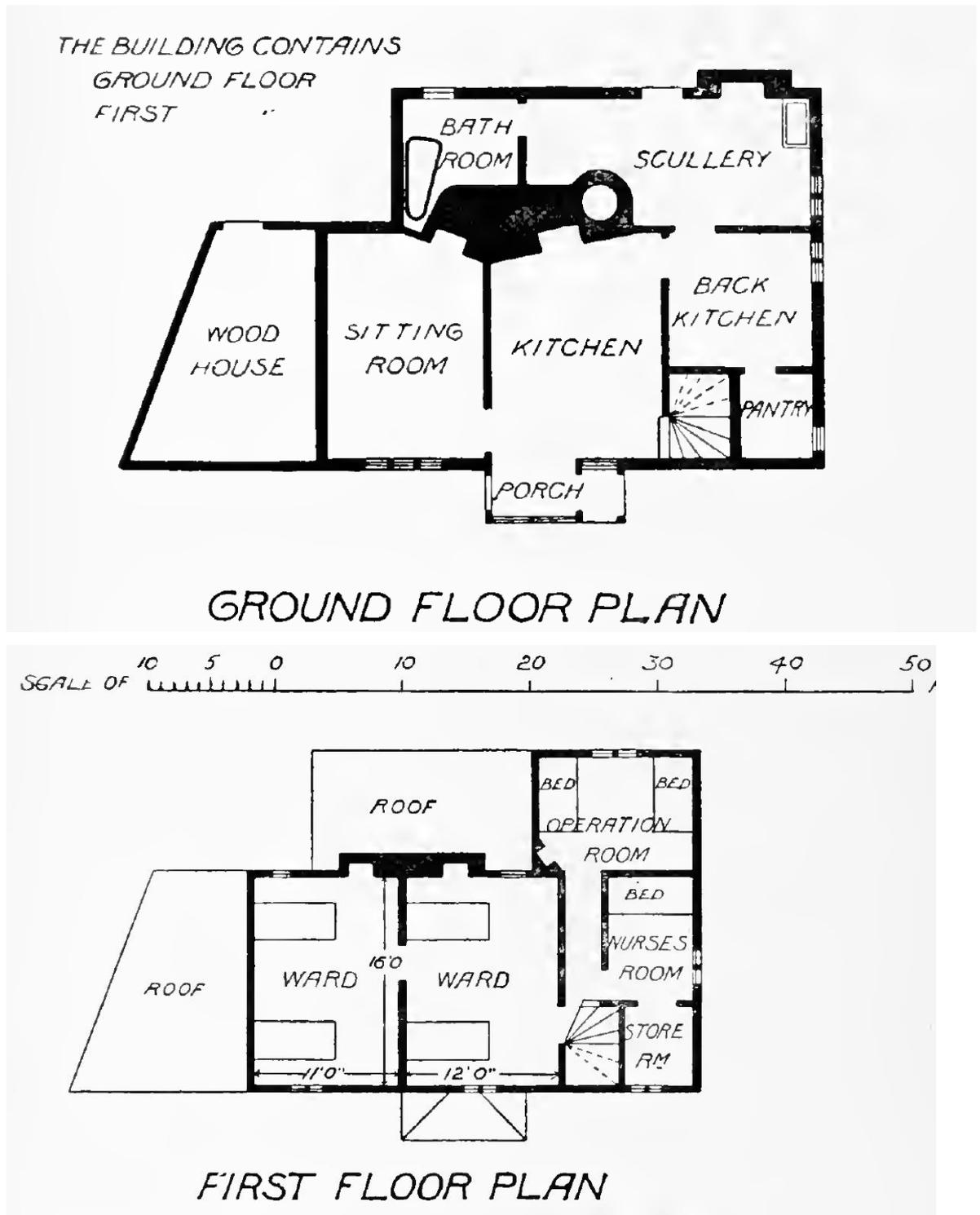
The latter point regarding improved relationships and collaboration between local practitioners had not been evinced in earlier reports, and perhaps was only slowly becoming apparent to Napper through his experience since the foundation of Cranleigh. It paints a picture of rural doctors working in rather isolated circumstances, and that the presence of a hospital acted as a locus for them to gather together and share knowledge and experience.

The pamphlet included extracts supporting the foundation of cottage hospitals from the usual places such as *The Lancet* and the *BMJ* but also from more unlikely sources, including *The Builder* (23 November 1861) and *The London Review* (21 December 1861). The extract from *The Builder* included reference to the improved relations between country doctors: ‘Strong professional jealousies so prevalent in small places [hinder the extension of cottage hospitals]’, continuing, ‘Could country surgeons be made to see how much to their material advantage it would be to combine in order to show that as hospital surgeons they are not inferior to their city brethren ...’.⁶² *The Builder* went so far as to suggest that a successful cottage hospital might actually attract patients to travel in the opposite direction – not from country to city hospital but from city to country. *The London Review* highlighted the positive aspects of a rural location, positioning the benefits of clean country air against the ‘foulness of the air in great cities’ and the high incidence of hospital acquired infections associated with urban institutions, to which ‘the badly wounded agricultural peasant is by the present system transported [...] to almost certain death.’⁶³

In the pamphlet Napper provided a detailed physical description of the ideal cottage hospital building. It should be 'a well-ventilated cottage containing a kitchen and room adjoining, with a wash-house and pantry on the ground floor, and four airy bedrooms ... allowing one bed to about 1,000 of the population'.⁶⁴ He estimated the set-up costs to be £9/7s/5d per bed, a nurse at 12s/- per week and a charwoman for three days a week at 1s/- a day, with the total cost of setting up a 6-bed hospital as £70.⁶⁵ He also included suggestions as to furnishings and the recommended type of bed and mattress. The pamphlet reproduced the rules of Cranleigh Village Hospital, to ensure his philosophy could be transferred to new ventures, intact. Most early cottage hospitals adopted Napper's recommendations and opened with between four and ten beds in converted premises. The emphasis on size prevailed, and fifty years later Burdett defined a cottage hospital thus, 'A cottage hospital is a small unpretentious institution for the treatment of disease in rural districts. Strictly the number of beds should not exceed twenty, if it should even amount to so many. The rules should provide for small payments by the in-patients according to their means.'⁶⁶ The limit on the number of beds had certainly grown, but the emphasis on a small, homely institution was still present.

In his book on cottage hospitals, Burdett reproduced the floor plans for several such hospitals. That for Cranleigh can be seen in Figure 1.2. From this it is clear to see the effect Napper was looking for. To all intents and purposes, this floor plan would resemble that of the type of cottages its patients would be very familiar with. As Napper wrote:

Figure 1.2. Plan of the Cranleigh Village Hospital (source: Burdett, *Cottage Hospitals, General, Fever and Convalescent* ⁶⁷)



'The aim in constituting a Village Hospital should be to obtain a convenient cottage, as nearly as possible assimilated to those usually occupied by the labourer, but supplemented by all such appliances as are required in the treatment of the sick or injured. ... There need be no special day wards for males and females, as experience has shown this to be unnecessary. The patients are not confined to their bedrooms, but when able to sit up usually occupy, by preference, the kitchen, where they feel perfectly at home.'⁶⁸

In keeping with Napper's principle that the hospital and its accommodation should be modelled closely upon the type of dwelling and home environment with which patients were familiar, he avoided the term 'ward' when describing the two, two-bed rooms which the hospital possessed when it opened. It was expected that during the day, ambulant patients would pass time in the simply furnished sitting-room/kitchen, which he likened to the main room of an agricultural worker's cottage, with the important difference that it was both clean and warm. Napper held the opinion that the rural poor were fearful of entering hospital and therefore familiar surroundings would be reassuring. He wrote that 'the rustic labourer ... is often prejudicially influenced by the bustle and excitement of a large hospital ... he is generally averse to the removal to a large and distant hospital ... bring a hospital home to him ... and he has no hesitation in availing himself of the boon.'⁶⁹

Napper advocated that the hospital should be of such size as enabled just one surgeon to oversee it, with the local medical community participating, making the hospital subservient 'to the whole medical body of the district.'⁷⁰ The patient's doctor could choose to operate and specify the medical treatment or delegate it to the Medical Officer, a principle which had been endorsed and agreed at a BMA sectional committee held in 1863 in Bristol, attended by Napper and Swete.⁷¹

In 1864, Napper published his second pamphlet on cottage hospitals, which he wrote in response to the 'increasing interest manifested [...] from ladies, medical practitioners, clergymen and others, respecting the best mode of establishing [...] a village hospital'.⁷² It included a reprint of the hospital's

Annual Report for the year ending 1863, and a summary of admissions and outcomes for his first one hundred patients. Perhaps to counter any fear of encroachment on their territory, the opening paragraphs praised the services provided by the ‘noble scale of [...] our public hospitals’, but continued that as they were only found in London and the larger towns ‘they fail to meet the requirements of the rustic and mining population [...] when machinery has become so general in use.’⁷³ It was important that Napper did not

give the influential city institutions any cause to accuse him of competing with them directly for patients (or for funding).⁷⁴ Napper repeated his argument that it was not possible for the country practitioner to give effective medical aid when the only accommodation available was ‘the miserable abodes of the poor’, in which ‘the patient lingers on in misery, or suffers from deformity, injurious to himself and the reputation of his medical attendant’. What rural communities needed was a village hospital along the lines of that established in Cranleigh.⁷⁵ The pamphlet went to three editions, indicating the level of interest in Napper’s work.

Napper’s pamphlets and the advocacy of medical journals spread knowledge of Cranleigh Village Hospital beyond the British Isles. In 1866, the *BMJ* reported that Dr Herz of Vienna (in a publication titled *Wien. Med. Woch. [Vienna Medical Week]*), had urged his colleagues to consider the benefits of village hospitals as adopted in England with particular reference to Cranleigh.⁷⁶

It is no coincidence that Napper conceived the idea of a cottage hospital at this time. The middle of the nineteenth century was a time of rapid introduction of steam-powered agricultural machinery, expansion of the railway network which ploughed through rural England, and the emergence of new and mechanised industries.⁷⁷ The causes of admission to Cranleigh Hospital, as detailed in Napper’s ‘Statement of the Chief Medical Officer’ and the early Annual Reports, illustrate well the impact of industrialisation on his local community. One third of male admissions to the hospital were agricultural labourers suffering from trauma to limbs, rib and spine fractures, head and face injuries, wounds and

lacerations, as a result of accidents at work. Others had been injured during the building of the local railway between Guildford and Horsham.

The detailed descriptions of the accidents, diseases, treatments and outcomes provided in the Annual Reports illustrated the severity of the injuries and served the purpose of demonstrating the skills which Napper could offer. The reports also enabled Napper to demonstrate the advantages of being able to treat the patient in a local hospital, reinforcing the need to maintain subscriptions and donations. The trustees had written in their report of the hospital year:

‘Most of the cases have been of a severe and dangerous nature: the admission of many railway accidents, which could not have been successfully treated in the huts of the navvies, has made the Village Hospital instrumental in saving the lives as well as alleviating the severe and protracted sufferings of the men in these terrible accident cases.’⁷⁸

The examples of serious and life-threatening injuries to agricultural workers and railway navvies in Napper’s 1864 pamphlet served to reinforce the argument that a hospital was a necessity which had to be supported by the community, even if this was not the primary argument in support of the hospital. EJT Collins has investigated the pace at which agricultural machinery was introduced during the first half of the nineteenth century and observed that its impact on employment was slight when compared to manufacturing. However, after 1850, the agricultural labour market had tightened as migration to new industries and towns took place, and investment in equipment such as threshing machinery and steam ploughs began to increase. Collins analysed the speed at which threshing machines displaced hand-threshing between 1850-1870 and cited a study of farm sale notices in Oxfordshire which showed that in the year 1859/60, a manufacturer sold 1800 reaping machines, compared to only 1,000 sold in the previous eight years.⁷⁹ He concluded that ‘machines were introduced as a reaction to shortages of labour [...] with the result that [...] when the labour current turned there were now more workers chasing fewer jobs and therefore more unemployment’.⁸⁰ Collins’ research provides evidence that as the rate at which machinery was brought into use increased so did the incidence of serious accidents which, as Napper had described, could not be

adequately treated in the labourer's primitive dwelling. While this phenomenon certainly contributed to Napper's reasoning for the establishment of a hospital, in his pamphlets and letters he does appear to give more weight to the significant impact such institutions brought to bear on the local surgeon's status.

A distinguishing feature of all cottage hospitals was the requirement, established by Napper, for the patient to make a weekly contribution of a few shillings to their treatment and care, an obligation which persisted into the twentieth century and in some hospitals continued until the formation of the National Health Service in 1948. This was a significant attribute which clearly demarcated cottage hospitals from their voluntary counterparts. At Cranleigh the sum was set at between 3s/- and 5s/- per week and similar weekly amounts were charged by other early cottage hospitals.⁸¹ Napper's reason for requiring a payment stemmed from his objection to the practice in voluntary hospitals by which most patients were admitted without charge. He argued that:

'It is well known that numerous cases admitted into the hospitals, and more especially to those supported by voluntary subscriptions, are persons capable of obtaining medical attendance, without having recourse to charity [...]. Of all the ruinous evils [...], this is one of the greatest [and] there could be no more effectual remedy than requiring from each patient a small weekly payment.'⁸²

His position was at odds with the financial status of most patients, the 'rural poor', most of who were unable to pay. This is well illustrated by a table in his pamphlet which showed that of his first 100 patients, seventy-four were parish paupers or their dependents and ten had their fees paid by the Guardians.⁸³ He contended that payment should not be an obstacle to admission as the fee was less than the cost to the family of keeping the patient at home and, if the patient was destitute, the Union would pay. Despite his apparent optimism, the total contributed by patients was modest, about 15 per cent of the annual running costs of about £200 in each of the first few years; he had hoped for 30 per cent and in his pamphlet used that value to aspire to. He glossed over his own hospital's difficulty in this, stating 'a plan (for patients to make a weekly

payment) has been found to work remarkably well, realising a sum equal to about one-third the total expenditure'.⁸⁴

Male agricultural labourers, who comprised the largest group of patients, only earned when working, thus a stay in hospital, often of a few weeks duration was calamitous; but that did not seem to concern Napper. He was clearly confident that payment could be made; he explained that 'friends, relatives or employers are ever ready to provide the means when under the influence of anxiety or fear' and as a final recourse the patient could call upon the sponsor.⁸⁵

The principle of small weekly payments by patients found ready support amongst the medical profession. The *BMJ*, in 1860, praised Cranleigh and observed: 'how can we feel anything but disgust for a system which fills St George's and other West-End hospitals with plethoric butlers and lady's maids, whose salaries are amply sufficient to provide all their wants outside of the hospital. Payment of a small fee ensured the patients were adhering to Victorian society's belief in self-help as a bedrock of respectability. Napper found many of his supporters agreed with this principle. Edward Waring, writing in 1867, observed:

'Payment serves to maintain a degree of self-respect in the minds of patients by preventing them from feeling that they are purely objects of charity [...] prevents hospital funds being abused [...] protects the personal interest of the medical officer [and] lessens materially the demands on public benevolence.'⁸⁶

Horace Swete also supported the move: 'My own experience [at Wrington Cottage Hospital] has been that patients are more satisfied to pay; it renders them independent and takes away the feeling they dislike "of being beholden to any one"'.⁸⁷ Agreeing with Swete, a retired physician from Guy's Hospital observed, 'It is well also to encourage the self-respect that is produced by the payment for medical relief, and to encourage self-reliance.'⁸⁸ Henry Burdett, some years later, continued the theme, associating the payment of a fee with feelings of self-help and independence amongst patients, which 'forms the brightest jewel in [the cottage hospital] crown'.⁸⁹ He observed that in a small community where people were known to the vicar and medical officer there was

no difficulty in assessing how much an individual could pay, 'according to their means' and assumed that the thrifty poor would have had the self-respect to put aside a sum to pay for their treatment. 'The really deserving' he wrote, 'are only too glad to show their gratitude, by contributing something.'⁹⁰

According to Brian Abel-Smith, while the practice in voluntary hospitals of charging patients had largely died out by mid-nineteenth century a small number of specialist institutions retained weekly fees, and the practice continued in cottage hospitals, an observation which is supported by this research.⁹¹ The debate about the advisability of charging patient fees rumbled on throughout the century and into the next. In 1907, the BMA, after considerable debate over the merits of pay beds and associated fees in voluntary hospitals, resolved that in cottage hospitals all patients who could contribute towards their maintenance should do so, whilst those in general hospitals should not be charged.⁹² The income and expenditure accounts published in the near-complete set of Annual Reports of Cranleigh Village Hospital from 1860 to 1947 each contained an entry for patient payments and although the sums were trivial, the records showed that the practice did not cease until the hospital was absorbed into the National Health Service in 1948.⁹³

In one of his many publications on the subject, *On the Advantages Derivable to Medical Practitioners*, Napper made the argument for cottage hospitals by emphasising the demand for such services in the countryside. He made a rather dubious calculation based on the assumption that one person per 1,000 (in a population of 29 million) required hospital treatment and that at the time of writing there were only 21,000 beds available in the whole country. If each Poor Law Union housed at least one cottage hospital of six beds, then the deficit could immediately be overturned.⁹⁴ These figures do not quite stack up; Abel-Smith claims there were only 11,000 beds in the whole of England and Wales in 1861, somewhat short of the figure Napper was quoting. Nevertheless, this actually makes Napper's argument even stronger.⁹⁵

Napper again emphasised the importance of patient contributions: he argued that many patients were admitted to hospitals who could well afford to pay for their care, but were admitted free of charge to voluntary hospitals more as a gesture towards the subscriber. The introduction of patient fees (even if of very modest levels) would discourage such behaviour, and the cottage hospital was the best place to implement and encourage such a policy.

The designation 'village' hospital was important to Napper and he dismissed suggestions that 'district' would be a better term, which implied a larger institution than could be managed by a single medical officer and nurse and therefore would require 'an enormous increase in expenditure.'⁹⁶

Notwithstanding Napper's dogged support of the term 'village', 'cottage hospital' had started to be used synonymously and remained the most popular designation for hospitals of this type, even when, later in the nineteenth century, purpose-built hospitals with twenty or more beds were established in rural settings and small towns, both using the 'cottage hospital' label.

The replacement over time, of 'village' with 'cottage' can be traced in the Cottage Hospital Database. In Liskeard (Cornwall) and Dorking (Surrey) cottage hospitals opened in 1861 and 1863 respectively, while Bourton opened as a village hospital in 1861, and in 1863 it was reported that the working men of Weston-super-Mare were on the point of establishing a village hospital.⁹⁷ A report in *The Standard* of 1869, which described the opening of Speen Village Hospital, referred to the Village Hospital Movement, which must have pleased Napper, but despite his urging, within a few years 'cottage hospital' had become the common suffix.⁹⁸

Horace Swete in a paper delivered before the Bath and Bristol branch of the BMA, in 1866, entered the debate with an unhelpful contribution:

'In the year 1859, two new hospital plans arose: that of Cottage hospitals, of a small number of beds, from twelve to twenty; and Village hospitals of a simpler character still. Nor must we confound the two plans, though the names of village and cottage hospitals are used synonymously.'⁹⁹

He appeared to differentiate between the two, but failed to identify what the differentiating features were, other than the 'village' hospital was even simpler in character than its 'cottage' counterpart.

Napper gave his time and expertise *gratis*, a policy which appeared to be practised in all early cottage hospitals. The giving of free medical services, often including medicines, was common in the voluntary hospitals, but was strongly opposed by the *BMJ* and remained highly contentious. The *BMJ*'s perspective, arising from the 1858 Medical Act, was that medicine had now been established as a profession for which payment for services rendered was to be expected and it therefore condemned the widespread custom of doctors giving their services *gratis* in hospitals.

William Bynum has discussed the paradox of the doctor who worked free of charge in hospitals, yet needed an income. As most prestigious hospital appointments were part-time, the remainder of the day was available for private, that is fee-paying, patients. Additionally, fees could be earned from lectures and from teaching surgery through what was an apprentice system. Being a hospital appointed surgeon conferred status and perceived expertise, which attracted private patients.¹⁰⁰ Cranleigh Village Hospital, adjacent to Napper's home, with only six beds did not require his full-time attendance as rarely more than four of the hospital's six beds were occupied.¹⁰¹ He was therefore in a similar position to a voluntary hospital consultant, with time to treat those in the middle and upper classes in his community who were able and willing to pay. Napper also had a private income; by 1871 he had inherited the nearby 120-acre family farm which employed four men.¹⁰²

As cottage hospitals continued to be founded during the 1860s, the *BMJ* saw them providing the rural practitioner with a further source of income and contested any extension of unremunerated services to these new institutions. In October 1863, it praised the benefits which village hospitals provided, but commented that resulting from the practice of gratuitous services in these new establishments 'an enormous system of professional demoralisation will be established throughout the country.'¹⁰³ The article invited replies to the

question: 'Give us the reasons why it is right and proper that this work shall be done without pay and reward?'¹⁰⁴ Napper responded, observing that he did not wish to discuss gratuitous services 'as it would raise questions far too intricate for my present purpose' and proposed that those interested in village hospitals should meet to determine a 'just and equitable system of management' which he would be pleased to coordinate, a suggestion supported by the Editor.¹⁰⁵ There were no later references in the *BMJ* to progress having been made.

Two months later though, the *BMJ* returned to the topic, observing that if village hospitals were to be worked gratuitously 'the degraded position of our profession will be still further promoted and extended'. It posed a number of questions to those doctors giving their services free of charge, notably 'Do they do the work out of a pure love of charity, or is it to promote their own private ends?'¹⁰⁶ In a letter to the journal, Napper replied, perhaps deliberately misinterpreting the meaning of the *BMJ*'s second proposition, that it was for both reasons: 'the first by providing for the poor, comforts and efficient treatment [and] the second, by relieving ourselves of a great amount of labour [...]'.¹⁰⁷ He neatly sidestepped the *BMJ*'s implied criticism that doctors were undertaking the work free of charge to boost their local reputations and thereby their practices amongst paying patients in the community. Instead, Napper explained the benefit as being in terms of efficiency: as his patients were accommodated in one building, the doctor avoided the time and effort required to travel and treat a number of individuals in their own dwellings. He defended gratuitous services arguing that it would not be possible to 'establish a village hospital on the principle of payment for professional services.'¹⁰⁸ To Napper, it was normal practice for a hospital doctor to give his services freely, and it would not have occurred to him to expect the hospital patient to pay him a fee. It should be noted that when Napper is talking about fees, he is referring to fees paid directly to the doctor by the patient. He strongly supported the concept that patients should pay something towards their 'maintenance' while in hospital, but was adamant that the doctor should give his services to the hospital free of charge. In its editorial for the same issue, the *BMJ* made a powerful argument against Napper's stance. It opened by restating the arguments in favour of

village hospitals, reiterated its continuing support and encouragement for the movement but asserted:

‘We have opposed, and still oppose, their [cottage hospitals] being carried out on the gratuitous medical services principle, just as we oppose that principle as adopted in our hospitals and dispensaries ... We are anxious not to see [...] so vicious a principle [...] so injurious to the standing and credit of our profession [...] carried out still further into practice, as it will be, if village hospitals are to spring up all over the country.’¹⁰⁹

The Editor scorned Napper’s opinion that medical men give their services partly out of a ‘pure love of charity.’ He observed that such services were not given out of charity, but because the giving ‘promote[s] indirectly the worldly interests of the giver of them.’ The article asked why the doctor should give his services free; the butcher and baker were not expected to. If society decided to provide a village hospital, then it was also the duty of society to remunerate the surgeon. The article concluded, again, that ‘nothing has done more to degrade and lower our profession [...] than the enormous system of gratuitous medical services [...] and what is worse, we shall further lower the value, the money-value, of our services in the eyes of the public, and our own reputation.’¹¹⁰

Clearly, the *BMJ* was not going to let the issue lie. A leader in the February 1865 issue drew attention to the practice, ‘prevalent in the metropolis’, by which some practitioners provided free advice and services to entice clients to consult them. It railed that ‘as a pretence of benevolence, the whole thing is a bare-faced sham.’¹¹¹ Despite the *BMJ*’s opposition, early cottage hospital medical officers continued to give their services *gratis* and it was not until the 1890s that doctors’ salaries began to feature in the accounts published in Annual Reports.¹¹²

Alongside Napper’s two pamphlets, Horace Swete and Edward Waring (both strong advocates of cottage hospitals) published guides to their principles and benefits, aimed at medical practitioners. In 1866, in his address to the Bristol and Bath Branch of the BMA, Swete described at length the principles and benefits of the cottage hospital.¹¹³ His paper, largely based upon Napper’s

pamphlet of 1864 coupled with his own experiences at Wrington, described the health and recovery issues which resulted from a lack of beds for rural patients suffering from the results of accidents, and the disparities in bed provision between counties. He proposed that the need should be met by establishing a network of cottage hospitals.¹¹⁴ In contrast to Napper, his concern as a rural surgeon was the lack of facilities for those suffering from hernias, compound fractures and gunshot wounds, rather than from accidents caused by agricultural machinery.¹¹⁵

Swete also entered the debate on gratuitous medical services, arguing that having access to a village hospital saved the country doctor miles of hard riding. 'We cannot honestly call such services gratuitous', he wrote, 'and go cap in hand to the public and ask them to pay us a salary for helping ourselves.'¹¹⁶ The Editor of the *BMJ* responded by restating support for village hospitals, but repeated the journal's long-standing objection to free medical services which added a new 'burthen' to country doctors. It further criticised Swete for not understanding the delicate relationship which must exist between country and workhouse doctors: treating paupers free of charge endangered the salaries of Poor Law doctors, which were already low. A note added to the end of Swete's article rebutted several of his arguments, and concluded that Swete's point of view would inevitably, '[make] village hospitals a set-off against Poor-law shortcomings.'¹¹⁷

Swete had collected information about a number of cottage hospitals with a view to publication, 'to show how simply and inexpensively a Cottage Hospital may be managed' but noted that circumstances had prevented him from publishing his observations. He had left Wrington for employment elsewhere, and had made his papers available to Edward Waring who used them in his own publication on the topic in 1867. Waring was an influential and respected physician and surgeon whose words carried considerable weight. He had had a distinguished career with the East India Company for which he was made a Companion of the Indian Empire (CIE).¹¹⁸ On his retirement he moved to Uckfield, East Sussex, and would have known Napper, then President of the South-Eastern Branch of the BMA, to which both belonged. In his 1867 book,

Cottage Hospitals: Their Objects, Advantages and Management, his opening words were, 'Of all the schemes which of late years have engaged the attention of philanthropists, few, if any, appear more worthy of commendation than the Cottage Hospital system.'¹¹⁹ His intention, on writing the book, was 'in the sincere hope that it may [...] tend to promote the extension of the system.' He acknowledged Albert Napper as the founder of the movement but took issue with him over the use of the term 'village', proposing that 'cottage' be adopted instead '[...] in that it serves to define the true character of the establishment [...] when a labouring man or a mechanic becomes an inmate [...] his surroundings will approximate as nearly as possible to those of his own humble dwelling.'¹²⁰ The image of Napper's Cranleigh Cottage Hospital in Figure 1 illustrates this well.

Waring's influential slim volume was a valuable guide for the rural practitioner seeking to open a cottage hospital and it provided arguments which could be deployed against critics, structured under four headings: 'the Poor, the Medical Practitioner, the Clergy, and the Rich.'¹²¹

To reassure those concerned that a local hospital would simply be a further charge on the rates, Waring (in a departure from Napper's principles and practice), carefully distinguished between the 'large and deserving class who support their families by honest labour' for which the hospital was intended, and the pauper with a claim on the parish. His 'deserving poor' in agricultural districts included small farmers, tradespeople and mechanics who lived in unsatisfactory, unhygienic, unheated, dimly lit and badly furnished dwellings. This he contrasted with the facilities provided by a hospital: strict cleanliness, good ventilation, heated, with 'a steady bed with a good hair mattress', clean bed linen, and a good night's sleep unbroken by the noises of children; and with the benefits of constant and regular supervision by the doctor or surgeon.¹²² Good nursing too was essential; the services of a 'permanent nurse [...] would be a boon of no small amount', citing cases in which patients resident at home had had splints loosened, bandages removed and medicine administered incorrectly. Unlike Napper, Waring favoured the employment of a trained nurse, provided funds were available.

Waring supported Napper's argument that one of the many benefits to the practitioner of having their own hospital, provided it was central to the village and near the medical officer's residence, was that he was better placed to give assistance than if he had to ride several miles in all weathers to the patient's inadequate dwelling. He also, importantly, supported Napper's stance on the subject of payment of medical officers for their services, contending that payment for medical attendance should be rejected as a cottage hospital could not afford to pay an adequate salary, '£20 [would be] the utmost which could be expected [and would be] regarded more as an insult than a remuneration.' He concluded 'No! Rather let the services be gratuitous'.¹²³

Waring knew that support of the rural parish priest was essential and appealed to his self-interest, observing that in the hospital he would have a captive audience: 'The spiritual welfare of the parochial sick and suffering is intimately interwoven with the legitimate work of the Christian pastor', he claimed.¹²⁴ He stressed that in most cottage hospitals, the clergyman acted as Manager and exercised considerable influence over the running of the hospital and that much of the success of these hospitals depended upon the clergy. Not only that, every guinea raised from sermons and collections conferred the right to recommend admissions, 'without entailing [...] an expenditure which many clergymen are not in a position to defray', a helpful extension of the parson's authority and standing in the community.¹²⁵

For the medical practitioner, 'No plan could have been devised more calculated to raise his professional status', wrote Waring, again referring to the difficulties in transferring sick patients to distant hospitals.¹²⁶ 'No longer would he have to transfer patients to the County Hospital, over poor roads, where the risk of hospital borne disease was much higher than in cottage hospitals.' Not only did such practice put the patient's life at risk, it also raised a question mark over the doctor's competence, begging the question, why he was not able to treat the patient at home? A further consequence of moving patients to county hospitals was the impact on the experience gained by the local doctor. As Waring states, '[the local doctor's] hand gets out of practice, [his] knowledge languishes, he

loses nerve and confidence [...] in time, [he is] incapable of undertaking the more serious surgical cases.¹²⁷ Waring referred to the detailed diagnostic, treatment and outcome data in the early Cranleigh annual reports, which he included to demonstrate to his readers what was possible if the right conditions were created and to encourage rural practitioners to establish a cottage hospital where they too could undertake advanced surgery.

Waring was blatant in his appeal to the self-interest of the wealthy. Not only could they be certain where and how their largesse was being deployed, but when they themselves needed medical attention, they would have confidence that the local doctor would have up to date skills, practised in the hospital using the latest surgical equipment and appliances. He repeated an opinion voiced in *The Times*, that the local gentry would benefit greatly from the lessons learned in the hospital, claiming ‘the peasant’s misfortune may be the means of saving the life of the squire.’¹²⁸ The article continued, ‘It is an act of wisdom on the part of wealthy county families [...] to encourage these establishments [...] of which so great an advantage may accrue to themselves.’¹²⁹ He reminded the wealthy that funding or endowing a hospital was a great opportunity to perpetuate a cherished name, ‘associated with deeds of kindness and benevolence.’¹³⁰

In 1869, evidently familiar with Waring’s pamphlet of 1867, D H Monckton wrote to the *BMJ* from Rugely, Staffordshire suggesting that the cottage hospital could also serve as a depot for medical equipment to be stored and accessed by the local medical fraternity, echoing previous claims that the establishment of such an institution would foster harmonious and collaborative sentiments among local practitioners. Monckton also identified the possibilities offered for the establishment of a ‘humble school’ for the training of nurses for the neighbourhood. It was clear from his letter that by 1869 the general principles of cottage hospitals were well established and understood: ‘It is well for the community to feel and know there is [...] a bed, a nurse, a medical staff [...] for [...] the maimed, the crushed, the burnt, of whatever rank or station’ close at hand.¹³¹

By mid-century, the publication of Napper and Swete's ideas had received significant levels of publicity and generated great interest, resulting in the foundation of some forty-six cottage hospitals by the end of 1866. In fact, it seems that in some ways, they had been too successful. Disquiet had arisen amongst some sections of the medical profession about the possible adverse financial impact upon those practising in the voluntary hospitals, as hinted at in the *BMJ* article of 1866 (referred to above), where concern was raised about the impact of cottage hospitals on the income of Poor Law medical officers.¹³² To counter these concerns, Waring recommended that a cottage hospital should not be too close to a County hospital as it might 'interfere with [its] legitimate operation', and it should not be too near another cottage hospital, ideally between seven and ten miles distant with a catchment area of about 4,000 inhabitants. Maintaining a reasonable distance between the cottage and county hospitals ensured that either one or the other would be accessible to the rural patient yet minimised the risk of the subscription income of one being cannibalised by its near rival.¹³³

In 1870, Swete returned to the subject of cottage hospitals and published the *Handy Book of Cottage Hospitals* which supplanted Waring's booklet and became the standard work for some years.¹³⁴ Swete acknowledged concerns that 'village hospitals [...] would and must injure older establishments [...] by diminishing their funds, and taking cases from their medical staff'.¹³⁵ But he countered this criticism, citing his own hospital at Wrington and another at nearby Hambrook in Gloucestershire, where he could find no example of subscribers cancelling their subscriptions to near-by town institutions (in this case, Bristol Royal Infirmary). Rather the majority had never previously subscribed to any hospital, 'their purses had never before been opened', he wrote rather dramatically, revealing another benefit of cottage hospitals: enabling local inhabitants to experience the luxury of aiding others, in true Victorian philanthropic zeal.¹³⁶ He asserted that county infirmaries were filled with patients who could be more efficiently treated in a village hospital, close to home, which could deal speedily with minor cases, fractures and hernias, thus leaving space for 'difficult or obscure cases', to be treated by the county hospital.¹³⁷

Ten years on from the beginnings of the cottage hospital movement, Swete's book restated the arguments. He supported most of Waring's suggestions and reiterated Napper's core principles, that patients should make a small weekly contribution. The hospital should admit all ages and both genders of the rural poor and it should be sited in a local vernacular building containing ten beds or fewer, accessible to all local medical men but supervised by one. Swete stressed the importance of support from local subscriptions and donations. He was especially critical of the practice common in voluntary hospitals of 'Governor's notes', which were commonly used as an encouragement to maximise the individual annual subscriptions. The subscriber was usually entitled to a seat on the governing board and the right to recommend one or more patients each year for admission. The higher the subscribed the more admissions could be sponsored. This system was subject to much criticism, said to be abused by subscribers who used it gain free treatment for their servants or employees, when they could afford to pay. Swete strongly opposed extending the practice to cottage hospitals, as that could potentially allow the rich subscriber to fill the hospital with his nominees; he commended Napper's principle of equality of privilege, by which a subscriber, irrespective of status, could recommend a person for admission: '[in a cottage hospital] the farmer or shopkeeper has as much right to recommend patients as the squire', he stated.¹³⁸

Swete had conducted meticulous research in order to compile his book, visiting many of the cottage hospitals then in existence, from which he concluded that the majority were 'conducted on the Cranleigh model'.¹³⁹ His brief descriptions of the hospitals add further details as to their organisation. At East Grinstead (Surrey) for example, 'the special feature of this hospital is the garden, which teems with a profusion of flowers, Dr Rogers being an enthusiastic botanist and florist.'¹⁴⁰; at Shedfield (Hampshire), referring to the sole nurse, he wrote 'She is a person of that parish, particularly clever, active, and judicious, and knowing how to treat those of her own class better than a lady could'.¹⁴¹ In Newick (Sussex) 'The wards are ventilated by Watson's patent ventilators [...] Moule's earth closets are also used,'¹⁴² and at Burford, St Mary's (Oxfordshire), 'This

institution is provided [...] with a complete store of linen, dressing gowns, slippers etc., for the use of the patients.’¹⁴³

While most cottage hospitals did follow Napper’s simple plan, some were beginning to deviate from it, much to Swete’s disapproval. He cited, with some disdain, a hospital in North Wales which housed the paralysed and epileptic (incurable and therefore in Napper’s vision not eligible for admission), which offered homeopathic treatments which ‘most happily did not work’, had a lending library, was an evening meeting place for the wives and daughters of tradesmen, and was a home for training ‘Bible-women Nurses’, a particular dislike of his.¹⁴⁴ He also quoted the example of Dorking Cottage Hospital (Surrey) which had attempted to include a home for girls and an orphanage. It had failed, no doubt through overstretching itself. A new institution was in the process of being established at Dorking which would focus solely on medical and surgical work, he reported: ‘Such institutions mixed with [...] a cottage hospital [...] is a mistake... Mix up two or three different objects and the whole inevitably languish and ultimately fail.’¹⁴⁵

Among the hospitals he visited he found examples of innovation which impressed him. An invalid kitchen at Shedfield (Hampshire) was one such. Here dinners and other meals were distributed to parish invalids who were not in the hospital, and parishioners were able to purchase a 6d ticket which entitled them ‘to roast or boiled meat, broth, beef tea or puddings on Wednesdays and Saturdays at one o’clock’.¹⁴⁶ A second commendation went to Savernake Hospital (Wiltshire), which employed an itinerant nurse: ‘A bed and mattress and all necessaries for the sick are made to pack up in a large box, which, with the nurse, are carried in a donkey cart to the patient’s house.’¹⁴⁷ Both initiatives seem close to breaking Swete’s rule about focus on medical care, especially the first, but do support one of the key objectives of a cottage hospital, to be at the centre of the community it served.

Unusually, three cottage hospitals described by Swete paid their medical officers – although it should be noted at rates Waring would have described as insulting. At Mansfield Woodhouse (Nottinghamshire) an annual *honorarium* of

£12 was paid; Lady Dunraven's Hospital at Clearwell (Gloucestershire) was 'open to all medical men, one acting as director, and receiving payment for his services'; while the services of the acting medical officer at the Countess de la Warr Hospital, Sevenoaks (Kent) were 'provided at the cost of the foundress [...], the medical officer [receiving] £25 per annum.'¹⁴⁸ Swete did not discuss these exceptions to the usual practice, but it is interesting that two of them were established in honour of local dignitaries (Countess de la Warr and Lady Dunraven), who Swete noted, paid for the medical attendant's salary themselves.

Collectively, Napper, Waring and Swete generated an enormous amount of publicity around the innovative cottage hospitals, through pamphlets, books and articles and a mass of correspondence to medical journals, both promoting and defending their experiment. All three were active BMA members in the south and south-west of England, where many of the early cottage hospitals were founded. Waring and Swete both published simple guides which presented the arguments and demonstrated the relative ease and low cost of establishing a cottage hospital whilst Napper included evidence in his two pamphlets of the success of his hospital by including details of cases and their outcomes. It is probable that all these publications were available at BMA Branch meetings in the south and south-west, and generated significant levels of interest among both their fellow medical men, but also in the wider philanthropic community. The importance of the philanthropic urge to cottage hospital development

All cottage hospitals shared a common goal, clearly stated in the rules of each of the hospitals included in this study and published in their Annual Reports. Various worded, it asserted that the hospital was first and foremost for the benefit and accommodation of the poor.¹⁴⁹ Victorian society acknowledged poverty as the natural condition of the working class, defined by the Poor Law Commission as 'the state of one, who, in order to obtain a mere subsistence, is forced to have recourse to labour'.¹⁵⁰ For most working poor what they earned was barely sufficient for daily life, let alone for contingencies such as in times of sickness.¹⁵¹ The 1864 Annual Report of Bourton Cottage Hospital, confirming historian David Englander's observations, noted that 'it was specially founded

[for] those who, beyond the aid of parochial relief, are yet unable to meet the expenses attendant upon medical help at home.’¹⁵²

Entirely relevant to the founding of the early cottage hospitals was an ethos of ‘giving’ to relieve hardship, grounded in Christian ideology and motivated by altruism. Napper and John Moore (the founder of Bourton) attributed their successes to the active support of the local Anglican Church and having suitable premises in which to work. Waring, as discussed above, also put forward strong arguments in favour of the active involvement of local clergy. Local churchmen were well-represented on hospital committees, were subscribers and some acted as hospital managers, as such, as Waring succinctly noted ‘he is thus enabled to exercise great influence’.¹⁵³ In a similar manner to local surgeons a new hospital offered local clergy the opportunity to boost their standing in the community.

Uplifting pamphlets and magazines, which encouraged the philanthropic urge driven by religious tenets were prominent in popular culture. *Good Words*, with a focus on promoting orthodox Anglican beliefs by publishing content of a religious or pious nature, was one of three large circulation illustrated magazines which dominated the market in the 1860s. In 1866, Andrew Wynter, former editor of the *BMJ*, wrote an article for *Good Words*, which was, essentially, a rewrite of Napper’s 1864 pamphlet with some additional content of his own. It described Cranleigh in detail, referred to the early cottage hospitals at Fowey and Bourton and was presented in a style designed to encourage readers to perceive support of their local hospital as a Christian duty. ‘In looking over the annual reports of these village hospitals’, he wrote, ‘we cannot help being struck with the willingness which neighbours exhibit in supplying the needs of the sufferers.’¹⁵⁴ The importance of local charity was hammered home as he continued, ‘how much more we feel inclined to help those we know something about than strangers, and in the country we all know one another.’¹⁵⁵ An extract from another article by Wynter, titled ‘Help for the Agricultural Sick’ from the magazine *Fruit between the Leaves* was included in the 1877 Annual Report of Bourton Cottage Hospital and stressed a different benefit, alluded to above: ‘The country gentleman who gives his annual subscription [...] is at the same time keeping the Village Surgeon in school, against the time

when some terrible accident overtakes him in the hunting field.¹⁵⁶ In other words, what starts out as a charitable act, for which reward will be received in heaven, may be of benefit to him in a more earthly context as well.

Major acts of philanthropy such as donating land and funding the construction of a building were examples of significant philanthropic activity. Capel Memorial Hospital which opened in 1866, was funded by the Broadwood family in memory of Rev. John Broadwood.¹⁵⁷ Swete recorded eight similar examples in his list of early cottage hospitals: Countess de la Warr, Sevenoaks (Kent); Crewkerne (Somerset); Ilfracombe (Devonshire); Lady Dunraven's, Clearwell (Gloucestershire); Rugeley (Staffordshire); Savernake (Wiltshire); St. Mary's, Burford (Oxfordshire); and St John's, Ashford (Kent).¹⁵⁸ However, this level of investment was not common in the early hospitals, although significant individual gifts of money and/or land began to be much more important from the mid-1870s, and is discussed in Chapter 2. For most of the early hospitals, the initiative came from a local surgeon and/or churchman with money raised in many small individual contributions, the hospital supported by modest annual subscriptions and donations of money, food, drink and decorative furnishings.

It can be readily understood why local aristocracy and wealthy landowners would be willing to lead fund-raising appeals and become trustees; it was in tune with the vogue for philanthropic giving, it married with the concept of *noblesse oblige*, benefitted local people many of whom would have been employees and, most appealing, it did not cost very much: about £25 to the building fund and £10 a year subscription thereafter.¹⁵⁹ Historians have considered the influences which came to bear on the opening of these hospitals. Economic historian E L Jones, in his work on the condition of agricultural workers in the second half of the nineteenth century, put forward a more prosaic explanation of the philanthropic urge. '[M]any Victorians', he wrote, 'unashamedly admitted their economic motive for improving the lot of their workmen'.¹⁶⁰ He noted that 'fringe' benefits, such as allotments and cottage improvements, were being offered as inducements to skilled workers to remain on the land rather than move to the new towns and industries and considered that the cottage hospital movement should be seen as one of those

benefits in kind. A worker who could be cured by a short stay in hospital could quickly return to employment so not only he and his family avoided becoming a long-term charge on the parish, but the employer was inconvenienced for the shortest possible time.¹⁶¹

There is some evidence in this study to support Jones' suggestion; patients with simple fractures, wounds and concussion sustained in accidents at work were treated and discharged reasonably quickly. Patient records showed that most were discharged after between four and seven weeks, so a stay in a cottage hospital should be compared with the length of time to recover whilst remaining in their unhealthy dwelling, treated by a doctor travelling on horseback in all weathers.¹⁶² No comparative data has been found, but it is more likely that recovery was faster and more effective in the cottage hospital. Reduction in the doctor's travelling time coupled with proximity to a patient admitted to the hospital were frequently mentioned as a major benefits to both parties by Napper, Swete and Waring.

Another aspect of cottage hospitals, which would have appealed to Victorian philanthropists according to Emrys-Roberts, was the low cost and relative ease of opening a local hospital. While middle-class Victorians were imbued with a philanthropic urge to help those worse off than themselves, they also assigned a high premium to efficiency: 'the value for money [which these institutions represented] appealed [...] to the many members of the middle classes [...] looking for suitable outlets for their goodwill', he observed.¹⁶³ He also argued that in the mid-century the changed climate of opinion resulting from the abysmal medical care provided to the wounded during the Crimean War, publicised by Florence Nightingale, had refocused attention on the quality of care provided to the general population.¹⁶⁴ This, combined with a flourishing philanthropic sentiment, created an atmosphere conducive to new charitable organisations which focused on the care of the sick poor.

Philanthropy was an essential element in the foundation and maintenance of cottage hospitals and to a certain extent it shaped how those hospitals developed. For instance, most hospitals included rules which excluded certain

groups of patients, namely those suffering from infectious diseases, from tuberculosis in its various forms, maternity cases and incurables. The practical reasons for these exclusions are described above, but another consideration is the impact of these cases on donations. The potential for such cases to become, in modern parlance, 'bed-blockers' and thereby reduce efficiency in the hospital's model was real. If too many patients appeared to be taking up too much space for too long in the hospital's meagre accommodation, donors might withdraw their support – particularly if it meant their sponsored patients could not gain access as a result. Equally, some of the conditions covered by the exclusions would have a higher than normal death rate associated with them. The last thing the hospital wanted in its annual reports were increasing numbers of deaths among its patients; suggesting to subscribers that their money may not be well spent.

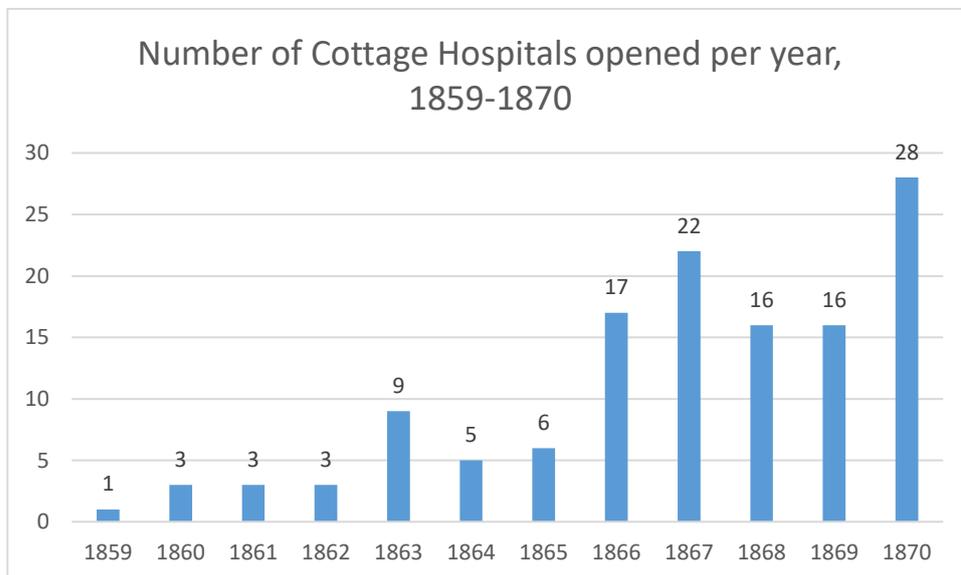
Cottage hospital growth and spread

As suggested above, the initial response to Napper's 'experiment' in Cranleigh received a significant level of publicity, and public support from influential bodies such as the BMA, and as a result, doctors and clergy around the country began to consider the possibility of establishing similar institutions in their locality. The rate at which hospitals were founded increased throughout the decade 1860-70, as shown in Chart 1.1 below.

As indicated earlier there were a small number of modest institutions established before Cranleigh Village Hospital, which have been described by contemporary writers as cottage or village hospitals. It is not possible to state with confidence if these hospitals were open continuously, and certainly, although Burdett included them, he expressed doubt as to their status.¹⁶⁵ Initial uptake of the idea was slow, after the opening of Cranleigh in 1859, only three opened in each of the following three years, and these were scattered around England and Wales, including one in Jersey (Channel Islands) and another, the Dinorwig 'Quarry' Hospital, in north Wales, which could be considered industry-specific and may not have admitted patients from the whole community.

Chart 1.1. Cottage hospitals opened each year between 1859 and 1870.

Source: Cottage Hospital Database.



However, from the mid-1860s to the end of the decade, a cavalcade of new institutions emerged, and by 1870 there were at least 137 cottage hospitals open for business, as Chart 1.1 indicates. In this period cottage hospitals were opening at rate of c20 per year. Map One in Appendix 4 displays the locations of these early cottage hospitals, and shows clearly how the successes at Cranleigh and Bourton influenced other nearby general practitioners to develop their own institutions. Early hospitals were concentrated in rural villages in the south and south-west of England; about 60 per cent were located below a line from Bristol to the Wash, notably in the counties of Surrey, Hampshire, Wiltshire and Gloucestershire. Towards the end of the decade cottage hospitals were beginning to open in the Home Counties of Middlesex, Essex and Kent. Chapter 2 discusses possible reasons why southern and south-west counties were early adopters of cottage hospitals, yet counties which were predominantly rural, such as Lincolnshire and Shropshire and the new industrial towns in Lancashire and Yorkshire took little part in the first phase of development.

The advocacy of professional journals such as the *BMJ* and *The Lancet*, Napper's pamphlets, and books by Waring and Swete had found a ready

response amongst the south and south-west rural medical communities, with which the authors were closely associated. The case details and results which Napper had included in his early Annual Reports had shown how the treatment of serious accidents, emergencies and certain chronic illnesses in a clean, warm environment accompanied by good diet, could improve the chances of a successful outcome; and how this in turn could lead to increased professional standing of the founding medical officer.

As discussed earlier, Cranleigh rector John Sapte vehemently disputed that Napper was the founder of village hospitals, claiming credit for himself and his wife. His outburst, in a long letter printed in the *Surrey Advertiser* on 1 April 1882,¹⁶⁶ was the result of a proposed testimonial fund for Napper initiated by the south-eastern branch of the BMA, in recognition of his role as the ‘originator and founder of the cottage hospital system’.¹⁶⁷ After much lengthy correspondence, Sapte remained convinced of his position, but unfortunately for him, the medical profession preferred the view that Napper, the surgeon, had opened the first cottage hospital and Sapte’s putative role as founder of the movement was quietly erased from history. Napper, on the other hand, continued to assert his claim to be the originator of the idea. The title page of his book, *On the Advantages Derivable to the Medical Profession*, was inscribed, ‘By Albert Napper, Esq., MRCS, LSA, Founder of the System, Cranley, Surrey.’¹⁶⁸ With the support from colleagues and the BMA, regardless of Sapte’s objections, Napper became recognised as the *de facto* initiator of the cottage hospital movement.

Conclusions

The decade of the 1860s saw the emergence of a new type of hospital in England and Wales, whose purpose was specifically to cater for the healthcare needs of the rural poor, a section of society which had been much neglected to this point. From the foundation of the first cottage hospital in the village of Cranleigh in 1859, by the end of the 1860s there were over 130 established on the same principles, situated mainly in the south and south west of England. Albert Napper, founder of the Cranleigh hospital, was generally recognised at the time as the founder of what became known as the Cottage Hospital

Movement. He established certain principles which he encouraged others to follow in establishing their own local hospitals. The institution should be small and homely, to help patients feel comfortable in surroundings they recognised. It should be open to anyone in the locality who could not afford to pay for medical treatment (with a few exceptions); patients of all ages (including children) and both genders should be admitted. To encourage self-sufficiency (and to prevent abuse) patients should pay a small fee towards their maintenance, but the cost of treatment should be provided free of charge, and the medical officer should (ideally) not be remunerated but should provide his services *gratis*. In return, all practitioners in the locality should have access to the hospital's facilities and could opt to treat their patients in the hospital if they desired. Finally, the hospital should be funded by local donations and subscriptions, with the whole community encouraged to contribute through collaboration with the local clergy.

Such institutions would confer obvious benefits to the patients, providing local treatment, avoiding long and arduous journeys to the local county hospital (and all the dangers implicit in such institutions, such as hospital infections). Local medical practitioners would benefit from the ability to use the well- equipped hospital to hone their skills, with a by-product of raising their local standing and attracting more fee-paying patients. Their treatment of the sick poor would be facilitated by gathering patients together in one place, thus averting the need for long and tiring rides to outlying patients over poor roads. Finally, the local gentry would benefit from the presence of a doctor who could practice his skills on the poor in the hospital, but then use those same skills in the treatment of his paying patients, obviating the need for the patient to travel to London or other big city where he would normally go for treatment.

There were dissenting voices, particularly from practitioners who feared new competition, especially when it became apparent that these new hospitals were not mere 'vanity projects', here today and gone tomorrow, but were becoming established for the long-term. This criticism was especially acute from Poor Law doctors, who feared their already miserly pay would be further eroded. However, these voices were generally quietened by reassurances from Napper

and his colleagues that this was not their intention, and that in fact the presence of a cottage hospital offered the opportunity for doctors to work together, rather than in competition.

Cottage hospitals clearly fulfilled a growing need for healthcare closer to the patient, than provided by large voluntary and county hospitals. These needs were changing with the increasing mechanisation of agriculture and the construction of railways through the countryside, both of which were associated with increased levels of accidents. In cottage hospitals, such injuries could be treated on the spot, keeping the patient local for a speedier return to work. They also provided opportunity for the middle-classes to indulge the growing philanthropic urge, providing them with eminently deserving local charities, whose effects could be seen at first hand, and whose beneficiaries would be local and known to the hospital's supporters.

Where cottage hospitals emerged was a random process which bore no relationship to national need. However, the majority of the early hospitals were established in the south and south west of the country, mirroring to a certain extent the networks of Napper and his two supporters, Swete and Waring. As all three were active in regional BA branches, it is perhaps not surprising that it is in these regions the 'Movement' first found its feet. It was a slow development though: the 130 plus hospitals which had opened by 1870, provided fewer than 1,000 beds and probably only treated between 600 and 700 patients each year, a trivial number unless you were one of the lucky ones. Nonetheless, the publicity that cottage hospitals received contributed to awareness that there were significant unmet health issues in the countryside and as Chapter 2 will show, growth and expansion continued in the years leading up to the first world war, resulting in over 500 cottage hospitals by 1914.

¹ The hospital was titled Cranley (original spelling) Village Hospital, a name it retains today with its modern spelling of Cranleigh. The term 'Cottage' rather than 'Village' was adopted in the names of nearly all these small hospitals, with exception of Cranleigh.

² The Cottage Hospital Database, developed for this thesis, contains 600 hospitals in England and Wales of which 526 had opened by the end of 1914.

³ The term 'Cottage Hospital Movement' was first used by Horace Swete in his *Handy Book of Cottage Hospitals*, (London: Hamilton Adams and Co., 1870), p. 3, in which he wrote 'The principles of the Cottage Hospital Movement [are as] I laid before the Meeting of the Bristol and Bath Branch of the British Medical Association in 1866.' His paper was titled 'Village Hospitals: their position with regard to county infirmaries, unions, and the profession', 25 January, 1866. It was published in full in the *British Medical Journal (BMJ)*, 12 May 1866, Transactions of Branches, pp. 491 - 494.

⁴ See Research Methodology (Appendix 5) for technical and explanatory details of the digitised records and Cottage Hospital Database.

⁵ See for instance, Lindsay Granshaw, 'Fame and fortune by means of bricks and mortar: the medical profession and specialist hospitals in Britain, 1800-1948' in Lindsay Granshaw and Roy Porter (eds) *The Hospital in History* (London and New York: Routledge, 1989), 199-220.

⁶ Source: Cottage Hospital Database created as part of this research.

⁷ Napper had practised in Cranleigh from 1854, John Moore, founder of Bourton Cottage Hospital (opened 1861), qualified in 1845 and George Moore, co-founder of Moreton Cottage Hospital (opened 1873), qualified in 1830. Drs Leman and Ackland at Teignmouth qualified respectively in 1828 and 1847. All had established local practices.

⁸ Spencer Thomson, 'Nurses and Cottage Hospitals for the Sick Poor', *British Medical Journal*, 10 November 1854, pp. 1019-20.

⁹ *Ibid.*

¹⁰ 'Obituary for the late George Ross MD', *British Medical Journal*, 2 October 1875, p. 445.

¹¹ Steven Cherry, 'Change and Continuity in the Cottage Hospitals, c. 1859-1945: the experience in East Anglia', *Medical History*, 36 1992, p. 272.

¹² Barry Doyle, *A History of Hospitals in Middlesbrough* (Teesside: Gazette Media Company for South Tees Hospitals NHS Trust 2002:), p. 8.

¹³ John Hall, 'From cottage to community hospitals: Watlington Cottage Hospital and its regional context, 1874 - 2000', *Local Population Studies*, 88 (2012), pp. 33-59.

¹⁴ R M S McConaghey, 'The Evolution of the Cottage Hospital', *Medical History*, 11/2 (1967), pp. 128 - 40.

¹⁵ Southam Hospital (or Infirmary), described as a self-supporting dispensary which specialised in the treatment of diseases of the eyes and ears, was built on land owned by Dr Henry Lilley-Smith (1787-1859) and contained fourteen beds. It closed in 1872 for financial reasons. Swete (in his *Handy Book of Cottage Hospitals*) noted that it had opened in 1818 with four beds. An Account Book for Southam United Charities (Warwickshire RO ref CR3947), refers to the 'Dispensary Cottage' which opened in 1834. Accessed at www.warwickhouse.co.uk/88/the-history-of-warwick-house (5 November 2014).

¹⁶ Dr Meyrick Emrys-Roberts, *The Cottage Hospitals 1859-1990: Arrival, Survival and Revival* (Southampton: Tern Publications, 1991). pp. 18-22.

¹⁷ Brief biographies of these three leading proponents of the Cottage Hospital Movement can be found in Appendix 3.

¹⁸ *Cranleigh Village Hospital, First Annual Report, 1860*. Surrey History Centre ref.1397.

¹⁹ A biography of Albert Napper is included in Appendix 3, Biographies. The use of the term Village Hospital as opposed to Cottage Hospital will be discussed later in this chapter.

²⁰ Hambledon is on the outskirts of Godalming, about 10 miles from Cranleigh. The Union was comprised of sixteen parishes, including Cranleigh, serving a population of 11,882, recorded in the 1841 census. The Workhouse was built to the 'Gilbert' design on the site of an earlier Workhouse, dating from 1786. The Infirmary was in a separate building and, from a contemporary photograph, quite substantial.

²¹ John Sapte later became Archdeacon of Surrey. His biography notes that he was a friend of Gladstone, with whom he would ride. John Bradshaw was described in the 1861 census as Landed Proprietor and Magistrate; James Elmes farmed 150 acres and employed 6 men.

- ²² In the 1861 census, Ellen Pocklington, age 28, was described as Fundholder and Annie Crewdson, age 20, was the daughter of local master builder, Richard Crewdson. All lived in Cranleigh.
- ²³ *Cranley Village Hospital, First Annual Report*, 'Rules of the Hospital', 1860. SHC ref. 1397.
- ²⁴ Chapter 4, The Patients, their Diseases and Treatments, discusses the causes for admission.
- ²⁵ Illustration from Andrew Wynter 'Village Hospitals', *Good Words*, 1 May (1866), p. 352.
- ²⁶ *Ibid.*
- ²⁷ Chapter 3 discusses the organisation and management of cottage hospitals.
- ²⁸ Henry C Burdett, *Cottage Hospitals, General, Fever, and Convalescent, Their Progress, Management, and Work*, 2nd Edn. (London: J & A Churchill, 1880), p. x., includes a line drawing of Napper who is described as Founder of Village Hospitals. Burdett was a hospital administrator, financier, writer and publisher of medical gazetteers and advocate of evidence-based medicine, later knighted for his work in founding the charity Prince of Wales Hospital Fund for London in 1897. A summary biography is included in Appendix 3.
- ²⁹ Burdett wrote Napper's obituary, published in the *BMJ*, 24 November 1894, p. 1211.
- ³⁰ Hospital Saturday and Hospital Sunday funds collected donations from workers and church attendees respectively, towards the upkeep of their local hospital. Pound Day was an institution whereby local individuals contributed either a pound weight of goods such as flour, potatoes or fruit or £1 in cash. In practice donations in kind exceeded one pound in cash. For further reading on the subject see, for instance, Steve Cherry, 'Hospital Saturday, Workplace Collections and Issues in late Nineteenth-Century Hospital Funding', *Medical History*, 44, (2000), 461-488.
- ³¹ The financing of cottage hospitals is discussed in detail in Chapter 3.
- ³² Cottage hospital admission practices are discussed in Chapter 4.
- ³³ 'Cottage Hospitals', *British Medical Journal*, 24 March 1860, p.230. A year earlier a small hospital, supported by a local employer, opened in Fowey in Cornwall. It lasted only a few years, before being relocated to form a larger institution and therefore is discounted among the list of known early cottage hospitals. Fowey Cottage Hospital: Fowey Harbour Heritage Society, <http://foweyharbourheritage.org.uk/heritage/places/fowey-cottage-hospital/>, downloaded 6 July 2017
- ³⁴ *Bourton Village Hospital Annual Report, 1871*, Gloucestershire Archives.
- ³⁵ *Bourton Village Hospital Annual Report, 1871*. W C Coles, *A Rural Village Hospital* (London, Taylor & Co., 1877), p. 6.
- ³⁶ *Bourton Village Hospital Annual Report, 1892*, Gloucestershire Archives.
- ³⁷ Cherry, 'Change and Continuity'.
- ³⁸ Cherry, 'Change and Continuity', p. 273.
- ³⁹ *Ibid.*
- ⁴⁰ Henry C Burdett, *Cottage Hospitals, General Fever, and Convalescent*, 3rd Edn. (London, The Scientific Press, 1896), p. 368.
- ⁴¹ Martin Gorsky, John Mohan and Martin Powell, 'British voluntary hospitals, 1871-1938: the geography of provision and utilization', *Journal of Historical Geography*, 25/4 (1999), pp 463-82.
- ⁴² McConaghey, 'The Evolution of the Cottage Hospital'.
- ⁴³ *Cranleigh Village Hospital Annual Report, 1864*.
- ⁴⁴ *Ibid.*, patient no, 17, April 1864. Albert Napper, 'Amputation of the Arm in Pregnancy' delivered to the Obstetrical Society of London, 4 January 1865.
- ⁴⁵ Great Bookham Cottage Hospital opened in 1866 and closed as a hospital in 1868. Swete, *Handy Book of Cottage Hospitals*, p. 144, noted, 'this is the only case [...] in which a hospital once started has been put down, and the animus against it must indeed be strong.' Leatherhead and District Cottage Hospital opened in 1893 and closed in 1902 'for lack of funds.' Burdett listed a small number of others.
- ⁴⁶ Cherry, 'Change and Continuity', p. 273. The financial accounts of the early cottage hospitals do not show 'private patients' contributions were a significant income source for the hospital.
- ⁴⁷ Swete, *Handy Book of Cottage Hospitals*, pp. 25-6.
- ⁴⁸ *Surrey Advertiser and County Times*, 15 April 1882, p. 2. Napper reproduced this correspondence in the *Surrey Advertiser* in rebuttal to Sapte's claims in an earlier edition that he was the founder of the Cranleigh Hospital.
- ⁴⁹ Ruth Shaw, a 63 year old farmer's wife from nearby Ewhurst was admitted on 28 November 1859, for extensive leg ulcers. She is almost certainly the first patient referred to in this quote. She was discharged in March 1860 'the leg having healed and her general health much improved.' *Cranleigh Village Hospital, First Annual Report*.

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² 'Cottage Hospitals', *British Medical Journal*, 3 March 1860, p. 171.

⁵³ Laurel Brake and Marysa Demoor (eds), *Dictionary of Nineteenth Century Journalism in Great Britain and Ireland*, (Ghent: Academia Press, 2009), p. 78.

⁵⁴ *BMJ*, 24 March 1860, pp. 230-1.

⁵⁵ *BMJ*, 20 October 1860, pp. 820-1.

⁵⁶ *Ibid.*

⁵⁷ *BMJ*, 2 November 1861, p. 471.

⁵⁸ *The Lancet*, 20 October 1860.

⁵⁹ *BMJ*, 28 February 1863, p.227.

⁶⁰ Albert Napper, *Statement of the Medical Officer of Cranley Village Hospital* (London: G J Palmer, 1862), p. 2.

⁶¹ *Ibid.*, pp. 2-3.

⁶² *Ibid.*

⁶³ *Ibid.*, pp. 3-7.

⁶⁴ *Ibid.*, p. 7.

⁶⁵ *Ibid.*, p. 8. It is noteworthy that Napper did not include a room for operations. In the early days an attic room was used, accessible only by ladder, to which the patient was carried. An early unattributed history of the hospital stated that amputations were carried out in the room adjacent to the kitchen, which normally served as the patient's sitting room.

⁶⁶ Correspondence and Papers (1876-1893) of Sir Henry C Burdett relating to the *Cottage Hospital, Its Origin, Progress, Management, and Work* (London, 1877), Bodleian Library, ref c5980.

⁶⁷ Burdett, *Cottage Hospitals, General, Fever and Convalescent*, (1880) p. 208.

⁶⁸ *Ibid.*

⁶⁹ Albert Napper, *On the Advantages Derivable to the Medical Profession and the Public from the Establishment of Village Hospitals with general instructions concerning costs, plans, rules etc and an appropriate dietary* (London: H K Lewis, 1864), p. 6.

⁷⁰ *Ibid.*, p. 7.

⁷¹ *Ibid.*, p. 8.

⁷² *Ibid.*, p. 9.

⁷³ *Ibid.*, p. 5.

⁷⁴ For a discussion of the competition for the public's funds in the voluntary hospital sector see for instance, Keir Waddington, 'Subscribing to a Democracy? Management and the Voluntary Ideology of the London Hospitals, 1850-1900', *English Historical Review*, April (2003), pp. 357-379.

⁷⁵ Napper, *Statement of the Medical Officer*, p. 5.

⁷⁶ *BMJ*, 8 September 1866. The international interest in the idea of cottage hospitals will be discussed in more detail in Chapter 2.

⁷⁷ E.J.T. Collins, 'The Rationality of 'Surplus' Agricultural Labour: mechanisation in English agriculture in the nineteenth century', *The Agricultural History Review*, 35/1 (1987), pp. 36-46.

⁷⁸ *Cranleigh Village Hospital Annual Report, 1864*, p.11.

⁷⁹ Collins, 'The Rationality of 'Surplus' Agricultural Labour', p.40.

⁸⁰ *Ibid.*, p.45

⁸¹ Napper, *Statement of the Medical Officer*.

⁸² Napper, *On the Advantages Derivable to the Medical Profession*, p. 9.

⁸³ *Ibid.*, p.19.

⁸⁴ *Ibid.*, p. 7. This was a surprising statement as Napper's own pamphlet contained a copy of the Annual Report for 1863, in which patients' payments contributed £35 12s to an annual expenditure of just under £200.

⁸⁵ *Ibid.*, p. 7.

⁸⁶ Edward John Waring, *Cottage Hospitals: Their Objects, Advantages and Management*, (London: Savill, Edwards & Co., 1867), pp. 25 - 6.

⁸⁷ Swete, *Handy Book of Cottage Hospitals*, p. 23.

⁸⁸ S.O. Habershon, 'Remarks on Cottage Hospitals', *BMJ*, 31 December 1881, pp. 1047-48.

Habershon was Vice President of the Metropolitan Counties branch of the BMA and late Senior Physician, Guys Hospital.

⁸⁹ Burdett, *Cottage Hospitals, General, Fever and Convalescent* (1880), pp. 94-8.

⁹⁰ *Ibid.*

- ⁹¹ Brian Abel-Smith, *The Hospitals 1800-1948* (London: Heinemann, 1964).
- ⁹² *BMJ*, 13 April 1907, pp. S189-90. The article did not discuss why this different approach to fee-paying was necessary or desirable.
- ⁹³ *Cranleigh Village Hospital Annual Reports*, SHC ref 1397/1-11; 5412/1-8; DCH/9/2/1-62; and 9581.
- ⁹⁴ Napper, 'On the Advantages Derivable to the Medical Profession', p. 8.
- ⁹⁵ Abel-Smith, 'The Hospitals', p.41. Abel-Smith estimated that voluntary hospitals provided about 11,000 beds in 1861.
- ⁹⁶ Napper, 'On the Advantages Derivable to the Medical Profession', p. 8.
- ⁹⁷ *Trewman's Exeter Flying Post and Cornish Advertiser*, 4th November 1863, p. 6.
- ⁹⁸ 'The Village Hospital Movement', *The Standard*, 22 October 1869, p.3. The Cottage Hospital Database, developed as part of this research, contains the full name by which each hospital was known when founded and later additions and changes to its name.
- ⁹⁹ Horace Swete, 'Village Hospitals: their position with regard to County Infirmarys, Unions and the Profession', *BMJ*, 12 May 1866, pp. 491-4.
- ¹⁰⁰ W F Bynum, 'Ideology and Health Care in Britain: Chadwick to Beveridge', *History and Philosophy of Life Sciences*, 10 (suppl.), (1988), pp.75-87.
- ¹⁰¹ Analysis of the number of occupied bed days for a sample year of 1862 showed that the six beds in Cranleigh Village Hospital were never fully occupied. The lowest occupancy was 32 per cent in January 1862, the highest 86 per cent in May 1862. Median bed occupancy was 63 per cent. Chapter 4 discusses bed occupancy in more detail.
- ¹⁰² 1871 census.
- ¹⁰³ *BMJ*, 3 October 1863, p. 376.
- ¹⁰⁴ *Ibid.*
- ¹⁰⁵ *BMJ*, 17 October 1863, p. 433.
- ¹⁰⁶ *BMJ*, 21 November 1863, p.559.
- ¹⁰⁷ *BMJ*, 19 December 1863, p. 679.
- ¹⁰⁸ *Ibid.*
- ¹⁰⁹ *Ibid.*, pp. 672-3.
- ¹¹⁰ *Ibid.*
- ¹¹¹ *Ibid.*, 11 February 1865.
- ¹¹² Discussed in Chapter 2
- ¹¹³ Swete, 'Village Hospitals'.
- ¹¹⁴ See Appendix 3 for a brief biography of Horace Swete.
- ¹¹⁵ Horace Swete had founded one of the early cottage hospitals in Wrington (Somerset). It opened in July 1864 with five beds to serve the 'respectable labouring class and small tradesmen' and but was closed in 1870. *Wrington Cottage Hospital, First Annual Report, 1865*. Swete left Wrington in 1867 to become Honorary Medical Superintendent of the West of England Sanatorium, Weston-super-Mare. The hospital closed in 1870 as the result of a religious dispute.
- ¹¹⁶ Swete, 'Village Hospitals', p. 494.
- ¹¹⁷ Editorial Note, *BMJ*, 12 May 1866, pp. 494. Swete had collected information about a number of cottage hospitals with a view to publication, 'to show how simply and inexpensively a Cottage Hospital may be managed' but noted that circumstances had prevented him from publishing his observations, possibly as he had left Wrington in 1867. For more details of Swete's career see Appendix 3.
- ¹¹⁸ See Appendix 3 for Waring's biography.
- ¹¹⁹ Waring, *Cottage Hospitals*, Preface.
- ¹²⁰ *Ibid.*, p. 6.
- ¹²¹ *Ibid.*, pp 7-19.
- ¹²² Waring, *Cottage Hospitals*, pp. 7-8.
- ¹²³ *Ibid.*, p. 31.
- ¹²⁴ *Ibid.*, p. 16.
- ¹²⁵ *Ibid.*, pp.16-17.
- ¹²⁶ *Ibid.*, p.14.
- ¹²⁷ *Ibid.*
- ¹²⁸ Edward John Waring, 'Village Hospitals', *The Times*, 3 January 1866, p.9.
- ¹²⁹ *Ibid.*
- ¹³⁰ Waring, *Cottage Hospitals*, p. 17-19.
- ¹³¹ *BMJ*, 6 Feb 1869.

- ¹³² Editorial Note, *BMJ*, 12 May 1866, pp. 494.
- ¹³³ Waring, *Cottage Hospitals*, p. 22.
- ¹³⁴ Swete, *Handy Book of Cottage Hospitals*, pp. 8-19.
- ¹³⁵ *Ibid.*, p. xi.
- ¹³⁶ *Ibid.*, p.7.
- ¹³⁷ *Ibid.*
- ¹³⁸ *Ibid.*, p21.
- ¹³⁹ These entries provided valuable data which included year opened, bed numbers, founder, income and expenditure and background information, which has been incorporated in the Cottage Hospital Database.
- ¹⁴⁰ Swete, *Handy Book of Cottage Hospitals*, p. 128.
- ¹⁴¹ *Ibid.*, p. 146.
- ¹⁴² *Ibid.*, p. 160.
- ¹⁴³ *Ibid.*, p. 161.
- ¹⁴⁴ *Ibid.*, p. 122.
- ¹⁴⁵ *Ibid.*, pp. 122-123
- ¹⁴⁶ *Ibid.*, p. 147.
- ¹⁴⁷ *Ibid.*, p. 123.
- ¹⁴⁸ *Ibid.* pp. 124 – 168.
- ¹⁴⁹ See Annual Reports for each hospital: Cranleigh: '[...] for the accommodation of the Poor when suffering from disease...'; Bourton: '... for the relief off poor persons in illness, or suffering from accidents ...'; Moreton: '... 'for the benefit and accommodation of the poor when suffering from disease or accident ...'
- ¹⁵⁰ David Englander, *Poverty and Poor Law Reform in Britain: from Chadwick to Booth, 1834 – 1914*, (Harlow: Longman, 1988), p. 78.
- ¹⁵¹ Englander, 'Poverty and Poor Law Reform'.
- ¹⁵² *Bourton Village Hospital, 1864*, Gloucester Record Office. Englander, 'Poverty and Poor Law Reform'.
- ¹⁵³ *Ibid.*
- ¹⁵⁴ Wynter, 'Village Hospitals', p. 349
- ¹⁵⁵ Wynter, 'Village Hospitals', p. 350.
- ¹⁵⁶ Andrew Wynter, 'Self-help for the Agricultural Sick' in *Fruit between the Leaves Vol II* (London: Chapman and Hall, 1875), pp. 246-7.
- ¹⁵⁷ Waring observed that the cottage element has been sacrificed and that the money expended on the building would have funded three cottage hospitals. Waring, *Cottages Hospitals*.
- ¹⁵⁸ Swete's book was dated June 1870, so his list included hospitals open in 1869 and those expected to open in 1870.
- ¹⁵⁹ For further discussion of the phenomenon see for instance, David Owen, *English Philanthropy 1660-1960* (Cambridge, Mass.: Harvard University Press, 1964) or Frank Prochaska, *The Voluntary Impulse: philanthropy in modern Britain* (London: Faber and Faber, 1988).
- ¹⁶⁰ E.L. Jones, 'The Agricultural Labour Market in England 1793-1872', *Economic History Review*, 17/2 (1964), pp. 322-338.
- ¹⁶¹ Jones, 'The Agricultural Labour Market'.
- ¹⁶² Seventy per cent of patients admitted to the three rural cottage hospitals researched were discharged within seven weeks.
- ¹⁶³ Emrys-Roberts, *The Cottage Hospitals*, p. 105.
- ¹⁶⁴ Swete in his 1866 address to the British Medical Association titled 'Village Hospitals: Their Position with Regard to County Infirmarys, Unions, and the Profession', opened by referring to the shocking state of medical services in the Crimea: '[it] was a crying evil, one that reflected great discredit on the Executive.' *BMJ*, 12 May 1866, p. 491.
- ¹⁶⁵ Burdett, *Cottage Hospitals: General, Fever and Convalescent*.
- ¹⁶⁶ *Surrey Advertiser and County Times*, 1 April 1882.
- ¹⁶⁷ *British Medical Journal*, 19 November 1881, p. 824. The proposal noted 'In the year 1859, with the exception of one or two miners' hospitals [...] there were practically no institutions in this country which could be classed as village or cottage hospitals. In that year Mr Napper established the first village hospital on the present model at Cranleigh, Surrey.'
- ¹⁶⁸ Napper, 'On the Advantages Derivable to the Medical Profession'.

Chapter 2: The Cottage Hospital Movement: Consolidation, Expansion and Growth, 1871 - 1914.

Introduction

The rapid growth in cottage hospitals in the second half of the 1860s, discussed in the previous chapter, continued into the 1870s. In the decade 1871-1880, new cottage hospitals opened at an average rate of about one per month, following the patten already established, located mostly in small rural communities concentrated in south and south west England and on the periphery of London. In addition, some of the early hospitals increased in size during this second decade, or moved to new premises with better facilities, such as a separate operating theatre and improved nursing accommodation. Others added out-patient services and a dispensary, and a few began to offer home-visiting nursing.

By 1880, twenty-two years after Cranleigh Village Hospital had opened, a total of 272 cottage hospitals had been founded of which at least seventy contained between eight and twelve beds and most, if not all, had separate male and female wards.¹ The average number of beds also increased from about five or six in the first decade of the Cottage Hospital Movement to about seven or eight in its second decade. The total number of beds available in cottage hospitals in England and Wales doubled in this period to c2,000.²

In a move away from the original schema, town-centred cottage hospitals started to appear from the late 1870s. Between 1880 and 1914 the Movement continued to grow, with many new hospitals established and existing hospitals expanded with extra facilities, additional beds and children's cots. By the end of the nineteenth century 449 cottage hospitals had opened, and at the onset of the First World War there were 528, providing an estimated c5000 beds in England and Wales.³ No new cottage hospitals were opened during World War One, but many were adapted or expanded to treat military casualties, although it does appear that civilian admissions continued.⁴ Growth resumed after 1920 when new 'Memorial' Cottage Hospitals opened, commemorating the war. The

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last cottage hospital to open was in Didcot (Oxfordshire) c1940, as a twelve-bed convalescent facility managed by Radcliffe Infirmary.⁵

The Cottage Hospital Database contains details of 601 hospitals which opened between 1841 and c1940 of which perhaps fifty to sixty had closed during the twentieth century, prior to the founding of the NHS in 1948.⁶ A few cottage hospitals have survived into the twenty-first century (including Cranleigh Village Hospital), providing simple medical and surgical services such as minor surgery, scans, podiatry, audiology and pre- and post-natal services to their local communities, while others have been redesignated as local 'community hospitals'. This continuity of local care has been discussed in detail by Steven Cherry, using the region of East Anglia as a case study.⁷

This chapter discusses the period between 1870 and the First World War in which significant social developments influenced where cottage hospitals opened and how they were financed. Aristocracy and gentry continued to support 'their' local hospitals in the countryside, as at Bourton and Moreton, and were joined by new benefactors in new locations, such as the wealthy industrialists who built and furnished cottage hospitals in towns such as Braintree (Essex) and Chorley (Lancashire). Hospital management committees expanded from their initial membership of the local doctor and clergyman, with the arrival of local businessmen and in small number of institutions, one or two middle-class women. The number of local churchmen reduced, perhaps an indication of an increasing secularisation of society.

With the establishment of town hospitals came a new funding source. These institutions, particularly in Yorkshire and Lancashire, benefitted from the financial contributions from organised labour, and a number of new cottage hospitals were founded through the efforts and money contributed by local workers.⁸ Insurance companies, Friendly Societies and benefit clubs, which had expanded significantly in the last quarter of the nineteenth century, provided a safety-net for workers and their dependents when suffering sickness, unemployment or the death of a breadwinner.⁹ Later, in 1911, the National Insurance Act required workers with an annual income of less than £160 to contribute 4d per week to an approved society, their employer was also obliged

to contribute 3d per week and the state added 2d per week. All such funds could be called upon to pay the fee required from all patients admitted to a cottage hospital, as discussed in the previous chapter.¹⁰

This chapter draws particularly upon research into the records of the cottage hospitals in Cranleigh, Bourton, Moreton, Braintree and Chorley to provide insight into how the numerous social changes in the last quarter of the nineteenth century influenced growth in the Cottage Hospital Movement.

1871-1880: a decade of consolidation and expansion

As discussed above, the decade 1871 to 1880, was a period of both growth and consolidation for the Cottage Hospital Movement. New cottage hospitals continued to spring up in rural locations around the country, but for the first time they also began to appear in small towns. Furthermore, some of the small rural hospitals, which had opened in the 1860s, began to expand, adding a new wing or moving to new and larger premises. During this period Napper's original concept of a cottage hospital also started to evolve, developing beyond the simple rural cottage model he favoured, with its small number of beds, admitting only between twenty and thirty patients each year, to an institution of ten to twelve beds, processing sixty to eighty in-patients annually, and adding facilities such as dispensaries and out-patient services. Napper, who saw himself as guardian of the village hospital and defender of the Cottage Hospital Movement, observed these developments with increasing reservation, concerned that his principles were being compromised by deviations from his model. He was especially incensed by adoption of the suffix 'cottage', in place of his preferred 'village' to describe the hospitals. He expressed his frustration in a supplement included in the *Cranleigh Village Hospital Annual Report for 1876*:

Following our success of the *Village* [sic] Hospital (as was anticipated), a more pretentious institution has now arisen, now known by the designation of the *Cottage* [sic] Hospital, supplying the requirements of small towns and more populous districts The experience of seventeen years has shown that to be successful the Village Hospital must be restricted to the limits to which it was originally confined; viz., "An institution of from four to

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six beds, under the management of a single nurse, who will, with occasional assistance, perform all the necessary work.”¹¹

Napper considered that larger buildings, with increased sophistication in design and function, which departed from his simple six-bed model would be difficult to finance through local subscriptions. Such hospitals, serving wider catchment areas, would cost more to run, but more importantly would break the personal connection between donor and receiver of charity, exposing the continued finances of the institution to the vagaries of anonymous donations. Napper was concerned that closure of cottage hospitals, through lack of funds, would prove his critics right; that such institutions could and would not be financially viable. Having successfully generated a high level of public awareness of his Cottage Hospital Movement, adverse publicity associated with closures would be extremely damaging, hence his determination to protect the original model.

He also maintained the importance of familiarity for the patients, as described in Chapter 1, arguing that these larger institutions, with sophisticated layout and design could not reproduce the ‘feel’ of a labourer’s cottage which was so much a part of a successful cottage hospital.

In 1877 William Coles (long-term honorary surgeon to Bourton Cottage Hospital) expressed similar concerns in his pamphlet titled ‘*A Rural Village Hospital*’, which described the achievements of Bourton Cottage Hospital (Gloucestershire) since its opening in 1860.¹²

A Village Hospital has been described as the smallest and most simple mode yet devised for the attendance upon patients away from their home. What is called the “Cottage Hospital System” is on a larger and more pretentious scale. It is a system better suited for towns of some considerable size, where a furnished house can be obtained, where beds for ten or twelve can be provided, where a matron can be maintained and where, perhaps, nursing can be performed by Sisters of Charity, or others.¹³

Regardless of Coles’ polemic, the hospital as described in his book did not conform to his own definition of a village hospital: ‘On the first floor there are three ... wards ... each capable of containing two or more beds ... [while] the

upper floor has one large ward capable of holding three or four beds'.¹⁴ Clearly this hospital had the capacity for at least nine beds, but could have accommodated more, pushing it out of the realm of the simple 'village' hospital and into the realms of the 'pretentious'. It is not surprising therefore that many contemporary commentators used the terms 'Cottage' and 'Village' synonymously, and even ardent supporters of Napper appeared to be capable of confusing themselves.

Despite Napper and Coles' disquiet, the emergence of a substantial number of larger hospitals and the expansion and rebuilding of existing hospitals confirmed that the Cottage Hospital Movement was well established and thriving. Napper's vision clearly did not suit every community, and local initiatives adapted Napper's ideas to suit their own needs, commensurate with their ability to raise initial funds and maintain subscription income. Napper's concern over the fragility of hospital finances however was well-founded: Annual Reports from a number of institutions periodically expressed concern that income was barely sufficient to maintain the hospital and there is some limited evidence that in a few, patient admissions were restricted to conserve funds.

General adoption of the 'Napper model' is confirmed by analysis of the number of beds and children's cots provided in the cottage hospitals which opened during this period, most of which contained between five and seven beds.¹⁵ No consistent differences in size can be discerned between countryside or town-based institutions; the rural cottage hospital in Yeovil (Somerset) opened in 1871 with up to twenty beds, yet Warwick Dispensary and Cottage Hospital founded in 1874 had only five. The determining factors must have been the ability of the community to raise initial finance (through subscription or the presence of a generous benefactor), the expected demand for such facilities, the capacity of the building (most hospitals were opened in donated buildings) and the new institution's proximity to existing county hospitals.

Map 2 (see Appendix 4) shows where the new hospitals were located. Growth in this period continued to be concentrated in rural communities in south and

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south-west counties radiating out from Napper's heartland of south-west Surrey and north-west Sussex; and from John Moore's early cottage hospital in Bourton, Gloucestershire.¹⁶ The trend which had started in the late 1860s for cottage hospitals to open in agricultural communities close to London in Kent, Essex and Middlesex continued through the 1870s, extending into Berkshire and Buckinghamshire. Cottage hospitals also began to appear in south Wales, associated with centres of mining and industry, from the late 1860s, and in the north in the 1870s.

It is striking that some rural counties, such as Bedfordshire, Huntingdonshire, Cambridgeshire, Nottinghamshire, Rutland, Shropshire and Cumberland, appeared not to follow the trend and up to the end of the nineteenth century (and beyond) had very few cottage hospitals. Further research is needed to establish if there were economic or social circumstances which explain why these, mainly agricultural counties, did not participate in the Cottage Hospital Movement.

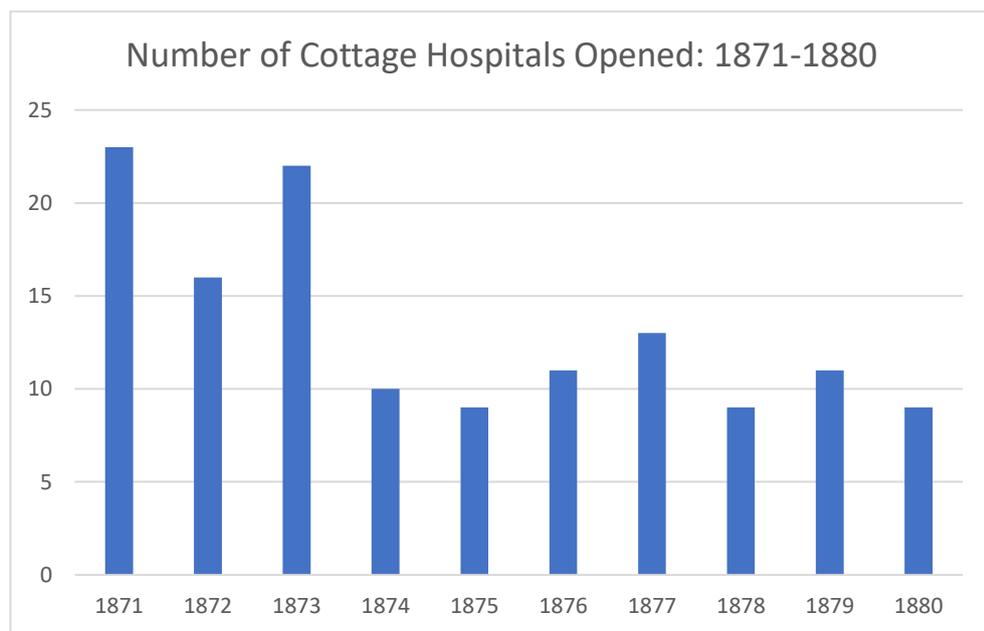
Cottage hospitals also began to appear in the northern industrial towns of Yorkshire which were centres for mining, manufacturing and textiles. By 1880, the three Yorkshire Ridings had twenty-two cottage hospitals, more than any other county, although distribution was predominantly in the industrial West Riding. Unlike the previous decade in which the Yorkshire hospitals had opened in rural, spa or seaside locations such as Richmond, Harrogate and Scarborough, the decade ending 1880 showed hospitals appearing in industrial areas of Yorkshire such as Brotton, an important ironstone mining district, and Rotherham which had several ironworks and was later a centre for steel manufacture.¹⁷

Expansion of the cottage hospital movement was slower in Lancashire, with only a handful of hospitals opening before 1880. Most notable of these, as an example of the new town-based institutions and of industrial philanthropy, was the hospital at St Helen's, a centre for glassmaking and mining.¹⁸ Representing a different type of town-based hospital, the one which opened at Lytham, a

seaside town, was founded by the local squire for visitors to the town and those referred from elsewhere for the supposed benefit of sea air.

The years 1871 to 1873 continued the rapid growth seen in the second half of the previous decade but the rate at which hospitals opened was slowing down, declining by about one half, as illustrated in Chart 2.1 below. This is a possible indicator that initial enthusiasm for cottage hospitals was beginning to falter, or as Napper had predicted, finding appropriate levels of funding was proving more challenging than the initial enthusiasm promised, and confidence in maintaining subscription income to support a larger facility was wavering.

Chart 2.1: No. of new cottage hospitals opened annually between 1871 and 1880¹⁹



The agricultural depression of the 1870s and early 1880s presented challenges to communities seeking to raise money for a local hospital. Between 1870 and 1880, imports of cheap wheat from the Americas had increased significantly which led to a reduction in landowners' and tenant farmers' incomes and increased agricultural unemployment. The crisis was exacerbated by a series of poor harvests resulting from adverse weather conditions which occurred throughout the 1870s and extended into the early 1880s, particularly affecting the south and east of England.²⁰ According to agricultural historian P J Perry,

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the incidence of bankruptcies in the farming sector rose five-fold between 1871 and 1881, concentrated in ten counties in south-east England.²¹ In fact, despite Perry's findings, cottage hospitals continued to open in Surrey, Gloucestershire, Hampshire, Somerset and Devon at much the same rate as in the previous decade but a decline can be seen in Wiltshire and Dorset.²² So the agricultural depression cannot be the main cause in decline of openings. A possible alternative explanation is that by the end of the 1870s, and twenty years after the Movement first stirred into life, the early adopting regions had met their immediate need for such institutions. By the end of the 1870s nearly 60 per cent of all the Cottage Hospitals established before the end of century had already opened, and in the very early adopters such as Gloucestershire, this figure was even higher (at 80 per cent). It is likely that in areas where a hospital had not yet been established, the depression probably contributed to a slowing in uptake, but the evidence is by no means conclusive.²³

It certainly had an effect on established hospitals. The impact of the depression on hospital income was described in successive Annual Reports of Moreton Cottage Hospital, (Gloucestershire). It opened in 1873 with seven beds in a new building on land gifted by Lord Redesdale, who had also donated £150 to the Building Fund.²⁴ Two years later a gas supply was connected and in 1881 a bequest enabled the hospital to expand to nine beds.²⁵ But despite this progress, the Trustees report for 1878 stated 'The stagnation and depression which have overtaken the general trade and business of the country, have, during the past year, somewhat reduced the income of Moreton Cottage Hospital'; however, by 1881 the Trustees observed that despite the continuing agricultural depression subscriptions had increased slightly. This was a short-lived optimism as the following year church collections had reduced again, 'no doubt owing in a great measure to the continued agricultural depression which has been quite as severe [...] as in any former year'.²⁶ The hospital survived and continued to serve the local community until 2012 when it closed following the opening of the North Cotswold Hospital.²⁷

In 1877, the year after Napper's plea to retain the simplicity of his concept and in the same year as Coles' pamphlet, Henry Burdett published *The Cottage*

*Hospital, its Origin, Progress, Management and Work.*²⁸ He had previously asked Swete to publish a second edition of his own *Handy Book of Cottage Hospitals* which Swete had declined to do, and having had an increasing number of enquiries for a book on cottage hospital management, Burdett concluded this was an opportune time to publish. His book, which was based on personal communication with all the hospitals he could identify, and which was so successful as to extend to three editions, became the definitive guide to establishing and managing a cottage hospital.

Burdett confirmed that the concept of the cottage hospital was well established. In his introduction to the 1877 edition he stated:

The time has long since gone by for an elaborate explanation of what the Cottage Hospital proper was intended to do for the poor, the country practitioners, and the county magnates. It is not now necessary for us, nor for any one, to defend the system, to enlarge upon its merits, nor to disarm opposition.²⁹

The book contained chapters and sections on medical and surgical issues, hospital construction, finance, sanitary arrangements, domestic supervision, nurse selection and training, midwifery, furnishings, equipment and appliances. Appendices recorded 152 cottage hospitals with foundation dates, bed numbers and income and expenditure, tables comparing the outcomes of four types of limb amputation in cottage and general hospitals and included recommended formats for annual accounts and patient records. He found the comparison of amputations to be very favourable from the cottage hospital's point of view.³⁰ His list of hospitals omitted ten, which in his view had expanded 'far above the scope of Mr Napper's scheme', and which he considered to be small general hospitals, despite having 'cottage' in their title. As examples of such institutions he named Middlesbrough Hospital which had opened in 1859 with twenty-eight beds and later expanded to sixty, and Walsall Cottage Hospital 'which had been enlarged more than once' and by the time the second edition of his book was published had 30 beds.³¹

His examination of hospitals which had closed revealed a variety of causes. Only two appeared to have difficulty with funding, one being forced to close

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after its main benefactor failed to have his nephew installed as surgeon, the other as a result of apathy among the local elite. At Southam the problem was a lack of patients, and at East Rudham there was suspicion that the local doctor, who was allegedly giving his services *gratis* was nevertheless receiving 'some unknown benefit' from the hospital.³² Burdett described the problems at Wrington Cottage Hospital, which had been opened by Swete in 1864, as the sole example of a hospital which had failed because of a religious dispute; the secretary, 'a dissenter', wanted patients to attend his chapel but the medical officer wanted them to go to his church. The secretary bought the hospital and closed it in 1869.³³

By way of introducing his recommended hospital organisation, Burdett quoted at length the words of medical officer, Dr Rogers, who had given the reasons why East Grinstead Cottage Hospital, was closed in 1874, after only 11 years: 'In this district', Dr Rogers wrote to Burdett,

There are many very wealthy resident and landed proprietors, but scarcely any volunteered to help me. [...] This was especially annoying, as I was not only giving my daily professional services, but was also the greatest pecuniary contributor. [...] At length, having experienced for some years the meanness of the wealthy, and too often the ingratitude of the poor, I closed the hospital.³⁴

Whilst commiserating with Rogers, Burdett observed that had he had a lay manager and a management committee he would have been relieved of fund-raising and able to concentrate on giving medical services.³⁵

Burdett's overarching conclusion regarding these closures was that they were caused in the main by lack of proper communication and resulting misunderstandings. He urged anyone setting out on the experiment of opening a hospital to consult widely with the community, to hold public meetings, chaired by the rector or squire, and to which even those initially opposed should be invited to attend. A committee of local gentlemen should be quickly established to 'disarm all suspicion of interested or personal motives ... [and] to carry out the necessary details'.³⁶

Despite difficulty in obtaining reliable responses to his enquiries, Burdett concluded that there were probably about 200 cottage hospitals in the United Kingdom.³⁷ He paid tribute to the pioneering efforts of Napper, Waring and Swete, which had resulted in there being only five English counties without a cottage hospital; Cumberland, Huntingdon, Leicestershire and Monmouthshire, and Rutland which had no hospital of any sort.³⁸ He was scathing, but not surprised by this lack of provision. These counties he claimed showed little interest in the health of its populations, Huntingdon, Monmouthshire and Rutland, providing collectively, at best, one bed per 2,000 inhabitants in their general hospitals, when one per 1,000 was the recommended norm. 'It is ... evident', he wrote, 'that, where the inhabitants are so little sensible of the benefits to be derived from general hospitals, it would be quite unreasonable to hope they would display any interest in the progress of these humbler institutions.'³⁹

He found the lack of cottage hospitals in Cumberland and Leicestershire 'somewhat surprising' particularly as 'both [are] in the main agricultural', and made an interesting observation about the reluctance of local medical men to take the initiative. 'The probable explanation', he mused, 'is to be found in the fact that the county infirmary has such a widespread and overshadowing influence here, that it would be treason indeed to encourage, much less foster, a movement, which might at first sight appear hostile to the interests of the older hospital.'⁴⁰

Burdett's argument provides yet another explanation for the slow uptake of cottage hospitals in certain regions of the country, exemplifying the well documented competition between medical institutions discussed in the previous chapter. Certainly, these tensions between general and cottage hospitals did not always exist, for instance there were thirty-five cottage hospitals in Somerset, Wiltshire and Gloucestershire which treated several hundred patients each year, working in parallel to several large voluntary hospitals including the Royal United Hospital at Bath, Bristol's General Hospital and Royal Infirmary and the Taunton and Somerset Hospital, among others. In Cumberland it seems more likely that a combination of low population density and poor terrain

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presented obstacles to the establishment of cottage hospitals there, while a lack of entrepreneurial doctors, prepared to go into battle with the powerful Leicester Infirmary, and a lack of generous benefactors in Leicestershire were the reasons why cottage hospitals were absent there, and in adjacent counties.

Burdett discussed at length the benefits to the country general practitioner of having access to a local hospital, less so to the patient, an indication, perhaps, that any philanthropic urge to establish a cottage hospital was mediated by the potential financial benefits to their medical founders. He agreed entirely with the arguments put forward by Napper (and discussed in the previous chapter) that a cottage hospital would bring 'a wider field for practice [for the surgeon] under conditions which reward care and skill, whilst they increase both reputation and income.' He also stressed the opportunity a hospital offered to all local practitioners, providing access to the Hospital's facilities and thereby promoting a spirit of shared best practice, rather than the more usual atmosphere of suspicious competition which often existed. Instead the hospital would encourage the sharing of knowledge and new techniques, new equipment could be discussed and introduced, and skilled help would be readily available to assist in complex surgery.⁴¹

Despite Burdett's urgings and his voluminous descriptions of all aspects of founding, organising, funding, equipping and managing a cottage hospital, the first edition of his book, published in 1877, had little impact upon the rate at which new hospitals opened subsequently. As discussed above, between 1860 and 1880, it seems the combination of an established surgeon, collaborating with a supportive local clergyman, the availability of suitable and low cost property, the presence of one or more wealthy benefactors and an expectation of reliable annual subscription income were the characteristics which facilitated and supported the opening of a cottage hospital. Using Cranleigh and Bourton as case studies it seems that it was the characteristics of the local community that were important factors in the successful establishment of a cottage hospital.

Perhaps the most important though, was the presence of a population already imbued with a sense of Christian duty and charity. The intertwining of Christian beliefs and philanthropy in the Victorian period contributed to the foundation of hospitals and other public institutions such as schools and orphanages established, in the main, to improve the welfare of the working poor. The historiography of Victorian philanthropy is extensive and provides numerous explanations for this aspect of Victorian society which bear upon the foundation of cottage hospitals, yet none satisfactorily explain why three hospitals, geographically separated, in Surrey, Gloucestershire and Cornwall, appeared within a few months of each other.

Historian David Owen has described philanthropy as a social imperative for middle-class respectable Victorians, which he attributes to compassion for the poor, inspired by evangelical religion and a very real concern for the stability of society.⁴² Alan Kidd added a further dimension, observing that the objective of the pervasive nineteenth century evangelical movement was to 'Christianise the poor, to extirpate vice and to encourage the growth of virtue ... [which was] understood to reside in self-proprietorship, sobriety and thrift'.⁴³ Keir Waddington has introduced a more personal motive for philanthropic activity; the pursuit of social status associated with 'good works' and emphasised the role of Christian morality: 'A religious and moral imperative remained a recurrent theme in writing on charity after 1850: in the 750 works published on philanthropy between 1850 and 1898 Christian dogma remained prominent ... [and] Victorian philanthropy continued to be idealised as a Christian virtue.'⁴⁴

It is clear from early Annual Reports that the established Church had a strong influence over the foundation, financial maintenance and governance of cottage hospitals. Local churchmen had major roles in all the early hospitals studied here, either as active participants in its establishment, such as Rector Sapte at Cranleigh who provided the church-owned cottage or Rev Crawford's fundraising for Bourton. Annual Reports described the significant roles played by local churchmen, either as co-founder, trustee, governor or hospital manager, as at Cranleigh and Bourton. Churches and chapels had regular collections and fundraising days, local clergy were prominent regular subscribers, and used

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their important role in society to encourage, as a Christian duty, regular subscriptions and the giving of money and goods.

Clergy on hospital committees used their influence to encourage their fellow clerics to support the hospital; the Annual Reports for Bourton and Moreton cottage hospitals published the amounts contributed by each local church and chapel. The annual reports were also used to name and shame: lists were published of parishes which had made no contribution to the hospital's coffers, but nevertheless were happy to send parishioners to the hospital for treatment. The 1878 Annual Report of Moreton challenged parishes which it considered were not pulling their weight:

'Churches and Chapels continue to contribute, but the fund from these collections and offertories, limited to 11 parishes, should be larger, and derived from a more extended area. Villages for miles around participate in the benefits of the institution, and every place of worship might fittingly forward such a work of charity and mercy, and establish its annual Hospital Sunday.'⁴⁵

Despite such chidings, little changed. In 1884, the Trustees again complained about a lack of support from certain quarters: 'the District available for patients comprises 30 parishes, 10 of which sent no aid to the hospital.'⁴⁶

Once the hospital became established in the community, active involvement of the clergy, such as that exercised by Sapte at Cranleigh as co-adjudicator of patient admissions, declined. Annual Reports indicated that from about 1880, direct clergy influence weakened as the post of Hospital Manager (or similar), often held initially by the local vicar, had disappeared while the position of Medical Officer had become more prominent. Although it had remained normal practice for local clergy to be members of management committees, these bodies usually had a majority of lay members, usually male, although, albeit infrequently, some committees did also include female members of local aristocracy or gentry. Such members were sometimes women related to a person instrumental in founding the hospital, such as the donor of the land or building.

The importance of charitable giving was well understood by early proponents of cottage hospitals; the preface to Waring's 1867 book opened with the observation that, 'The Cottage Hospital system is one of the many offspring of modern philanthropy', indicating the level to which philanthropy permeated respectable society.⁴⁷ The extent to which early cottage hospital development can be attributed mainly to local philanthropy is questionable, however. There is no doubt that without sponsorship, money and sometimes land or property donated by the wealthy, few if any hospitals would have opened but, as Chapter 1 has shown, the driving force in the early years was an established local surgeon who was keen to demonstrate his technical skills, with the expectation that such experience would result in an expanded private practice, and a population of patients suffering from chronic illnesses and accidents. These innovative doctors certainly needed philanthropy to make a success of their venture, but without the initial drive from the doctor it is unlikely many of the cottage hospitals would have ever come into being. This theme was also identified by Gorsky *et al* when considering the growth of voluntary hospitals. They argue that it was the activism of doctors, asserting their professional role, to be the most important factor in the growth in number and dispersion of voluntary hospitals.⁴⁸

Doctors were not, of course, solely motivated by the opportunity for financial gain. Healing the sick and the poor was an important Christian tenet. Mary Carpenter has argued 'that the entire decade of the 1860s and the first years of the 1870s were perhaps the most unhealthful in the history of Victorian England', with a death rate of 22.5 per thousand.⁴⁹ It perhaps is no coincidence that it was during this period that the Cottage Hospital Movement became firmly established. As argued in Chapter 1, industrial growth and the continuing introduction of machinery in agriculture and manufacturing had led to an increase in serious accidents and illness, which along with the impact of increasingly unhealthy living conditions in towns, strengthened the case for a local hospital and provided medical evidence which could be deployed when appealing for funds.

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Steven Cherry cited industrial paternalism, religious non-conformity and medical influence as important factors in cottage hospital foundation.⁵⁰ With a couple of notable exceptions, such as Sir Titus Salt at Saltaire and the Walker Alkali Works in Newcastle, whose works-related hospitals opened in 1868 and 1870 respectively, industrial philanthropy was to become more important in the 1880s.⁵¹

Gorsky, Mohan and Powell have plotted the growth in voluntary hospitals, in the widest definition of the term, meaning hospitals supported by public subscription and open to members of the deserving poor, during the nineteenth and early twentieth centuries. They observed peaks in this activity in the decades of 1870-9 and 1890-9 which they attributed to the establishment of cottage hospitals and small general hospitals, many founded by local philanthropists. They argued that while earlier institutions, especially in large provincial cities were founded by the aristocracy and gentry, it was the middle-class subscriber who supported the new provincial hospitals financially. Such individuals, they concluded, were motivated by a combination of altruism, religious duty and paternalistic concern for employees' welfare, demonstrated by the subscriber ticket system which facilitated admission to hospital.⁵²

However, the research conducted for this thesis does not necessarily support that argument. In the period of Gorsky *et al's* first peak (the 1870s), cottage hospitals in this study continued to be funded largely by the local aristocracy and wealthy gentry. For instance, in 1872, Lord Redesdale donated the site for the Moreton Cottage Hospital and the Marquis of Northampton contributed £50 to its foundation.⁵³ Similarly, the Earl of Egmont was Patron and major donor to Epsom & Ewell Cottage Hospital in Surrey, which opened in 1873; and High Wycombe Cottage Hospital (Buckinghamshire), which opened 1875, was built on land given by Lord Carrington. The practice continued in the 1880s; Totnes Cottage Hospital (Devon), opened 1885 and was housed in a converted villa provided by the Duke of Somerset. Aristocracy and gentry, mostly in rural areas, continued to support the local cottage hospital as subscribers, trustees and honorary presidents, made their gardens available for bazaars and other fund-raising activities, donated food and drink (for patients) on a regular basis

and occasionally gave furniture and equipment. Whilst the middle classes certainly supported cottage hospitals through their subscriptions, aristocratic support and money was essential, especially where expansion or rebuilding was called for.

At Moreton, support of local aristocracy aside, annual subscribers for the most part were people of status in the community; the published subscriber's list included three 'Sirs', one 'Lady', one 'Honourable', seven 'Esquires' and seven 'Reverends' and the wives and daughters of local gentry. Moreton also obtained support from two local businesses, the University of Oxford and the Loyal Rose of England Lodge.⁵⁴ Most subscriptions however were for only one guinea, evidence (perhaps) that it was a payment made from a sense of social duty, rather than full-hearted support for this new venture.

At Cranleigh, it too was beginning to draw support from the middle-class section of its population. The 1879 Annual Report listed seventy-five subscribers, from the higher echelons of Cranleigh society, including local landowners and major farmers and their wives and daughters, Members of Parliament, clergy from the surrounding villages and local 'worthies' (including the garden designer Gertrude Jekyll), each subscribing one or two guineas. The list ended, though, with eleven people of decidedly lower rank, as suggested by their simple titles (Mr or Mrs) and the size of their subscriptions, 10s/- or 10s/6. These subscribers may well have been some of Cranleigh's 'solid middle-class', but they were few in comparison to the gentry and local aristocracy.⁵⁵ In 1880, Henry Burdett noted that 'Mr Napper has been offered an entirely new hospital, but it is his wish to let the hospital stand as a memorial of the first of its kind.'⁵⁶ It is more likely that a larger hospital would have contradicted Napper's public stance that a village hospital should be on a small scale and one larger with a consequent need for more staff would dilute his sole medical control and put strain on the subscription income.

The rise of the town-centred cottage hospitals

Albert Napper retired in 1881, and at a meeting of the East Surrey District of the BMA, the success of his 'cottage hospital movement' was acknowledged in glowing terms. It was proposed that a testimonial should be promoted in recognition of Napper's achievement 'which has done so much for the profession and the public'.⁵⁷ Dr Holman, who made the proposal, stated that there were now about 300 cottage hospitals in the country with an annual combined income of £150,000, of which about 15 per cent was contributed by patients, and collectively they dealt with at least 50,000 in-patients annually.⁵⁸ There were also cottage hospitals in the United States, on the Continent, and in the colonies, and that permission has been obtained for a French edition of Burdett's '*Cottage Hospitals*' for use by the French Government in promoting public health. 'The profession at large has found the cottage hospital of great value [...] in raising the status of the profession in the eyes of the public', Holman continued.⁵⁹ The emphasis upon the benefit to the medical profession reinforces the conclusion that the opportunities offered by the presence of a hospital which conferred financial and reputational advantages to the medical officer were as least as important as the welfare and treatment of patients.

Up until the early 1870s, the expansion of cottage hospitals and the success of the movement had been mainly restricted to the rural communities, but as the century progressed, supporters began to ask if such hospitals might find a role in more urban settings too. In the same year that Napper retired, Dr S O Habershon, Vice-President of the Metropolitan Counties Branch of the BMA, gave a paper to the South London District in which he reviewed the benefits to patient and doctor of cottage hospitals before posing the question of the need or not for cottage hospitals in the London suburbs. He argued that although it was a short rail journey from Greenwich or Sydenham to Guys or St Thomas', bed numbers were too few to service the tens of thousands of potential patients living in south London. As had already been established beyond question, cottage hospitals were cheap to establish and operate, and (with an eye on objections from the large voluntary hospitals in the capital), their presence would not adversely affect large institutions. Patients, saved a precarious journey into the centre of London and the ravages of hospital infections, stood a

better chance of recovery and, for efficiency's sake, such hospitals could be associated with existing dispensaries.⁶⁰

Although Habershon's encouragement came rather late in the day (a number of suburban cottage hospitals had already opened on the outskirts of London, in Beckenham, Blackheath and Eltham), his intervention may have helped further expansion. Between 1881 and 1890, five more hospitals opened on London's south-east fringes at Bexley, Chislehurst, Orpington, Sidcup and Woolwich. Cottage hospitals also opened in north London (in Hampstead, Highbury and Newington Green), in the south at Norwood and to the south west of the city in East Molesey and Thames Ditton. Elsewhere, suburban cottage hospitals appear to have been less common; with those at Bootle (founded in 1866) and Garston (1882) on the edge of Liverpool, and Urmston opening in 1873 in Urmston, on the south west fringes of Manchester. The relative lack of cottage hospitals in the close suburbs of other cities perhaps reflects the relative size of these cities and the influence of their major voluntary hospitals.⁶¹

The emergence of cottage hospitals in suburban London during this period was likely to have been influenced by the spread of railways, which had prompted population expansion in these peripheral London communities, attractive to those with wealth who sought clean air and a country environment yet with ready access to the metropolis.⁶² The influx of wealthy inhabitants into these new, or newly expanding, communities acted as a spur to local practitioners to develop their own facilities to service patients from the large class of servants, artisans and small shop-keepers through the cottage hospital, but also establish or expand his private practice among their newly arrived wealthy masters and customers. For a subscriber who paid a modest annual subscription to the cottage hospital, which then published lists of such subscribers, this was a marker that one had 'arrived', in tune with respectable Christian ethics

In the 1880s wealthy business owners began to give substantial sums to their local towns for charitable purposes, endowing parks, libraries, schools and hospitals, often bearing their name. John Passmore Edwards, Chartist, journalist, newspaper owner and Liberal Member of Parliament, exemplified the

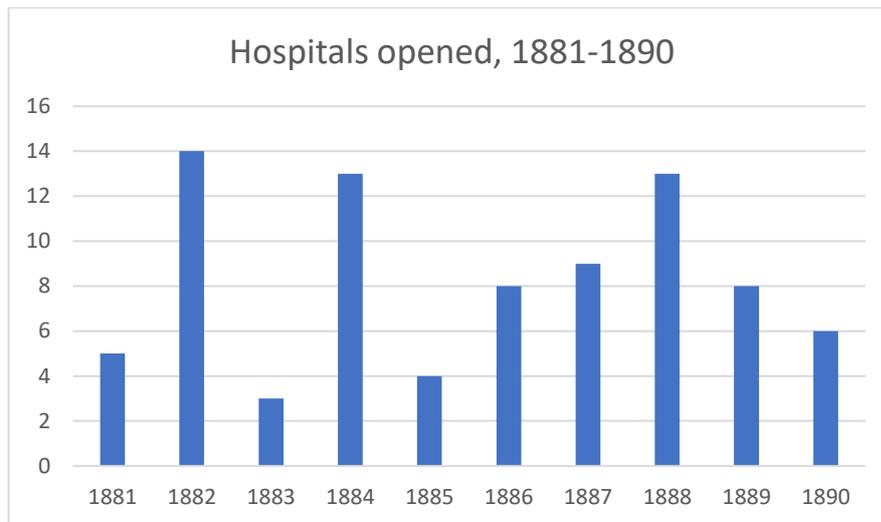
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new style of philanthropist. By the time of his death in 1911 he had established or supported financially over seventy public facilities which included the Whitechapel Art Gallery, the London School of Economics, many libraries and schools. He had also contributed to eight cottage hospitals at Acton, East Ham, Sutton, Willesden and Wood Green, in Middlesex, Tilbury in Kent, and further afield to hospitals in Falmouth and Liskeard (Cornwall).⁶³

In a significant act of industrial philanthropy, Courtauld textiles family founded the four-bed Braintree and Bocking Cottage Hospital in 1886.⁶⁴ Their mills in Bocking and Halstead Essex, employed about 1,300 workers at the time (most of whom were women), out of a population of about 8,500.⁶⁵ Between 1870 and 1890, the company also funded the Courtauld Estate (following the examples already established by earlier industrial philanthropists such as Titus Salt at Saltaire and the Lever brothers in Port Sunlight) which provided accommodation for its workers, a Workmen's Hall for employees' recreation, a Literary and Mechanics Institute and Bocking Public Gardens.⁶⁶

As the Braintree Cottage Hospital had been founded by Courtauld's it was assumed that the majority of patients would be women mill workers, but analysis has shown that admissions were equally split between male and female patients and very few of either gender were described as mill workers.⁶⁷ It seems possible therefore that the hospital had been provided for the use of the town's whole population, a broader philanthropic gift than one intended solely for the company's employees, yet it contained surprisingly few beds for the population and period.⁶⁸ In addition, and most unusually for that time, six of the governing committee of twelve were women, one of whom was Miss Courtauld, possibly Louise, daughter of George Courtauld. The family kept a close watch on the hospital; in 1907, the Annual Report noted that another woman, Miss M R Courtauld, had been appointed to the management committee.⁶⁹

Between 1881 and 1890 a further eighty-three cottage hospitals opened, bringing the total in England and Wales to just over 350.

Chart 2.2: Cottage Hospitals opened between 1881 and 1890⁷⁰

The irregular rate of opening does not appear to have had any particular causes. In the early years of the decade the agricultural depression was coming to end, and it is possible that facilitated the increased number of new hospitals in 1882 and 1884, although the location of these new hospitals does not tend to support that assumption. The surge in 1888 can be confidently assigned to the impact of Queen Victoria's Golden Jubilee celebrations the year before; many of the hospitals which opened in this year bore her name, to memorialise her fifty years' reign.

Although the Cottage Hospital Movement continued to remain concentrated below a line from Bristol to The Wash, as illustrated by Map 3 (See Appendix 4), a number of hospitals did open in the North, including in Northumberland, Yorkshire, Derbyshire and Lancashire.⁷¹ The three Northumberland hospitals were of a rural nature, while those in the other counties were situated in towns, such as Thirsk, Glossop, Matlock, Eccles and Burnley. The continuing expansion of cottage hospitals in the south and south-west can probably be attributed to the influence of the successful institutions opened in the previous twenty years, which had set the example and demonstrated that a small medical facility, initiated by an entrepreneurial doctor, could survive and prosper with support from the local gentry, Church and Chapel and an expanding middle class.

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Historians have put forward alternative explanations for the enthusiasm of local medical practitioners to found local hospitals. Anne Digby has suggested that the nineteenth century medical 'marketplace' had created a surplus of medical practitioners in the south of the country, where there was a concentration of wealthy patients, and a scarcity in the north.⁷² This provides a possible explanation: in the overcrowded south, doctors were driven to look for new opportunities to create a living for themselves, whereas in the north, where there were fewer doctors per head of population this urgency (and need for innovation) was missing. The evidence in this study, shows that hospitals in the south and west were generally founded by established local surgeons; these were not young doctors seeking to make a living, but experienced local practitioners looking to enhance their professional status. So while the urgency might have been less than that described by Anne Digby, it is still possible that the competition for patients caused by an oversupply of doctors still contributed to established doctors having to look for new ways to expand their practices, and to compete with the city-based practitioners.

Gorsky, Moham and Powell have argued that the growth in voluntary hospitals (in which they included cottage hospitals) in the counties of Devon, Somerset and Gloucestershire resulted from the existence of a strong provincial medical culture fostered by teaching hospitals in Bristol and general hospitals in Bath and Exeter, coupled with the affluence of the region. In the Sussex area, they attributed the growth in hospitals to the pull of fashionable Brighton, which attracted wealthy potential patients along with the overall attractiveness of the region, as a place to live and work.⁷³ Their argument appears to conclude that the number of hospitals was related not to the need of patients (after all the patients in these hospitals were uniformly from the lower classes), but to the number of doctors available, and the potential to build a lucrative practice (in a similar argument to that put forward by Digby). They observed a relatively slow establishment of voluntary hospitals in the 'home counties' and argued that this was the result of most philanthropic activity being focussed on the metropolis. However, they failed to acknowledge the impressive influence exerted by Napper on the formation and spread of cottage hospitals in south east England. According to this study, and using a broad definition of 'Home Counties', this

region was an early and enthusiastic adopter of the cottage hospital system during the whole of the period under study. Between 1891 and the end of the century, the counties surrounding London attracted a further twenty-eight cottage hospitals, as illustrated in Map 4 (Appendix 4).⁷⁴

Between 1891 and 1900 a further 107 cottage hospitals opened across the country, bringing the number recorded in the Cottage Hospital Database to 519. As discussed above, fundraising to celebrate Queen Victoria's Golden Jubilee in 1887 had provided communities with new public facilities such as parks, libraries and hospitals, and her Diamond Jubilee in 1897 gave a further opportunity to memorialise her reign by opening yet more cottage hospitals or by expanding existing institutions. Others were simply renamed, to mark the occasion, by including 'Jubilee' or 'Victoria' in the title. There was a trend towards new and expanding hospitals providing twelve beds or more, but most cottage hospitals (for which data is available) continued to contain eight beds or fewer.⁷⁵

In the last decade of the nineteenth century, wealthy industrialists increasingly took their place alongside the aristocracy in giving land, building cottage hospitals and endowing funds for future maintenance. It became popular for businessmen and industrialists, or their widows, to give large philanthropic donations for self-memorialisation and to demonstrate their success by building or endowing public facilities such as libraries, hospitals and parks, often in their birth town particularly in new industrial towns in the Midlands, Lancashire and Yorkshire. This period also saw an increased participation of workers' associations and trades unions in contributing to the upkeep of hospitals alongside membership-based Provident and Friendly Societies, to which individuals gave a small weekly sum which entitled them to hospital access in time of need. The 1890s was also the period which increasingly saw medical officers being paid for their services, and the appointment of professional trained nurses. Chorley Cottage Hospital and Dispensary (Lancashire), which opened in 1893, demonstrated all these features.⁷⁶ It is used here as a case study for town-based cottage hospitals.

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In 1893, when the hospital opened, Chorley was an expanding northern industrial town located about twenty miles north of Manchester with a population of about 20,000. It contained extensive cotton and yarn mills, railway wagon manufacturers, calico printers, fabric bleachers, and nearby coal mines and quarries.⁷⁷ One of the earliest provincial dispensaries in England had opened in the town in 1828, and by 1837-8, it had treated some 650 plus patients.⁷⁸ The Dispensary's Annual Reports provide an illuminating insight into the causes of death and the diseases of the inhabitants of Chorley in the early 19th century, and the statistics were used by House Surgeon, Septimus Farmer, to illustrate his plea 'that many valuable lives would be saved, had there been a properly managed Cottage Hospital in the town', a plea he repeated each year with increasing vehemence.⁷⁹ He clearly was pessimistic about his chances of success as he commented that there was little likelihood of a cottage hospital, and suggested instead that a competent nurse could be engaged 'who would make house to house visitations, and see that the Doctor's orders are carried out.'⁸⁰ The town had to wait nine years for Farmer's plans to come to fruition, with the establishment of a cottage hospital in the town in 1893; sadly by this time Farmer had retired. The final Dispensary report for November 1892 extended congratulations to the people of Chorley on the erection of the cottage hospital. It noted that the Dispensary dealt with an increased attendance in its final year, attributed to 'the depressed state of trade, and the severity of winter which caused out-door labourers to be thrown out of work.' There had also been sporadic cases of measles, diphtheria, scarlet fever, typhoid and smallpox, 'but they never assumed anything like epidemic form.'⁸¹ It seemed an auspicious time to launch a new hospital.

In the tradition of Victorian civic pride and philanthropy, the hospital came into being as a result of joint action by a local businessman and a clergyman. The building itself (and the furnishings to go in it) were financed by Alderman Henry Rawcliffe, a local master brewer, while the land the building stood on was donated by the Very Reverend Lennon, indicating that the practice of Church involvement in hospital foundation was still extant in the early 1890s.⁸² The hospital's first annual report in 1893 expressed appreciation for Rawcliffe's 'munificence', and in 1894, in further show of generosity he paid for a mortuary

to be added. The Hospital was a substantial building, as can be seen in Figure 2.1, yet only contained seven in-patient beds and a dispensary.

Figure 2.1. Chorley Dispensary and Cottage Hospital. (Reproduced courtesy of Chorley Heritage Centre)



John Pickstone, discussing the development of voluntary hospitals in Lancashire in the late nineteenth century, has argued that 'New hospital building did not depend upon on a large number of medium contributions; they were usually initiated by one or two large beneficiaries [...] and by organised contributions from the workers in the cotton mills.'⁸³ Whilst Chorley Cottage Hospital was on a smaller scale than those discussed by Pickstone, it seems his analysis applies here too; the Chorley hospital was fully supported by the workers of the town through workplace collections and later by a variety of community-based fund-raising events, including charity football matches.

The hospital clearly met a need. The Medical Officer's report for 1894 noted, 'We would especially draw attention to the large number of persons who have received treatment for injuries by machinery and other accidents, viz. 161. Thirty-one of these were admitted into the hospital ... [who] previously would have had to be taken at great inconvenience and risk to

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Preston or Wigan. Those not admitted were treated as out-patients [in the Dispensary].'⁸⁴

The arguments for the hospital being made here, especially that relating to dangers of transporting sick patients over long distances, echoes those arguments made by Napper, over thirty years previously.

The Dispensary treated substantial numbers of out-patients, who as well as needing a Governor's ticket, were means-tested, to prevent abuse of the charity. In order to receive treatment the rules stated that a single-person's income should not exceed 15s/- a week, and a two-person family income should not be above 21s/-. Each additional working family member added a further 3s/- per week to the maximum allowable income, before a patient was refused.⁸⁵ In 1893, 793 out-patients were treated, the large number being 'no doubt somewhat accounted for by the distress prevalent in the coal strike'.⁸⁶ The hospital and its facilities were made available to six local doctors, while Dr William Butterly was elected by the Governors as house surgeon to oversee the running of the institution. Moving away from the model espoused by Napper and followed by many cottage hospitals, at Chorley the hospital rules stipulated that the surgeon 'shall reside in the Dispensary, and shall receive a salary together with board and lodging'.⁸⁷ This generosity came at a price though, and the house surgeon was forbidden from taking on private patients, or from engaging 'in any other occupation than that which relates to the Dispensary and Hospital'.⁸⁸ The Hospital's management committee was expecting its House Surgeon's undivided attention, and were prepared to pay for this with a salary of £120 1s 6d, an example of a trend beginning to emerge in some cottage hospitals of employing salaried medical officers, rather than the hospital's medical officer giving his services for free.⁸⁹ The Rules also stated that a Nurse-Matron should be appointed who, besides undertaking normal nursing duties, would be responsible for ordering provisions, supervising domestic matters and maintaining the accounts. Miss Noble was the first person to hold this position. She lived in the hospital and was paid an annual salary in 1893 of £14 11s 8d., plus board and lodging.⁹⁰ This is a very low salary for a qualified nurse. At this time qualified nurses in voluntary hospitals could earn £20-25 a year and even probationers in the London teaching hospitals were earning

between £12 and £14 (with board and lodging in addition). By comparison, factory operatives earned £50 a year (although they would have to pay for their board and lodging out of this sum).⁹¹ The 1894 Annual Report noted that 'The District Nursing which was commenced at the end of last year has been continued. It is difficult to over-estimate the value of this work, and it is pleasing to note that it is so fully appreciated by the patients themselves.'⁹²

Services continued to expand: by 1898 the hospital had appointed an Honorary Dental Surgeon and in 1900 a new wing, funded by (and named after) Mrs Winstanley, increased capacity to twelve beds and one child's cot and included a new operating theatre 'admirably equipped with the most modern appliances'.⁹³ It is telling that Mrs Winstanley's address on the leaflet was Dundrum, co Dublin, indicating that philanthropy was not reserved for local ventures. Sometimes, as in Mrs Winstanley's case, donors chose to support causes in their home town, even if they no longer lived there.

In contrast to early southern cottage hospitals where religious contributors came almost entirely from the Church of England, in Chorley churches of numerous denominations contributed to the its hospital, including Wesleyan, Methodist, Baptist, Congregational, Unitarian and one which was probably Catholic (the Church of the Sacred Heart), reflecting the much more diverse nature of religious worship in northern towns. Of course, the Anglican churches also contributed. All ministers of religion within the Borough, regardless of denomination, were ex-officio governors of the hospital along with any clergyman or minister having a collection in his place of worship.

The hospital was also strongly supported by many of the town's businesses. Annual Reports contained several pages of subscriptions which included local banks, spinning and weaving mills, bleach works and printers and included the value of donations. Local shopkeepers placed collecting boxes in their premises, and the amounts collected were duly recorded. Workers also raised money for the hospital, their efforts acknowledged in the same way. The importance of publishing subscriber and donor lists (along with the value of the donation) has already been discussed elsewhere, as a key element in the

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cajoling of the public to support good causes. Those whose generosity was being recognised, bathed in the social approbation which was their just desert; while those whose names did not appear may be forced through shame to contribute in the future.

The extensive records of Chorley Cottage Hospital show that the hospital was a very important institution in the town, around which the various classes (and religious sects) came together for a common purpose which transcended social class. It enabled the 'new rich' to demonstrate their wealth and status by building, furnishing and extending a physically impressive hospital; but also allowed less wealthy inhabitants to make their contribution too. Like all cottage hospitals, in addition to cash donations, the community made regular gifts in kind, of meat, fruit and vegetables, magazines, toys and clothes. Several mills, notably the Chorley Cotton Spinning and Manufacturing Company, supplied calico bandages. Besides Chorley, a further nine cottage hospitals opened in Lancashire towns scattered across the county between 1890 and 1900, although generally acceptance of cottage hospitals still trailed developments on the other side of the Pennines.⁹⁴

Other new hospitals in this decade were relatively evenly spread across the regions, all opening at a much lower rate than in the south east and western counties. As already mentioned, Wales, a predominately agricultural country, had surprisingly few cottage hospitals. 'Quarry Hospitals', serving local mines had opened in Caernavonshire in the early 1860's so the benefits of these small local hospitals would have been known. The idea however, never seemed to gain traction, and only a handful of cottage hospitals opened each decade, despite the growing presence of heavy industry, especially in south Wales.

By 1914 (see Map 5 in Appendix 2), 527 cottage hospitals had opened. While many were situated in rural communities, as Napper had envisaged, they were also appearing in small towns and industrial areas, and around the periphery of London. There seems to have been less interest in the concept in other major conurbations such as Birmingham and Manchester, perhaps, as discussed in

the case of Leicester, as a result of the very strong influence of the large teaching hospitals in their vicinity.

Conclusion

A number of key themes have emerged in Chapters 1 and 2 which have contributed to a greater understanding of the origins of the cottage hospitals in the 1860s and why their successes resulted in over 527 of these small institutions having opened throughout England and Wales by the outbreak of World War One.

By 1914, Napper's influence and principles still infused the Cottage Hospital Movement although the nature of the hospitals was gradually evolving. Cottage hospitals continued to be funded from local subscriptions, donations and bequests, with diminishing contributions from patients.⁹⁵ They continued to be an integral part of the local community and local benefactors could still be relied upon for handsome contributions when additional facilities and equipment was needed. The wealthy continued to make their gardens open for bazaars and other fund-raising events but increasingly funds were raised through local charity events such as football matches, street collections and concerts. With a few exceptions doctors, until late in the century (as at Chorley), continued to give their services *gratis*.⁹⁶

The emergence of town-based cottage hospitals was certainly a step away from Napper's originally idea: especially in relation to his emphasis on the importance of familiarity between the donor and the recipient of charity, a relationship which would be strained. Nevertheless, with or without Napper's blessing many small towns drew inspiration from the rural hospitals and undertook their own initiatives to deal with local (often industrial) health issues.

There had been changes. Some hospitals introduced 'pay beds' and admitted private and convalescent patients. Burdett, in 1896, recognised that a middle class with disposal income had led to private patients being admitted to cottage hospitals and adapted his rules accordingly: 'Any suitable patient desirous of having the comforts and nursing of the hospital may, on the certificate of one of

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the medical officers, and subject to there being room, have the privilege of being admitted on payment in advance of not less than 20s per week in the ordinary wards, or 30s per week in a private ward.⁹⁷

Despite Napper's aversion to trained nurses, the newer hospitals were more likely to employ professional nurses, while his exhortation to keep things simple and focussed was being steadily diluted by the addition of district nursing and midwifery services and dentistry. Again, probably to Napper's disappointment, bed numbers were also growing, heading towards ten to twelve, with some having as many as twenty. In a typical hospital, annual in-patient number had increased from about thirty to over one hundred, patient-stay had reduced considerably and a wider range of treatments and operations, including maternity cases, had become commonplace.⁹⁸ The influence of the church was becoming less evident: there were fewer vicars on the expanded management committees, their places taken in many instances by women.⁹⁹

The initial impact of Napper's ideas should not be overshadowed by later developments. Not only did his vision inspire towns and villages around the country to establish hospitals for the treatment of their local working poor, but it spread wider, with cottage hospitals appearing across the Empire, and on the east coast of the United States, notably Massachusetts.¹⁰⁰ In the third edition of his book on cottage hospitals he wrote that 'it has been our privilege and pleasure to promote the success of cottage hospitals everywhere ... [which] has enabled the country practitioner to become an accomplished and skilful surgeon and keep himself well abreast of the new features of medical practice.'¹⁰¹

The first two chapters have established the success of these new hospitals. The next two will investigate in more detail how they were run and who the patients were. Financing a cottage hospital was always a challenge, especially in its early years, yet with very few exceptions they survived, prospered and were supported and cherished by their local communities. The following Chapter discusses the changing sources of income over time, how expenditure was allocated and the invaluable contribution of donations in kind to the diet and well-being of patients.

¹ Cottage Hospital Database

² *Ibid.*

³ *Ibid.*

⁴ In Cranleigh a local country house was converted into a military hospital, but Cranleigh Village Hospital also admitted military casualties, possibly as an overflow facility.

⁵ http://www.oxfordshirehealtharchives.nhs.uk/hospitals/didcot_cottage.htm. Accessed 2 September 2017.

⁶ Cottage hospitals closed for various reasons. The opening of a new larger hospital in a nearby town, could be the cause of closure; or hospitals could merge to provide more efficient services. Such closures then as now often faced vociferous local objections. Only a small number closed for financial reasons.

⁷ Steven Cherry, 'Change and Continuity in the Cottage Hospitals, c. 1859-1945: the experience in East Anglia', *Medical History*, 36 (1992), pp. 271-89.

⁸ For example, Porth Cottage Hospital, Pontypridd was funded largely from the contributions and efforts of local miners; and Crewe Cottage Hospital, built on land gifted by the London and North-Western Railway, was supported by employees of local railway engineering and building companies. Cottage Hospital Database.

⁹ Martin Gorsky, 'Self Help and Mutual Aid: Friendly Societies in 19th Century Britain', *Refresh, Economic History Society*, 28 (1999), pp. 1-4. Accessed online at <http://www.ehs.org.uk/the-society/refresh.html>.

¹⁰ Brian Abel-Smith, *The Hospitals 1800-1948* (London: Heinemann, 1964), pp. 237-251.

¹¹ *Cranleigh Village Hospital Annual Report 1876*, Surrey History Centre (SHC) ref 1397.

¹² W.C. Coles, *A Rural Village Hospital: an account of the Bourton on the Water and Cotswold Village Hospital, from the period of its commencement to the present time* (London: Taylor & Co., 1877). Coles was honorary physician to Bourton Cottage Hospital and retired surgeon-major in the Bombay Army, one of three 'presidency' armies established after the 1857 rebellion.

¹³ *Ibid.* p. 6. The hospital was the 'home of a pensioned soldier and his wife, the latter acting as nurse'. Possibly he was known to Coles from his time in India.

¹⁴ Coles, *A Rural Village Hospital*, pp. 7-8.

¹⁵ Cottage Hospital Database. Information on bed numbers is available for about 60 per cent of the hospitals opening in the period 1870-1880.

¹⁶ There were a few exceptions. Horton Cottage Hospital, opened in Banbury (Oxfordshire) in 1872, was named after a local businessman, William Horton, by his daughter. He was known for having invented an elastic yarn making machine for stocking manufacture. This was also an example of a larger cottage hospital containing twelve beds, six in each male and female ward. A children's ward was added in 1897.

¹⁷ Brotton was later renamed Cleveland Cottage Hospital.

¹⁸ Andrew Kurtz, local chemical manufacturer, was a major benefactor of St Helen's Cottage Hospital. The contribution of industrial and business philanthropists is discussed later in the chapter, Chorley and Braintree Cottage Hospitals as examples.

¹⁹ Cottage Hospital Database

²⁰ Alun Howkins, *Reshaping Rural England, A Social History 1850-1925*. (London: Routledge, 1992), pp. 138 – 198.

²¹ P.J. Perry, 'Where was the 'Great Agricultural Depression? A Geography of Agricultural Bankruptcy in Late Victorian England and Wales', *The Agricultural History Review*, 20/1 (1972), pp. 30-45.

²² Cottage Hospital Database.

²³ Chapter 4 discusses the patients admitted to cottage hospitals and the effect of the depression upon agricultural labourers' wages and their consequential dietary deficiencies and illnesses.

²⁴ Lord Redesdale, born Algernon Mitford, was a diplomat, MP and author. His estate, Batsford Park, Gloucestershire, was close to Moreton-on-the-Marsh. Edmund Goss (revised by H. C. G. Matthew), 'Mitford, Algernon Bertram Freeman-', first Baron Redesdale (1837–1916), in *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, in print and online 2004). <https://doi.org/10.1093/ref:odnb/35048>

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²⁵ The sum, described as 'handsome' in the Trustees Report for 1878, was bequeathed by Dr William Sands Cox, founder of Queen's College, Birmingham but the value was not quoted. A later set of Accounts showed that £3,000 had been credited to the Building Account. An article in *The Cotswold Journal*, 30 May 2013, proclaimed that the old cottage hospital had been saved from demolition and noted that Sands-Cox had bequeathed £3,000 and a further £1,000 was given in 1886 by the Joseph Phipps Charity.

http://www.cotswoldjournal.co.uk/news/10454421.Moretons_old_cottage_hospital_saved_from_demolition/. Downloaded 12 July 2017.

²⁶ *Moreton Cottage Hospital*, 6th, 9th and 10th *Annual Reports*, Gloucester Record Office. The records of Bourton Cottage Hospital, some twelve miles away, made similar references to the adverse financial impact of the continuing agricultural depression.

²⁷ http://www.cotswoldjournal.co.uk/news/10454421.Moretons_old_cottage_hospital_saved_from_demolition/. Downloaded 12 July 2017.

²⁸ Henry C Burdett, *The Cottage Hospital, its Origins, Progress, Management and Work*, 1st Edn (London, J & A Churchill, 1877).

²⁹ *Ibid.*, p.1.

³⁰ Burdett, *The Cottage Hospital (1st Edn)*. A discussion of Burdett's comparison of the outcomes between surgeries for fractures at cottage and general hospitals can be found in Chapter 4.

³¹ Henry C Burdett, *The Cottage Hospital, its Origins, Progress, Management and Work*, 2nd Edn (London: J & A Churchill, 1880).

³² *Ibid.*, p. 6.

³³ *Ibid.*, p.10.

³⁴ Burdett, *The Cottage Hospital (1st Edn)*, p.8.

³⁵ Despite this setback, East Grinstead Cottage Hospital re-opened in 1888, with five beds, and, following Burdett's advice, a Governing Body of twelve was appointed, plus trustees and life members. The Medical Officers (there were five now associated with the hospital) were free to focus entirely on caring for the patients. Henry Burdett, *Hospitals and Charities, 1899, being the year book of philanthropy and the hospital annual* (London: Scientific Press, 1899).

³⁶ *Ibid.*, p. 11.

³⁷ By the end of 1876, just prior to publication, 224 cottage hospitals had been identified. Cottage Hospital Database.

³⁸ Burdett, *The Cottage Hospital (1st Edn)*, p. 3. Burdett missed hospitals in Monmouthshire, which had four cottage hospitals at the time of his survey: Cwmcarn near Caerphilly, Cwmdu near Abergavenny, Monmouth and Rhymney. Cottage Hospital Database.

³⁹ *Ibid.*, p. 3. Burdett's observation also gives an insight into his personality and attitudes.

⁴⁰ *Ibid.*, p. 4.

⁴¹ Burdett, *The Cottage Hospital (2nd Edn)*, pp. 36 – 44.

⁴² David Owen, *English Philanthropy 1660-1960* (Cambridge, Mass., Harvard University Press, 1964), pp. 163 - 181.

⁴³ Alan Kidd, *State, Society and the Poor in Nineteenth-Century England* (Basingstoke: Macmillan Press Ltd., 1999), pp. 67-74.

⁴⁴ Keir Waddington, *Charity and the London Hospitals 1850 - 1898* (Woodbridge: Boydell & Brewer Ltd, 2000), pp. 25 - 6. Peter Shapely has also discussed the important connection between philanthropic activity and social standing, especially for men. See Peter Shapely, 'Charity, status and leadership: charitable image and the Manchester man.' *Journal of Social History* 32/1 (1998), pp. 157-77.

⁴⁵ *Moreton Cottage Hospital, Sixth Annual Report*, p.1. The role of the Hospital Sunday Fund will be discussed in detail in Chapter 3.

⁴⁶ *Moreton Cottage Hospital, Twelfth Annual Report*, p. 1.

⁴⁷ Edward John Waring, *Cottage Hospitals: Their Objects, Advantages and Management* (London: Savill Edwards & Co., 1867), Preface.

⁴⁸ Martin Gorsky, John Mohan and Martin Powell, 'British voluntary hospitals, 1871 – 1938: the geography of provision and utilisation', *Journal of Historical Geography*, 25, 4 (1999), 463-8, 467.

⁴⁹ Mary Wilson Carpenter, *Health, Medicine and Society in Victorian England*, (Santa Barbara, Calif., ABC-CLIO LLC, 2010), p. 11.

⁵⁰ Steven Cherry, 'Hospital Saturday, Workplace Collections and Issues in late Nineteenth-Century Hospital Funding', *Medical History*, Medical History, 44, (2000), 461-488; Gorsky, Mohan and Powell, 'British Voluntary Hospitals'.

⁵¹ Sir Titus Salt, a textile manufacturer, founded the model village of Saltaire near Bradford for his millworkers. The village included a six-bed casualty hospital which became Saltaire Cottage Hospital. David James, 'Salt, Sir Titus, first baronet (1803-1876)' in *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, in print and online 2004).

<https://doi.org/10.1093/ref:odnb/24565>. The Walker Accident Hospital opened c1870 funded by Walker Alkali Works and Losh, Wilson & Bell, iron foundry. *The Newcastle Courant*, 23 March 1866, reported that 'a village hospital is likely to be carried out for which 'contributions from manufacturers and iron and ship builders have been promised.'

⁵² Gorsky, Mohan and Powell, 'British Voluntary Hospitals', pp. 463-82.

⁵³ *Moreton Cottage Hospital, 1873*.

⁵⁴ *Ibid.* The Loyal Rose of England was one of many similar fraternal organisations loosely modelled upon the Masonic Order, such The Oddfellows, the Royal Antediluvian Order of Buffaloes and various Orange Lodges. Like Masons, they were all active philanthropic organisations.

⁵⁵ *Cranleigh Village Hospital, Twentieth Annual Report, 1879*, p. 7-9.

⁵⁶ Burdett, *Cottage Hospitals, General, Fever, and Convalescent* (2nd Edn), pp. 360-1. Burdett did not explain who had offered a new hospital nor when. By the end of the 1880s there were several very wealthy persons living in the Cranleigh area such as Sir George Bonham, Baronet and diplomat at Knowle Park and Lord Thurlow at the 2,000 acre Baynards estate.

⁵⁷ *British Medical Journal (BMJ)*, 19th November 1881, pp. 824-5.

⁵⁸ *Ibid.* By the end of 1881, there were 274 cottage hospitals in England & Wales. Source: Cottage Hospital Database. Holman's figures were a considerable exaggeration. A cottage hospital by the end of 1880 treated between 30 and 70 in-patients annually depending on bed numbers. It is possible that Holman was including out-patients in his 50,000 treated annually.

⁵⁹ *Ibid.*

⁶⁰ S.O. Habershon, 'Remarks on Cottage Hospitals', *British Medical Journal*, 31 December 1881, pp. 1047-48.

⁶¹ Cottage Hospital Database.

⁶² For a discussion of the impact of railways on the suburbs see for instance: I.N. Gregory and J.M. Henneberg, 'The Railways, Urbanization and Local Demography in England and Wales, 1825-1911', *Social Science History* 34/2 (2010), pp.199-228; or Nick Barratt, *Greater London: the story of the suburbs* (London: Random House, 2012).

⁶³ https://www.cornwalls.co.uk/history/people/john_passmore_edwards.htm, and A.J.A. Morris, 'John Passmore Edwards (1823-1911), newspaper proprietor and philanthropist', *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, in print and online 2004). <https://doi.org/10.1093/ref:odnb/32981>. Edwards' wife Eleanor was also active in supporting the work of voluntary hospital, as a member of the Ladies Guild for Charing Cross Hospital.

⁶⁴ Braintree District Council Heritage Site records a cottage hospital established by George Courtauld in Bocking which had opened in 1871 and was said to be the earliest cottage hospital in Essex. (This would seem to be a false claim: this research has identified at least three hospitals which predate this, at Buckhurst Hill and Saffron Waldren (both opened in 1866) and at Hatfield Broad Oak (1867). The first Annual Report for Braintree and Bocking Cottage Hospital is dated 1886. In 1897 it was enlarged to contain seven beds and in 1921 following redevelopment was renamed the William Julian Courtauld Hospital which survived until 2013 when the site was sold for housing. Sources: [http://www.bbcivsoc.org.uk/pdfs/BDC-Courtauld-LHL-final-PDF\(1\).pdf](http://www.bbcivsoc.org.uk/pdfs/BDC-Courtauld-LHL-final-PDF(1).pdf) accessed 10 July 2017; Essex Record Office; Burdett, 'The Cottage Hospitals'.

⁶⁵ GB Historical GIS / University of Portsmouth. Braintree CP/AP through time, Population Statistics, Total Population, *A Vision of Britain through Time*, http://www.visionofbritain.org.uk/unit/10235212/cube/TOT_POP. Date accessed: 24th January 2017.

⁶⁶ Such endeavours were designed to provide a wholesome environment for the industrialist's workers, encouraging them to participate in educational leisure activities and discouraging dissipation. Reference needed.

⁶⁷ The historiography of the recording of women's work in the Victorian censuses is in broad agreement, that it was under-reported, especially amongst married women in the agricultural and manufacturing sectors, and some service occupations. It is quite likely that many of the

women who were recorded as housewives in the hospital's patient records were actually employed in the local mills. Edward Higgs and Amanda Wilkinson, 'Women, Occupations and Work in the Victorian Censuses, Revisited', *History Workshop Journal*, 81/1 (2016), pp. 17-38.

⁶⁸ The occupations of the hospital's patients will be discussed in Chapter 4 in detail.

⁶⁹ Chapter 3 discusses the roles of women in cottage hospitals.

⁷⁰ Cottage Hospital Database

⁷¹ The database records 103 new hospitals south of the line, and 63 above. Of the total number opening in the period 1881-1890, almost 30 per cent were in the south east. Cottage Hospital Database

⁷² Anne Digby, *Making a Medical Living. Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994).

⁷³ Gorsky *et al*, 'British voluntary hospitals'.

⁷⁴ Gorsky *et al* did not define what they meant by 'Home Counties'. This study has used the definition which includes Berkshire, Buckinghamshire, Hertfordshire, Essex, Kent and Surrey. It has not included Sussex at part of this grouping. Using this definition, the Home Counties was one of the most enthusiastic adopters of cottage hospitals, with over 100 founded by the end of the century. If the definition of 'Home Counties' is restricted to those north of London (Berkshire, Buckinghamshire and Hertfordshire) then the analysis more closely matches to observations of Gorsky *et al*. (See Appendix 2 for an analysis of the growth of cottage hospitals by region.)

⁷⁵ Cottage Hospital Database.

⁷⁶ The recruitment of professional nurses, payment of medical officers and the contributions of Friendly Societies etc were discussed regularly in the Annual Reports for the hospital, held at the Lancashire Record Office.

⁷⁷ GB Historical GIS / University of Portsmouth, Chorley RSD through time, Population Statistics, Males & Females, *Vision of Britain through Time*. <http://www.visionofbritain.org.uk/unit/10027755/cube/GENDER>. Date accessed: 20th January 2017.

⁷⁸ The earliest reference to an operational Dispensary was the *Report of the Committee of Chorley Dispensary for y/e 1839*, Lancashire Record Office.

⁷⁹ *Chorley Dispensary, Report of the House Surgeon, Septimus Farmer, for year ending 1884*, Lancashire Record Office.

⁸⁰ *Ibid.*

⁸¹ *Report of the Committee for Chorley Dispensary y/e ending December 1892*. Lancashire Record Office.

⁸² Henry Rawcliffe was a local master brewer with family brewing interests elsewhere in Lancashire, including Wigan. In 1878 he purchased Gillibrand Hall, on the outskirts of Chorley, and its 250 acres of parkland. On his death in 1907 his will was probated at £135,000. 'Parks and Gardens UK/Gillibrand Hall' <http://www.parksandgardens.org/places-and-people/site/5433/summary> (Accessed 18 July 2017). In recognition of his generosity Rawcliffe was appointed hospital President, while the Rev Lennon was appointed Trustee and Vice-President.

⁸³ John V Pickstone, *Medicine and Industrial Society* (Manchester, Manchester University Press, 1985), p. 140.

⁸⁴ *Chorley Dispensary and Cottage Hospital Annual Report, 1894*.

⁸⁵ *Ibid.*, p. 8.

⁸⁶ *Ibid.*, p. 5.

⁸⁷ *Rules and Regulations of the Chorley Dispensary and Cottage Hospital, 1894*, p.6. Lancashire Record Office.

⁸⁸ *Ibid.*

⁸⁹ UK Medical Register for 1893 gives Dr William Butterly's address as the Dispensary and Hospital, Chorley, Lancs. According to the Register he gained his medical qualifications from the Royal College of Physicians in Ireland in 1891, so he was relatively inexperienced on his appointment at Chorley. Even if he was prohibited from taking on private patients, the role would have given him the opportunity to develop and refine his skills, and most important to develop a reputation. UK Medical Register, 1891. (Accessed online via Ancestry).

⁹⁰ *Chorley Dispensary and Cottage Hospital Annual Report, 1893*, p. 7-8. Lancashire Record Office. It is assumed that 'Sister-in-charge' replaced the term 'Nurse-Matron'.

⁹¹ Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century* (London: Routledge, 2010), p. 121. For further discussion on comparative wages of female workers in the late

nineteenth century see for example Lee Holcombe, *Victorian Ladies at Work* (Newton Abbott: David and Charles, 1973).

⁹² *Chorley Dispensary and Cottage Hospital Annual Report, 1893*. Provision of district nursing services by cottage hospitals is discussed in Chapter 3.

⁹³ *Chorley Cottage Hospital and Dispensary Annual Report, 1900*, p. 6. Lancashire Record Office.

⁹⁴ See Appendix 2 for analysis of cottage hospital openings by region and decade.

⁹⁵ Source: Cottage Hospital Database.

⁹⁶ The financing of cottage hospitals is discussed in Chapter 3

⁹⁷ Burdett, *Cottage Hospitals, General Fever, and Convalescent*, 3rd Edn (London, The Scientific Press, 1896), p. 368.

⁹⁸ Chapter 4 discusses the age profile and gender of patients, causes of admission and duration of stay.

⁹⁹ The organisation and management of cottage hospitals is discussed in Chapter 3.

¹⁰⁰ The titles of the 2nd and 3rd editions changed to *Cottage Hospitals, General, Fever, and Convalescent, Their Progress, Management and Work*, (London J & A Churchill, 1880 and 1896). For completeness, 84 cottage hospitals in Scotland, Ireland, the Colonies and Dominions and the United States listed by Burdett or in other sources have been included in the Cottage Hospital Database in a separate worksheet but discussion is outside the scope of this Thesis.

¹⁰¹ Burdett, *Cottage Hospitals*, 3rd edition, (London: Scientific Press, 1896), Preface, p. v.

Chapter 3: Governance and Financial Management of Cottage Hospitals

Introduction

Chapter 1 explored the social and historical factors which led to the foundation of the Cottage Hospital Movement in the early 1860s, while Chapter 2 developed the arguments and analysed how the successes of the early cottage hospitals inspired their rapid expansion throughout England and Wales in the last quarter of the nineteenth century. By 1900 there were just over 500 hospitals providing about 5,000 beds in rural communities and small towns concentrated in the south and south-west of England.¹

This Chapter analyses the governance and financial management of cottage hospitals, establishes the contribution made by upper- and middle-class women to their efficient running and discusses the contested status of nursing in the early hospitals. Chapter 1 revealed that early cottage hospitals were mostly founded and managed by established local surgeons who admitted patients recommended by subscribers or local doctors, but by the late nineteenth century, as revealed in the records of Chorley Dispensary and Cottage Hospital, which opened over thirty years after Cranleigh, the relationship between the hospital medical officer and local doctors had changed.

Early cottage hospitals adopted a simple organisation consisting of a small core of affluent regular subscribers, representatives of local churches and the founding surgeon. Subsequently, as hospitals increased in size and new institutions were founded, management organisations developed from the original basic model by expanding the number of members on governing committees and offering new members prestigious titles such as vice-president. Over time, governing committees began to take on a similar appearance, in terms of numbers of members, to their counterparts in voluntary hospitals and by the end of the century were beginning to reflect societal changes with the appointment of women. Wealthy middle-class and successful businessmen

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partly replaced the earlier aristocrats and landed gentry. The hospitals included in this study illustrate how and why these changes took place.

As discussed earlier, hospital finances continued to rely upon annual subscriptions for over half their income, the remainder came from small monetary donations, patient's payments (a unique feature of cottage hospitals), fundraising activities and, later in the nineteenth century, income from Hospital Saturday and Hospital Sunday funds, investments and local events such as Pound Day.² Hospital finances were always limited, and overspend was managed by restricting the number of patients by reviewing recommendations for admission at, for example, a monthly meeting and by keeping beds vacant. Usually, doctors and surgeons gave their services *gratis*, sometimes including medicines, as did some early matrons and Anglican nursing sisterhoods.

The contribution of women to the success of cottage hospitals received scant mention in cottage hospital publications, such as the all-important Annual Report, but by the end of century there is evidence of increasing involvement of local gentle-women. The cottage hospital provided women with an opportunity to escape from some of the restrictions of Victorian society through activities seen as respectable. They were prodigious fundraisers through bazaars and flower shows; visited patients to read to them and offer comfort; served on Ladies Committees which supervised the domestic management and housekeeping of the hospital and made regular donations of much needed commodities such as fruit and vegetables to augment patients' diets, furnishings, clothing, bedding, cloth for bandages and 'comforts' such as magazines, pictures and child's toys. By the beginning of the twentieth century women had taken prominent positions on governing committees.³

As the purpose of the Annual Reports was to reassure subscribers that the hospital was efficiently managed, it might have been considered less desirable to advertise the involvement of women, whose ability to manage efficiently was often called into question. It may have been feared that the public acknowledgement of the presence of women on management committees may have deterred donors and subscribers from supporting the hospital.⁴

Nurses in early cottage hospitals had little status and minimal training. Persuasive contemporary promoters of cottage hospitals, Waring and Swete, favoured Napper's approach at Cranleigh, of employing a local woman and training her to his requirements, a stance supported by the British Medical Association (BMA). By the 1880s though, the professionalisation of nursing was underway and Burdett in his influential publications endorsed the appointment of trained nurses, a policy to which Napper succumbed in his last year at Cranleigh.

Cottage hospital governance

When Cranleigh Village Hospital opened in 1859, the management organisation consisted of the Medical Officer and hospital founder Albert Napper, with the village rector John Sapte and two prominent local landowners, John Bradshaw and John Elmes as Trustees.⁵ Breaking away from the norms established by the voluntary hospitals though, Cranleigh Hospital, even at this early stage, acknowledged the contribution of two local women. Alice Pocklington, an independently wealthy single woman resident in the village, acted as Secretary/Treasurer, and Miss Crewdson (probably the daughter of a local farmer) was Collector of subscriptions.⁶ Sapte also acted as Visitor and Manager and co-approved admissions alongside Napper.⁷ In subsequent Annual Reports there was no listing of a Collector so it is possible that the post had only been established to ensure that promised subscriptions had been collected to pay for the cottage to be refurbished as a hospital.

This organisation was in keeping with Napper's philosophy that the management of a village hospital should be as simple as possible. It also ensured the Napper family and Sapte remained in charge; after Napper's retirement in 1881 his son Arthur became Medical Officer and he and Sapte continued to exercise control until Sapte's death in 1906. The only organisational change in forty-three years took place in 1903 when the number of trustees was increased to six, to facilitate and manage a building fund set up to expand the hospital. The board of Trustees at this time was chaired by Lord Alverstone, Chief Justice of England, who owned a substantial local estate,

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along with four other major local landowners and John Sapte, who by then had been appointed Archdeacon of Surrey. Attracting a trustee of the status of Lord Alverstone to support a small rural hospital offers confirmation that the part played by Napper in establishing the Cottage Hospital Movement had been widely recognised and therefore worthy of support.

Increasing the number of beds brought pressure on finances, as Napper had feared. The *Annual Report* of 1903 noted, 'The maintenance of the Village Hospital in full efficiency will necessitate some increase of annual subscriptions'⁸ and in 1906 the hospital had incurred a small deficit of £30 for which 'a substantial increase in the Subscription List is required.'⁹ The death of John Sapte that year provided an opportunity to review governance of the hospital. Expanding subscriber numbers and increasing the value of individual subscriptions was an important objective now that the hospital had increased its beds from four to eight.¹⁰ A large general committee was put in place in late 1906 to broaden participation by the wider community and to obtain the services and financial support of more of the local wealthy.¹¹

The new committee of twenty-three included nine women, the first time Cranleigh had appointed women to a governing post (the two women named in the first Annual Report, not being considered members of the management committee). While it was becoming more common for women to occupy places on management committees by the early twentieth century, this number is still somewhat surprising.¹² One of the women on Cranleigh's committee was Lady Bonham, wife of Sir George Bonham, diplomat and ambassador, who owned Knowle Park, a substantial Cranleigh estate.¹³ In addition to Lady Bonham, eight wives and daughters of local business or gentlemen of the village also occupied places on the committee. A cursory examination of the 1901 and 1911 censuses showed that besides local landowners, the middle-class were now the main participants: the committee included the daughter of a local farmer, the owner of the local department store which had opened in 1887, and a major local builder. Not all lived in Cranleigh itself, some lived in nearby villages or hamlets such as Alfold and Chiddingfold, seven to eight miles from Cranleigh. From this committee was drawn an executive of five, only one of

whom, Miss James, was a woman. This was likely to be either Julia or Alice James, both spinsters who had private incomes and lived next door to the Napper family home.¹⁴ Inviting affluent local people to join the management committee benefitted both parties: it further enhanced local standing of the individuals, while also ensuring that they would remain subscribers. The acknowledgement of the support of the local elites also enhanced the status of the institution, reassuring potential subscribers and donors that the hospital was in responsible and trustworthy hands. The changes had a beneficial outcome: in 1908 the *Annual Report* noted that the hospital finances were, once again, in a satisfactory condition, 'thanks to 'a handsome donation from one of our most generous supporters.'¹⁵

Bourton Village Hospital which opened in 1861 with six beds and a dispensary adopted a similar structure to that introduced by Napper: a management committee of seven, which consisted of the Medical Officer and founder, local surgeon John Moore, three local clergy and three local gentry.¹⁶ Like Cranleigh, the local rector, C W Payne Crawford, was Visitor and Manager. This arrangement survived for sixteen years until the opening in 1879 of a newly built hospital, with eleven beds, one child's cot and a dispensary, and a much-expanded management structure. Payne was appointed President and chaired a management committee of ten plus the medical staff and a manager. A second Medical Officer had also been engaged and four new posts were established: Honorary Physician, Honorary Chaplain, Honorary Treasurer, and a Steward and Collector. As at Cranleigh, the Bourton hospital received the support of local aristocracy: Lord Sherborne, whose Sherborne Park Estate was in located in south Gloucestershire, headed the list of nine trustees, alongside local MP, Henry Brassey.¹⁷ All officers were male.

As Cranleigh showed many years later, hospital expansion required, or provided an opportunity, to increase the size of the management structure, although it is probable that in practice the additional members contributed little other than money and their name, both of which were important in reassuring the local community that the management and finances of the hospital were in capable hands. Napper did not approve of the enlargement of cottage

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hospitals. Writing in 1876 he observed ‘The experience of seventeen years has shown that to be successful the Village Hospital must be restricted to the limits to which it was originally confined; viz., “An institution of from four to six beds, under the management of a single nurse, who will, with occasional assistance, perform all the necessary work.”’¹⁸

As a hospital became established in the community and publicised its effectiveness through its Annual Reports and press coverage, it attracted local gentry and wealthy middle-class who wished to see their name associated with a worthy and successful institution. In 1886, celebrating the 25th anniversary of Bourton hospital, the secretary described how in the early days its promoters had received only lukewarm support. ‘Mr Moore, and his chief coadjutor Mr Crawford, at first stood almost alone [...] but when the cottage hospital plan of medical relief became better known, there were not wanting sympathising and influential friends’.¹⁹ In 1892, the *Annual Report* returned to the theme, observing that ‘it is a most gratifying reflection that a system inaugurated in the village of Bourton should in 33 years, despite of much opposition and even ridicule on the grounds of its supposed impracticality, have resulted in bringing to the village-labourers door, hospital aid.’²⁰ The reference to early ridicule was a recurring theme in the hospital’s Annual Reports, perhaps because, after the hospital had proved its worth, the Trustees wanted to remind their supporters how close they came to never having such a worthy institution in their midst, and how easily it might be lost, if support waned.

Moreton Cottage Hospital which opened in 1873 with seven beds and a dispensary in purpose-built premises, established a top-heavy management structure from the beginning. The success of the Bourton Hospital, about nine miles from Moreton, would have been well-known after some twelve years of operation, and so the task of attracting influential residents to serve on various hospital committees would have been straightforward. Lord Redesdale, who had donated the site, was named as President and eight Governors were appointed, four of whom were members of the aristocracy. There were three Trustees, including the local rector, who chaired a management committee of fourteen. Unusually for Annual Reports of that period, the Matron (Rebecca

Horne) was named, possibly because, unlike at most cottage hospitals (and diverging from Napper's model) she was herself a member of the village's elite, and gave her services gratuitously. Rebecca's brothers, Frederick and Thomas, who ran a grocer's and wine merchants in the village, were on the Hospital's committee.²¹

Not all cottage hospitals followed the 'Cranleigh model'. Steven Cherry has shown there was a wide variety in the administrative organisation of cottage hospitals in East Anglia. At Cromer Cottage Hospital (Norfolk), opened in 1866, 'non-medical arrangements were in the hands of nine ladies, two of whom were titled', while local banking families were also involved.²² Rous Memorial Cottage Hospital, at Newmarket which opened in 1881, was managed by the Jockey Club.²³ At Gorleston (Suffolk), the cottage hospital was founded in 1888 by H. Harvey-George, manager of the Short Blue trawler fleet, for those injured at sea; representatives of local boatmen's companies and Friendly Societies, who had been instrumental in the establishment of the hospital, were in charge.²⁴ Newmarket and Gorleston were examples of facilities provided initially for local workforces which were progressively made available to a wider public in a similar manner to Braintree and Bocking Cottage Hospital (Essex), previously discussed in Chapter 2.

It is clear that the type of organisation employed by a hospital's founders was chosen to maximise subscription income, and the most effective approach was to create roles with prestigious titles which the local wealthy and socially elite members of the community were invited to fill, as the preceding examples have shown. The mix of aristocracy and middle-class members was important: for the community's middling classes, associating with the aristocracy at the cost of subscribing a few pounds each year was a tempting prospect. It offered the opportunity to advance their personal interests and their self-worth and participating and giving was in keeping with the philanthropic mood of the times. As Cherry suggested, improving the health of patients was not the only objective served by cottage hospitals.²⁵

Unsurprisingly, churches played a major role in fundraising. Hospital Sunday, led by the Anglican church, was first introduced in the Birmingham area in 1859,

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but by the 1870s had become a national annual event, raising funds specifically for local hospitals. In 1880 Bourton received £71 from that source, nearly 30 per cent of its annual income and in 1881 the trustees of Moreton reported that churches and chapels 'yearly increasing in number on their Hospital Sunday' had raised £55, or 16 per cent of its annual income.²⁶ Perhaps this exuberance in support was the result of admonitions in the late 1870s that some parishes were not pulling their weight, as discussed in Chapter 2. In contrast, the Cranleigh accounts for the years 1880 and 1881 showed no income from Hospital Sunday, nor from any church collections and only a few shillings were contributed through hospital alms boxes. Throughout the rest of the nineteenth century this income stream appeared unproductive for the Cranleigh hospital, or least was not reported as a separate item in its accounts.

It was common practice for the local parson to be a trustee and committees always included several members of the local clergy as it was most important to encourage church participation; the local vicar could encourage parishioners to subscribe or donate through collections and at church festivals such as Harvest Thanksgiving and Hospital Sunday, as discussed above. Clergy from parishes in a hospital's catchment area of about ten miles were usually able to nominate patients for admission, even if they were not subscribers. Bourton had a rule that clergymen and Ministers making annual congregational collections were entitled to make three out- and three in-patient recommendations each year,²⁷ and at Chorley any clergyman having a collection of one guinea or more was entitled to make recommendations and also to become a Governor.²⁸ In further encouragement for local clergy to become actively involved in raising funds for the hospital, individual church collections were often listed in the Annual Reports, adding to the incentive for the vicar to participate. Conversely, parishes omitted from these lists, especially those which had sent patients for treatment, could be publicly shamed, encouraging the offending parsons to be more diligent in his fund-raising the following year (as discussed in Chapter 2, in the example from Moreton mentioned above).

Town-centred cottage hospitals, which started to appear in number in the last quarter of the nineteenth century, were also reliant upon subscription income

and continued the practice of encouraging and rewarding wealthy subscribers by establishing positions with imposing titles such as patron, president, or vice-president, reinforcing the appointees' social status. As in the rural communities, charity was an important means of acquiring or reinforcing their symbolic capital and social position and was associated with notions of care, benevolence and Christian duty, making the select few appear as altruistic and morally upstanding members of the community.²⁹ Chorley Cottage Hospital and Dispensary which opened in 1893 was an example of the use of impressive titles to reward significant subscribers. The Officers consisted of the President, Alderman Henry Rawcliffe, a local brewmaster, along with eight vice-presidents, seven trustees, and a management committee of twelve, all male. Seven of the officers were clergymen, showing the continued importance of the Anglican church, although as noted in Chapter 2, Chorley Hospital was open to all denominations (both in terms of the patients it accepted and the support it received).

Some, though, adhered to Napper's recommendation of simplicity. Braintree and Bocking Cottage Hospital, for instance, which opened in 1886 had a simple organisation consisting of the President (and founder) Sydney Courtauld and a committee of twelve, half of whom were women. There was only one clergyman on the committee. As the hospital had been provided principally for Courtauld workers, decisions about its governance no doubt lay with the family and therefore wider public participation was not needed or invited. Of the women committee members it has only been possible to identify Ellen Hertslet, the daughter of a Braintree-based surveyor.³⁰

The Annual Report was the essential means of communicating the success of the hospital, as it was for most charities. It usually followed a common format including a list of officers, followed by a short statement from the Trustees or Management Committee, which described the successes of the hospital in the previous year, reported personnel and committee changes, the acquisition of new equipment and noted significant financial donations such as a bequest. Subscribers were thanked and additional funds requested either because of extraordinary events or because there was the risk of a deficit. The *Bourton*

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Annual Report for 1876, instance, reported that seventeen men and one woman had been admitted to the hospital as the result of accidents incurred during construction of the Banbury and Cheltenham Railway. Many had suffered severe injury, and as a result 'there was a large demand in the way of extras ... by which the necessary expenses were increased.'³¹ A list of subscribers and donors and their gifts, annual accounts, sometimes a summary medical report, a restatement of hospital rules and a record of patients was also included.

In the early years patient reports could include extensive personal and medical details, often enabling individuals to be identified. There seemed to be few qualms, if any, in the early days, of revealing personal details in a public document. By the end of the nineteenth century as numbers treated grew, details of individual patients largely ceased and were replaced by a simple summary of the number of cases treated by category.

Identifying individual patients and providing intimate clinical information on their treatment and outcome is problematical. The first nine Annual Reports of Cranleigh Hospital described in detail the reason(s) for admission and for about half the patients included details of their treatment.³² Each was identified by their forename and surname initials, age, gender, occupation (or husband or father's occupation), domiciliary parish and for many the name of their sponsor.³³ In close communities, as most cottage hospitals served, such information would immediately identify the individual. From 1870 until 1904, although the clinical information was reduced in detail, identification was made simpler as the forename was given in full along with the surname initial.³⁴ As an example of the ease with which identification could be made, the following appeared in the 1870 Cranleigh Annual Report: Walter W, age fifteen from the nearby village of Ewhurst, was admitted with necrosis of the thigh bone and discharged after eighty-seven days, then readmitted later in the year when his leg and thigh were amputated.³⁵ He was discharged, 'cured' after a further twenty-four days.³⁶ The 1871 census recorded a Walter Waller, age 16, son of a widowed farm labourer from Ewhurst as an invalid, almost certainly the same person.³⁷ While this case contained no sensitive information, and Walter would probably be easily identified anyway as a result of his amputation, patients with

less obvious and more socially unacceptable conditions, could have been identified, against their will.

At Cranleigh, Napper, as a pioneer, had to demonstrate the success of his hospital to confound critics and maintain subscription income. Including enough information to identify a patient ensured that in a small, relatively remote village subscribers and donors would have known who was being treated and could satisfy themselves that the hospital was serving the deserving rural poor. There was no concept of patient privacy, perhaps an indication of how the rural underclass were valued and perceived by those in authority; these were the mainly agricultural labourers and their dependents, paupers and itinerant navvies. The practice of identifying patients persisted in some hospitals. As late as 1901, Lydney published both the forename and surname of patients, such as Elizabeth Charles, a servant age 18 from nearby Aylburton, admitted with pneumonia and recorded in the 1901 census as a patient in the hospital.³⁸

The localised nature of cottage hospitals meant that the community would have been aware who had been admitted to hospital, and in many cases why, so printing this information in the Annual Reports was probably not considered an invasion of privacy. For patients suffering the results of an accident, the practice probably presented no problems. However, whether Ellen T from Ewhurst, whose case of phthisis was reported in the Cranleigh Annual Report for 1878, would have been happy for her neighbours to learn she was suffering from this most feared of diseases, is a different matter.³⁹

The practice remained widespread and continued into the twentieth century, illustrated by an extract from the published 1904 Annual Report of Lydney CH which fully identified patients, shown in Figure 3.1.⁴⁰

Figure 3.1. Causes of admission, Lydney Cottage Hospital, 1904.⁴¹

TABULAR STATEMENT OF CASES—IN-PATIENTS—1904.

No.	Date of Admission	Name	Age	Parish	Medical Attendant	Occupation	Case	Date of Discharge	Result
1	Jan. 23	Kerwood, Fred ...	6	Lydney ...	Dr. Ball ...	Child of Bootmaker	Enlarged Tonsils and Adenoids	Jan. 24	Op. Cured
2	Jan. 26	Hobbs, Herbert ...	5	Lydney ...	"	Child of Lab	Bronchitis ...	Feb. 10	Cured
3	Jan. 23	Powell, Edgar ...	24	Lydney ...	Dr. Thomas	Groom ...	Appendicitis ...	Feb. 13	Cured
4	Jan. 26	Taylor, Harold ...	13	Lydney ...	"	Schoolboy...	Circumcision ...	Feb. 1	Cured
5	Feb. 25	Ryan, Annie ...	37	Alvington...	Dr. Ball ...	Housemaid	Enlarged Glands ...	Mar. 21	Relieved
6	Mar. 2	Fogarty, Mary ...	22	Lydney ...	"	Servant ...	Chlorosis ...	April 10	Cured
7	Mar. 26	Legge, Jane ...	62	Aylburton	Dr. Thomas	Housewife	Pleurisy ...	April 10	Cured
8	Apr. 5	White, John ...	40	Lydney ...	"	Circus Groom	Amputation of Finger ...	April 30	Cured
9	Mar. 17	Austin, Edith ...	14	Aylburton	Dr. Ball ...	Child of Lab	Abcess ...	Mar. 27	Cured
10	Apr. 1	Beard, Hilda ...	1½	Lydney ...	"	Child of Lab	Scald on head ...	April 16	Cured
11	Apr. 7	Jones, Albert ...	21	Aylburton	"	Tin Worker	Tonsil excised ...	April 18	Cured
12	Apr. 22	James, Frank ...	3	Aylburton	Dr. Thomas	Child of Lab	Chronic Abcess ...		Sent to Glos. Infirmary

Annual Reports were widely distributed beyond core subscribers, extracts were reported in the local press along with extensive coverage of the Annual General Meeting and some were sent to the *British Medical Journal* and *The Lancet* which occasionally resulted in leading articles, notes and correspondence.⁴² Henry Burdett requested that he should be sent a copy of all hospitals Annual Reports each year, and it is obvious from the extensive details of individual hospitals included in his *Cottage Hospitals* that many complied.⁴³

The name and contributions of each subscriber and donor were published in the Annual Report, a practice which continued in some hospitals into the twentieth century and was, no doubt, intended to encourage retention and elicit larger sums the following year. In the early years the sums subscribed usually ranged between £10 or guineas to as little as 2s/6d. There was strong emphasis on the need for non-monetary donations such as food, alcohol, old linen for bandages and poultices and 'comforts' such as clothes, books, magazines and pictures. The practice of naming individual subscribers and donors gradually died out in most hospitals, probably to reduce the space taken up in the Annual Report.⁴⁴ From the mid-1890s, annual accounts began to only include the totals of subscriptions and donations with a simple acknowledgement of thanks for gifts in kind included in the Management Committee report.

Gifts of food and drink were a valuable contribution to the hospital which improved patients' diets and reduced expenditure from limited funds. Each

donation was listed and acknowledged by name which provided individual recognition and no doubt encouraged others to give. Donations to Cranleigh showed the range, quantity and regularity of gifts, such as meat and vegetables, old linen used for bandages, poultices etc., outdoor clothing and nightwear, and magazines, pictures, religious texts and children's toys.

Donating medical equipment, such as the galvanic battery donated by Sir William Bowman (see Figure 3.2), was unusual and probably the result of a direct request. Bowman was a noted ophthalmologist who had retired to Abinger, within the Cranleigh hospital catchment area, and he would have been known to Napper by reputation and through the BMA.⁴⁵ Records of other cottage hospitals also listed sizeable gifts such as hospital beds, kitchen equipment, furniture for the patients' sitting room and, occasionally, medical equipment. The tradition continues today in the form of charities such as a hospital's League of Friends, although today's gifts are often more substantial.⁴⁶

Donations were gendered. Women were frequent donors, and their gifts, besides fruit, vegetables and jams, tended to be items which would improve the wellbeing of the patient such as nightwear, texts and pictures of a moral or evangelical nature and magazines considered suitable for agricultural labourers and their families.

Miss Barnard Hankey's gift recorded in the Cranleigh Annual Report for 1887/1888, was unusual, and one of only a few instances in all records viewed in this research of a patient being sponsored for admission to a convalescent home.⁴⁷ Male donors of gifts tended to offer consumables: alcohol (for medical purposes) and meat, including pheasants and rabbits from the estate, along with male clothing.

Figure 3.2. Extract of gifts given to Cranleigh Village Hospital for the year September 1887 to August 1888⁴⁸

10	11
GIFTS, 1887-88.	
Lady Bonham	Mrs. Hannay
Mrs. Crompton	Miss Cock.....
Mrs. Rowcliffe	Miss Crompton
Miss Barnard Hankey.. ...	Miss Castellain
Mrs. Healey.....	Miss Sapte
Mrs. Barrett.....	Sir William Bowman, Bart., F.R.S.—Galvanic Battery.
Mrs. Francis.....	Joseph Godman, Esq.....
Mrs. MacLear	W. Barnard Hankey, Esq.
Miss Godman	Pandeli Ralli, Esq.
Mrs. Neumann.....	G. Barrett Esq.
Mrs. Arthur Napper.....	E. Lee Rowcliffe, Esq. ...
Mrs. Leach	F. DuCane Godman, Esq.
Miss Muriel Godman	Rev. A. W. Leach
Miss Neumann	John Ramsden, Esq.
	W. J. Essery, Esq.
	Cecil Sapte, Esq.....
	M. Cammell, Esq.
	— Bennett, Esq.
	— Castellain, Esq.

Similar gender differences in donations can be seen in the records of other rural cottage hospitals, so it is suggested that while women made regular contributions of vegetables, fruit, jams etc throughout the year, men were more likely to make one or two major annual donations. This may perhaps indicate that women donors were in touch with day-to-day needs of the hospital, possibly as visitors. The extent to which women, other than nursing staff, played a role in the day to day activities of cottage hospitals varied from hospital to hospital. From its beginning in 1859, Cranleigh had a rule that 'The domestic arrangements shall be under the management and supervision of some of the Ladies of the Parish',⁴⁹ whereas at both Bourton and Moreton the rules specified that the running of the hospital would be supervised by members of the Committee, all of whom were male.⁵⁰ Women were significant subscribers and donors as shown above and there were rare references to 'Lady Visitors' in

Annual Reports, but whether that was to inspect the hospital or to visit patients (or both) could not be established with certainty.

The role of women in Cottage Hospitals

The domestic boundary shifted as the Victorian age progressed, from the divide of men participating in business and politics and women largely confined to domestic and family duties. Women played an active role in hospital fundraising often by means of bazaars, flower shows, fetes and musical evenings, socially acceptable borderlands which equipped women with skills of later value in political campaigning.⁵¹ The Annual Reports of cottage hospitals occasionally thanked women who acted as collectors of subscriptions and donations individually or, more usually, as a group, but generally expressions of appreciation of women's contribution were infrequent and quite short: in 1874, the Committee of Moreton Cottage Hospital thanked 'very cordially the ladies' who had organised the annual bazaar and Flower Show which had contributed £61/10s to the hospital's funds, 25 per cent of its annual income. Their contribution 'materially extend[ed] the usefulness of the Institution' it reported; similar sentiments were occasionally repeated in later reports.⁵² Frank Prochaska provided another (practical) view on the growing participation of women, quoting a leading churchman's view that 'Female agency, besides being in some respects more efficient, is always less expensive.'⁵³

Women also made direct donations through legacies and gifts in kind and affluent women could be found providing the finance for a new hospital, such as Lady Dunraven's cottage hospital in Coleford, Gloucestershire. In 1899, Miss Winstanley, a former Chorley resident then living in Dublin funded the construction of a new hospital wing for the Chorley hospital which contained ten beds, an operating theatre, a new kitchen, two larders, a scullery and pantry, bathroom and other ancillary facilities. The new wing was named after her, in recognition. The Annual Report noted 'no event in its history of such importance has occurred.'⁵⁴

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The first reference to identify a woman in the Cranleigh Annual Reports was not until 1894, when the treasurer/secretary Miss Louisa Walker was specially thanked and Miss Alice Sapte, (daughter of rector John Sapte), was acknowledged for having 'kindly assisted in the Domestic and General Management.'⁵⁵ Prior to this, women were thanked for their contribution to the management of the hospital, anonymously. Braintree and Bocking Cottage Hospital extended its thanks to the 'Ladies who so willingly undertook the arduous duty' of a door to door collection but made few other references to the contribution of women although half its management committee was female.⁵⁶

The role of Ladies Committees was not described formally in any of the Annual Reports consulted, but a reading of Trustees' reports, hospital rules and contemporary writers indicates that their role was to supervise domestic arrangements such as cleaning and furnishings, checking supplies, examining records of purchases by the nurse-in-charge and the organisation of fund-raising events. Members of Ladies Committee were, typically, upper and middle-class women and their contribution was analogous to their home domestic role, such as supervising servants and being responsible for the general well-being of the household.⁵⁷

Edward Waring, writing in 1867, seven years after the first cottage hospital opened, suggested that the hospital's domestic arrangements 'may be advantageously confided to one or more ladies of the parish', a sentiment echoed by Horace Swete, founder of Wrington Village Hospital who, in discussing the housekeeping needs of a cottage hospital proposed that the services of 'one or more ladies ... will prove peculiarly valuable'. One of their important roles in his view should be to confer a regular basis 'with the nurse as to what supplies should be ordered.'⁵⁸ His description underlined the subservient role of the nurse, as analogous to that of a domestic servant, directed by the lady of the house.⁵⁹

Henry Burdett was also in favour of Ladies Committees and specified that their role was 'to supervise and advise the nurse in all domestic arrangements, limiting themselves entirely to this branch, or at the same time reading and giving instruction to such of the patients as may require it.'⁶⁰ He added the

caveat that 'some ladies may be disposed to interfere in the medical arrangements, but this action must be immediately checked by the Medical Officer before it assumes any shape and such ladies must be given to understand that they are to limit themselves strictly to domestic arrangements.'⁶¹ Burdett's observations showed that despite their perceived usefulness, he saw women as a threat to medical supremacy, especially as he also had issues with the role of trained nurses in cottage hospitals, which is discussed below.⁶²

Despite their contribution to fund-raising and domestic management, progress for women to positions of authority was as slow in cottage hospitals as in other sectors: by 1892 Braintree had appointed six women to its Management Committee along with six men and by 1906 Cranleigh had appointed nine women to its General Committee (out of twenty-four), only one of whom sat on the five-member Executive Committee. Gender parity at Cranleigh was not attained until 1915, fifty-five years after the hospital opened.

Opportunities for women to participate in the wider community were limited, and philanthropic work gave them the chance to contribute, through their perceived nurturing skills and 'good works', typified by a 'Lady Bountiful' dispensing gifts and housekeeping advice to the deserving poor.⁶³ Carrie Howse has argued 'the cultural philosophy of domesticity had inextricably linked such charitable acts with what were seen as women's 'natural' virtuous traits.'⁶⁴ Along with child-bearing and household supervision, managing sickness in the family was seen as one of the key duties of women and the arrival of a local hospital catering specifically for the poor provided a simple transition of skills from the home to the public realm and an opportunity to demonstrate, by example, the virtues of cleanliness, sobriety and Christian duty. The local cottage hospital could be considered an extension of the home and therefore acceptable for upper and middle-class women to deploy their skills in a socially safe environment. Shapely has demonstrated that women did not become significantly involved in charities until the second half of the nineteenth century mainly participating in children's, women's and medical charities, sometimes in an official position.⁶⁵ In cottage hospitals women did not appear in positions of

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authority before the end of the century, which may have resulted from rural conservatism and fewer middle-class women in the countryside compared to large cities such as Manchester, the subject of Shapely's discourse.

In 1894, Chorley Cottage Hospital noted that the 'sympathy of the young had been enlisted [by] the formation of a volunteer band of twelve girls as messengers, one calling at the Hospital each evening and acknowledged the proceeds of the "Juvenile Rose Festival" and the "Doll Bazaar".' No further details were given of the role of the messengers nor what was conveyed. The report also praised the contribution of the Needlework Guild which had provided clothes for in-patients; the members were presumably middle-class women who had some leisure time.⁶⁶

The simple governance model advocated by Napper did not survive as the Cottage Hospital Movement spread throughout the southern and south-western counties. The subscriber base needed regular topping with new members as early contributors lapsed or died and an effective means to achieve that was to expand the number of trustees and governors, sometimes with a prestigious title such as patron or vice-president. Active participation by local churchmen in parishes in the hospital's catchment area was encouraged by offering subscriber rights to recommend admission to parishes which contributed a minimum annual sum and middle- and upper-class women became active donors of food and patients' comforts as well as organising fund-raising events. Nonetheless, hospital finances remained very constrained especially in the early years when a surplus of a few pounds was seen as a major success.

Hospital finances

Early cottage hospitals were funded largely by the local aristocracy and wealthy gentry. As discussed earlier in this chapter, Lord Redesdale had donated the site for Moreton Cottage Hospital and the Marquis of Northampton had contributed £50 to its foundation.⁶⁷ Moreton was also supported by two local businesses, the University of Oxford and the Loyal Rose of England Lodge.⁶⁸ Elsewhere the Earl of Egmont was Patron and major subscriber to Epsom & Ewell Cottage Hospital (Surrey), which opened in 1873 and High Wycombe

Cottage Hospital (Buckinghamshire), opened in 1875, was built on land given by Lord Carrington. The practice continued in the 1880s: Totnes Cottage Hospital (Devon) opened in 1885 and was housed in a converted villa provided by the Duke of Somerset. Aristocracy and gentry continued to support the local cottage hospital as subscribers, trustees and honorary presidents, made their gardens available for bazaars and other fund-raising, donated food and drink on a regular basis and occasionally gave furniture and equipment. Despite this largesse, and aristocratic support and money was essential especially where expansion or rebuilding was necessary, the hospitals also looked to middle-class generosity to support their endeavours and ensure longevity of their new institutions.⁶⁹

By 1879, Cranleigh was beginning to record a number of middle-class subscribers from the local community. Seventy-five subscribers were listed in the Annual Report for 1879 which included local landowners, farmers and their wives and daughters, Members of Parliament, clergy from the surrounding villages and local 'worthies' such as garden designer Gertrude Jekyll. Each subscribed one or two guineas. The list ended with eleven people, ten of whom were male, subscribing 10s/6d or 10s/-. Among this group were George Grinstead, a road surveyor, Edwin Thirkell, a grocer and postmaster, Frederick Ansell, a farmer and coal merchant and Stephen Rowland, a draper and grocer. These may well have been some of Cranleigh's 'middle-class', but they were fewer in number in comparison to the gentry and local aristocracy.⁷⁰

Most voluntary and county hospitals were funded by subscriptions and donations, which usually entitled the subscriber to a seat on the governing board and the right to recommend one or more persons each year for admission ('Governor's Notes or 'Ticket System'); the number who could be admitted was often based upon the value of the subscription. Patients were admitted free of charge. Cottage hospitals also gave subscribers the right to recommend admissions (based on the value of their subscription), but there were two significant differences compared to the voluntary hospitals: accidents and emergencies were admitted without a recommendation; and most significantly, all patients were required to make a small weekly payment.⁷¹

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The cottage hospitals studied all implemented variations on the theme of subscriber tickets. At Moreton, a subscription of half a guinea entitled the subscriber to recommend one patient per year, while a guinea covered two or more. A subscriber to Bourton was entitled to unlimited recommendations for admission for an annual payment of one guinea, while Chorley applied a set of criteria depending on the amount subscribed and whether the recommendation was on behalf of an in- or out-patient.⁷² Cranleigh did not limit the number of recommendations a subscriber could submit in a year, but the Hospital Manager in consultation with the Medical Officer had the right to grant or refuse admission, other than for emergencies. It is not known how many potential patients were rejected in any of these hospitals or admitted later when a bed became available.

Early cottage hospitals relied upon annual subscriptions for at least half of their income. Payments by patients contributed a further 15 per cent, a proportion which dropped progressively over the years and provided only a few per cent each year by the end of the nineteenth century. Some patients were referred by the local workhouse and had their weekly payment paid by the Union; the Medical Officer receiving a statutory fee, to avoid or mitigate any conflict with Poor Law Medical Officers, as discussed in Chapter 1. The remainder of a hospital's income came from modest individual donations, church collections and alms boxes supplemented from the 1870s onwards by receipts from fetes, flower shows, bazaars, readings, Hospital Sunday (discussed above) and charity sporting events.

Interest from investments became an important source of hospital funds, usually originating from bequests. In 1889 for instance, nearly one quarter of Moreton's income was derived from dividends from investments worth nearly £4,000.⁷³ Moreton was unusual in obtaining such high value endowments: in 1880 Burdett urged hospital managers to encourage endowments more aggressively, reminding cottage hospital managers that interest from legacies made up more than half the income of voluntary hospitals in London and Middlesex, yet contributed, on average, only about 6 per cent of their own incomes. 'Experience has shown, as a rule, legacies are given to charities by annual subscribers

rather than by Life Governors or donors', he wrote, encouraging managers to cultivate their local subscribers. Subscribers were to be sought and encouraged as they were more likely to recommend the hospital to their friends and on their death 'the institutions [...] loyally supported in his lifetime will be remembered without fail in his will'.⁷⁴

The financing of cottage hospitals, therefore, was no different to the voluntary hospital community, apart from the relatively small sum obtained from patients' payments. Keir Waddington has established that in the nineteenth century subscriptions provided between half and three-quarters of the income of provincial voluntary hospitals and even by the 1890s they remained the hospitals' most significant income source.⁷⁵ It is no surprise therefore that rural doctors, familiar with voluntary hospitals, adopted a similar financial system.

There was discussion over the use of patient payments, as a possible solution to the ongoing argument about whether or not medical officers should be remunerated for their services. Henry Burdett suggested that some or all patients' payments could be divided amongst the district medical practitioners, citing the example of the Victoria Dispensary at Northampton, where 'nearly all [patients' payments] are divided amongst the medical men with the best results'. From the accounts of eighty cottage hospitals, he calculated that patient payments contributed an average of £48 each year, or 13 per cent of annual hospital income, which could go to the medical officer; 'The labourer is worthy of his hire', he wrote, appearing to choose his words carefully, and appearing to suggest that if the 'labourer' (meaning the farm labourer) was worthy of his hire, then so too should be the labour of the medical man. He stressed that his proposal was not intended to be at the expense of the running of the hospital, nor to the benefit of the doctor but should be seen as an alternative to the managers' 'accumulating invested property'. He was very clear that the system should only be implemented once a continuous yearly surplus was achieved.⁷⁶ His position was that once investment income was sufficient to cover a potential deficit from a reduction in subscription income, then any surplus should benefit the medical officer.

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Had Burdett's suggestion been adopted, it is likely that some cottage hospitals (including Cranleigh) would have closed. The income from patients' payments was often the difference between ending the year with a small surplus rather than a deficit. In the financial year 1877-8, when Burdett's *The Cottage Hospital* was first published, Cranleigh received £35 from patients and made a surplus of £17. If all patient payments had been made over to Napper, the hospital would have ended the year with a deficit of £18. The practice of patients' payments (as already discussed in Chapter 1 was not supported simply as means of raising extra cash but to engender the ideal of self-help among the poor continued in cottage hospitals) was occasionally debated in the correspondence pages of the *British Medical Journal (BMJ)*.⁷⁷ It was not until 1906 that the BMA, after considerable debate over the merits of pay beds and associated fees in voluntary hospitals, resolved that all patients in cottage hospitals who could contribute towards their maintenance should do so, whilst those in general hospitals should not be charged.⁷⁸

One strategy adopted by cottage hospitals for controlling expenditure was to limit the time a patient could spend in the hospital and to excluded those, such as the chronically or terminally ill, who would require significant resources.⁷⁹ Most hospitals had a rule which only allowed patients to stay for up to four weeks although in practice this was often disregarded; about 40 per cent of patients in the research sample remained in hospital for more than twenty-eight days, a few for over twelve months.⁸⁰ Burdett analysed data from 174 cottage hospitals and established that the average stay was thirty-six days.⁸¹ Whilst the data is not conclusive and varies between hospital, many patients were discharged after about four weeks, generally medical rather than surgical cases with conditions such as rheumatism, respiratory disorders, anaemia and other dietary deficiencies.⁸²

A pamphlet celebrating the first sixteen years of Bourton Cottage Hospital, written by W D Coles, honorary physician to the hospital, contained an analysis of patients' length of stay, which had averaged thirty-three days except for 1874 when it exceeded forty days.⁸³ That was 'an unusual year', according to Coles, 'because some diseases required a long time to effect [...] a cure, rendering it

undesirable to discharge a patient [...] to go back to an unhealthy home.’⁸⁴ Of the thirty-seven patients admitted along with three remaining from the previous year, more than half overstayed, including two who stayed for more than one year.

Overstaying was a problem not just for the hospital, but for the patient too. While overstaying blocked beds for new admissions, for the patient it meant extended payment of fees, and an extended period away from work (if the patient was the breadwinner for the family). If a patient needed to stay longer, the person who had recommended admission was invited to extend their approval, which carried a potential financial commitment if the patient was unable to pay. There is no substantial evidence that patients were discharged before recovery through the absence of sponsorship renewal, but the records do show that some patients were discharged ‘cured’, ‘better’ or ‘much improved’, within four weeks, whilst almost certainly still suffering from their original disorder, most likely because there was little likelihood of a successful outcome. At Cranleigh, a male age fifty admitted with pericarditis was discharged ‘better’ after twenty-eight days, and at Bourton a thirteen-year old male, admitted with ‘leucocythemia’, was discharged ‘cured’ after twenty-nine days.⁸⁵ Whether they left because no more could be done for them or because their sponsor declined to fund them for a further period remains a matter of conjecture.

Beds in the early rural hospitals were never fully occupied. At Bourton, Coles had calculated that the average daily number of patients occupying beds was three and a half, that is just over half its capacity.⁸⁶ Snapshots from other early hospitals confirmed that potential bed capacity was never fully utilised. At Cranleigh in 1862 average bed occupancy was 64 per cent and at Moreton in 1875, 61 per cent.⁸⁷ Burdett analysed the accounts of 174 cottage hospitals with an average of between nine and ten beds. Ninety-three quoted an average bed occupancy of between 70 and 77 per cent.⁸⁸

Whether hospitals kept beds vacant as a deliberate strategy to contain expenditure, or to ensure beds were available for emergencies is unstated but

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there was a built-in delay in the sponsorship and approval process; Bourton's Rule 7, stated 'Applications for admission shall be made to the Committee at their fortnightly meetings', except emergencies or severe accidents.⁸⁹ Moreton had a similar rule, also excepting accidents, but its Committee only met monthly⁹⁰, and as policy reserved one bed solely for accidents and emergencies.⁹¹ Clearly, strict application of these rules meant that beds were unoccupied for some period and gave management the opportunity to delay admissions if finances were stretched. In practice, the admission process must have been flexible; if a trustee or major subscriber proposed that one of his employees should be admitted and a bed was available, it is unlikely that the patient would have had to await approval from the next committee meeting. Unfortunately, the minutes of early committee meetings of Cranleigh, Bourton and Moreton hospitals have not survived, so no record of discussion about admissions is available.

The early accounts of the rural cottage hospitals provided an insight into how their income was disbursed; annual running costs were surprisingly low, a feature emphasised by Napper and Burdett. In its first full operating year, 1860-61, Cranleigh had an income of £177 of which patients' payments contributed £34, just under 20 per cent. Twenty-eight patients were admitted, and expenditure reached £140, an average cost of £5 per patient. Notable costs included nearly £12 on wine, beer and spirits and £55 (or about 40 per cent of all expenditure) on 'cost of patients', which presumably referred to food and laundry, while £33 was spent on wages for the nurse and charwoman.⁹² Expenditure on medicines and surgical instruments was only £2 and in next twenty years only averaged £3 p.a., a surprisingly small amount considering between twenty and twenty-six patients were admitted each year. It can only be concluded that most medicines were paid for by Napper himself.

The Bourton accounts for 1863 also showed that expenditure on food and alcohol was the largest item (accounting for about one third of the total), which confirmed that the principle treatment was a good diet in clean, warm surroundings. This assumption is further supported by the trivial amount, under £1, for 'Surgical requisites'. Coles' booklet described the hospital as the home

of a pensioned soldier who looked after the garden (its produce was used in the hospital) while his wife acted as nurse; Medical Officer John Moore had adopted Napper's practice of employing a local woman whom he trained.⁹³ Annual wages, presumably of the nurse, were £16.⁹⁴ In the first three years, Moore, besides giving his services gratuitously, also provided patients' medicines. The Annual Report for 1864 noted: 'The state of the finances this year, however, for the first time justified the Committee in putting to an end so unusual and generous a proceeding.'⁹⁵

Little changed at Bourton over time, despite moving to new, larger premises in 1879. The Annual Report for 1886 included a statement of income and expenditure for the twenty-five years since the hospital had opened: this indicated that annual income had averaged £153 and expenditure, £145, both showing only small fluctuations from one year to the next. It would seem that the increase in committee size, which had taken place when the hospital added additional beds, had not led to an increase in income; rather it ensured that income remained about the same during the agricultural depression of the 1870s and early 1880s, as discussed in Chapter 2.

Income and expenditure at Braintree and Bocking Cottage Hospital, a town-centred hospital, were similar to those of Cranleigh and Bourton although it opened twenty-five years later, in 1886, with only four beds. The balance sheet for its first nine months showed an income of £147 and expenditure of £109 for seventeen patients.⁹⁶ Finances changed little over time; the balance sheet for the year ending December 1900 reported an income of £197 plus £39 carried forward from the previous year and expenditure of £212 for forty-five patients. Although the cost per patient had decreased by over 20 per cent in the intervening years, by 1900 the Hospital's surplus was also reduced, to £24.⁹⁷

Table 3.1: Comparative income and expenditure, Braintree & Bocking Cottage Hospital, 1886 and 1900⁹⁸

	Income all sources	Patients' payments	Expenditure	No. of patients	Cost / patient
1886 (9 mths only)	£147	£14 (10%)	£109	18	£6
1900	£196	£34 (16%)	£212	45	£4/14s

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Burdett, drawing upon a large sample of cottage hospitals, calculated that the average cost/patient across the country was £6.⁹⁹ His analysis of the accounts of 174 cottage hospitals showed that they provided a cost-effective service when compared to voluntary and municipal hospitals.¹⁰⁰ He calculated that the annual cost of an occupied cottage hospital bed was c. £66, which he compared with the annual cost per occupied bed at five hospitals, the London, Charing Cross and Middlesex, the Royal Hospital, Belfast and the General Hospital, Birmingham, which ranged between £69 at the London and £92 at the Middlesex.¹⁰¹ He observed:

‘When the difficulties which surround the cottage hospitals are considered – the necessity of buying in small quantities, loss of trade discount, difficulties with water and drainage and many other matters, the result, as shown by the figures, must be gratifying to the original promoters of these institutions, and will cause some surprise to hospital managers generally.’¹⁰²

Steven Cherry, in his study of East Anglian cottage hospitals, observed that private patients were often used to boost funds.¹⁰³ There was little evidence of this practice in the early hospitals in this study except at Moreton. By 1887, Rule 1 for the Moreton Hospital had been amended by the addition of the following clause:

In the case of a private patient under the care of either of the Medical]Officers, in which an operation is necessary [...] he or she may be brought to the hospital [...] upon making a special weekly payment to be fixed by the Committee; provided the admission ... shall in no way interfere with the accommodation required for the poor, and that not more than one such patient shall be in the Hospital at the same time.¹⁰⁴

With such limitations the number of private patients must have been very low and the value of patients’ payments quoted in the Annual Accounts after 1887 showed little change year on year. It seems likely therefore that private patients were only admitted infrequently.

In the Bourton records there is reference to a number of patients being admitted and paid for by a private individual. Such cases could be considered quasi-private patients, as higher than usual fees were being paid, but they were not being paid by the patient, but by a sponsor. For instance, in 1878 a payment of £5 was received from Lord Sherborne on behalf of one patient, and £5 was also paid by the contractor building the Banbury and Cheltenham Railway for five patients admitted during the year.¹⁰⁵ An earlier Annual Report had noted that seventeen males and one female had been admitted as a result of accidents in the construction of the railway, 'many were cases of severe injury, requiring not only surgical relief, but also much nursing [...] and extras, as Wine, Beer etc.', putting pressure on hospital finances but there was no reference to any additional income as a result.¹⁰⁶

Cranleigh Annual Reports did not mention 'private patients' until 1911, when a new Rule similar to that at Moreton was approved under which a patient of one of the Medical Officers, requiring an operation, and any servant sent in by their employer on the recommendation of a Medical Officer, 'shall continue to be the private patient of that medical officer, admission subject to approval by the Executive Committee.'¹⁰⁷ The value of patients' payments changed little over the years which indicated that few private patients were admitted.

Bourton and Moreton both had dispensaries, yet the accounts only refer to hospital income and expenditure from which it is inferred that the dispensary was either a separate entity and its finances reported elsewhere, or the very small sum which out-patients were required to contribute for medicine (one shilling) may have been included within the entry for Patients' Payments (although this would not account for lack of costs for running the dispensary). A dispensary out-patient also had to be recommended by a subscriber unless the person had been an in-patient and referred by the Medical Officer; they were expected to pay for their own medicines and treatment. The only information on charges and entitlement regarding dispensary patients was given in two new rules added at Bourton in 1885:

'Rule 19. Subscribers of ten shillings and upwards, and Ministers who make annual Congregational Collections [...] are entitled to

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recommend as out-patients, *necessitous* (sic) persons who may obtain gratuitous medical and surgical advice [...]. Medicines will be supplied [...] on payment of *one shilling* (sic) on their first attendance, such payment to entitle the patient to medicine for one month.'

'Rule 20. Outpatients [...] without a Subscriber's Ticket, will [...]be required to make on their first attendance, a payment of *two shillings and sixpence* (sic) which will entitle them to a supply of medicine for one month, or they may receive gratuitous advice, and provide their own medicine as heretofore.'¹⁰⁸

It is possible that the practice of making a one-off time-limited charge for out-patient treatment was not unusual. Jonathan Reinartz has identified that in 1872 Birmingham's Children's Hospital introduced a registration payment of 6d for each out-patient as a means of controlling access, which substantially excluded paupers, but contributed nearly £250 in a full year.¹⁰⁹

Chorley Cottage Hospital and Dispensary, which opened in 1893, exhibited quite different financial characteristics to Cranleigh, Bourton, Moreton and Braintree from when it opened, in September 1893. Annual subscriptions provided only a quarter of its income, significantly lower than in the other cottage hospitals in this study, while Hospital Sunday, local charitable grants and workplace collections, (discussed in Chapter 2) provided nearly half. Patients payments as a separate item were trivial and were probably from those who were not contributors to one of the many factory schemes.¹¹⁰ By 1902, ten years later, the proportions of income from various sources had changed little: 30 per cent came from subscriptions and 53 per cent from a combination of workplace collections (Hospital Saturday), Hospital Sunday, and several charity events including Hospital Balls and football matches. Patients' payments, other than through the workplace, remained inconsequential, contributing only 4 per cent.¹¹¹

Cottage hospital doctors

Chapter 1 established that the typical founder of an early rural cottage hospital was a local surgeon with an established practice and sufficient income to give

his services gratuitously. Napper was forty-five years old when he opened Cranleigh in 1859, John Moore at Bourton was aged about forty and Leonard Yelf at Moreton about forty-three. All were well-established and respected in their communities, on good terms with local churchmen and had sufficient standing and credibility to obtain initial funding and subscription income from the local gentry and wealthy middle-class. Only one exception has been identified to this pattern of hospitals run by established doctors; in Fowey (Cornwall), a wealthy father had provided a small hospital for his recently qualified son.¹¹²

In most cottage hospitals the preferred title of the doctor-in-charge was Medical Officer. Moreton, exceptionally, described its two doctors, Leonard Yelf and John N Moore as Honorary Surgeons, and also listed a Consulting Surgeon, George Moore as being associated with the Hospital.¹¹³

Hospital rules usually allowed any local medical man to treat his patients in the hospital, providing continuity of care, but it is not known how frequently this occurred. Annual Reports in the research sample gave an impression that once admitted, the patients became the responsibility of the Medical Officer, although a few cases were described in the patient records where other doctors had assisted in more challenging surgery and where anaesthesia was used. In May 1860, a fourteen-year old female pauper was admitted to Cranleigh having 'a Hare lip which rendered her a hideous object.' Napper operated using chloroform 'with the assistance of Mr H Taylor of Guildford', and in June 1860, also assisted by Taylor, excised the diseased gum and an epulis (growth) on the upper jaw of an eight-year old male child, presumably also under anaesthesia.¹¹⁴

A different approach was adopted at Chorley Cottage Hospital where Rule 14 required that 'Six duly qualified Medical Practitioners shall be appointed by the Governors as Honorary Medical Officers (HMOs) alongside the resident House Surgeon', which was a salaried post.¹¹⁵ The appointment of the six doctors may have been a continuation of an earlier arrangement whereby the town was divided into six districts, each district allocated to a particular surgeon,

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presumably a restrictive practice designed to exclude competition and ensure some income for each doctor.¹¹⁶

The relationship between the HMOs and the House Surgeon at Chorley and their respective roles appeared unclear: Rule 16 stated that HMOs 'shall attend the Dispensary when their services are required, and also at the homes of patients in cases of consultation with the House Surgeon'. Yet, other rules clearly showed that the House Surgeon was subordinate to the HMOs: the House Surgeon 'shall reside in the Dispensary, and shall receive a salary together with board and lodging [and] shall not absent himself the whole night, without the consent of the acting Medical Officer [and] shall not visit Apprentices or Servants at the houses of their Masters, or Mistresses, or any person receiving parochial relief.'¹¹⁷ These rules were clearly intended to protect the private income of the six HMOs and limit opportunities for the House Surgeon to acquire his own patients. As seen in Chapter 2, the first house surgeon was a young man, just starting up in his career, whereas it can be assumed that the HMOs were all well established medical practitioners.

The House Surgeon's duties also included the preparation and dispensing of medicines prescribed by the HMOs, visiting patients at home (with the exceptions described above) who were unable to attend the Dispensary, receiving accident patients and 'sending immediate notice to the acting Medical Officer', submitting lists of drugs for approval by the HMOs and informing them before performing a significant surgical operation. It seems therefore that each HMO maintained a relationship with 'their' patients in most circumstances; the role of the House Surgeon (and Sister-in-Charge) being in many cases simply to administer prescribed treatments and take care of the running of the hospital.

The description 'acting HMO' also indicated that the role was rotated between the six doctors. No other examples of this practice have been found in the research sample, but Cherry identified similar arrangements between groups of doctors in North Norfolk and at Cromer Cottage Hospital, so it is likely that that the custom was more common than the research sample suggests.¹¹⁸

When the hospital opened in 1893, the House Surgeon was Dr William Butterly, age twenty-four, registered 1891 by the Royal Colleges of Physicians and Surgeons, Ireland. He was also a licensed midwife.¹¹⁹ His salary was c. £120 plus food and accommodation.¹²⁰ He had been the House Surgeon for Chorley Dispensary from April 1892, prior to the cottage hospital opening in September 1893.¹²¹ His appointment as House Surgeon despite the onerous restrictions and his continuing subordinate position relative to the Medical Officers must have been a promotion as the new facilities enabled him to perform operations. When he resigned in November 1897 he was replaced by Dr Harry Armitage who had only graduated four years previously.¹²² No reasons were given in the Annual Report for Butterly's resignation and in the 1901 census he was in practice in Blackpool.

There are aspects of both Butterly's and Armitage's appointments which were unusual for cottage hospitals; both were recently qualified when appointed as House Surgeon and both were salaried, a significant departure from the normal cottage hospital practice of gratuitous medical service. Swete only listed three early cottage hospitals at which the medical officer was remunerated: Mansfield Woodhouse (Nottinghamshire) where an annual *honorarium* of £12 was paid; Lady Dunraven's, Clearwell (Gloucestershire) at which 'the hospital is open to all medical men, one acting as director, and receiving payment for his services'; and Countess de la Warr, Sevenoaks (Kent), where 'the services of the acting medical officer are provided at the cost of the foundress.'¹²³ The sums involved were trivial and cannot be considered as salary but give an indication that in a few hospitals the doctor was provided with a modest subsidy. It is unlikely that Chorley was the only nineteenth century cottage hospital to employ a salaried doctor, but without further research, it is not possible to establish other examples. At Cranleigh where records have survived until 1945, the income and expenditure accounts show that the medical staff continued to give their services *gratis* throughout.¹²⁴

Cottage hospital nurses

Early cottage hospitals employed a single nurse, domiciled in the hospital and expected to be available at all times. Occasionally she might be aided for short periods by a second woman during a busy period and when continuous nursing

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of a patient was needed. The nurse may also have had responsibility for one or more part-time women who carried out cleaning and laundry tasks, described as charwomen or servants in the Annual Reports. For both medical and nursing matters she took instructions from the Medical Officer, and for housekeeping, provisioning and cooking she may have answered to a Ladies Committee. As hospitals expanded their bed numbers and services and employed additional nurses or probationers it became common to refer to the nurse in charge as Matron or Lady Superintendent, following the pattern established in voluntary hospitals.

The source and training of nurses in early cottage hospitals was a subject of considerable dispute and controversy. Edward Waring, discussing the 'class of women best adapted for Cottage Hospital work', described three types of nurse: a woman from an Anglican sisterhood, a 'simple country-woman' or a trained professional nurse, by which presumably he meant a woman who had trained in a voluntary hospital. He advocated the latter of these 'types', if there were sufficient funds to pay trained nurse wages and if the nurse was also willing to undertake menial tasks, for which a 'lady or "professed" nurse might [normally] be averse'.¹²⁵ Waring dismissed sisterhoods on the grounds of their 'peculiar' dress, because they were, typically, ladies, and because the 'ecclesiastical element' might give offence as cottage hospitals were open to all religious denominations.¹²⁶ Nonetheless, Anglican sisterhoods nursed in a small number of hospitals such as North Ormesby Cottage Hospital (Teesside) where the Sisters of the Holy Rood provided gratuitous nursing services until 1923.¹²⁷

Religious prejudice was not confined to Anglican sisterhoods. In 1899, an article in *The Tablet* criticised the decision to dismiss the head nurse at Braintree and Bocking Cottage Hospital, which had been made 'in consequence of the fact of the Roman Catholic Convent being so near the hospital, the Committee deemed it unwise for the hospital to be left in the sole charge of a Roman Catholic.'¹²⁸

Horace Swete considered the nurse to be 'next to the medical officer the most important personage in the cottage hospital'.¹²⁹ Her presence meant that the doctor could be confident that his instructions would be carried out, bandages

changed regularly and medicines given in the prescribed doses and strengths. He too discounted religious sisterhoods citing 'Miss Nightingale's opinion' that the idea of the 'religious order is always more or less to prepare the sick for death', which he ameliorated by observing that there were cases where ladies have undertaken the nursing of a small hospital with the holiest of motives 'without thinking it necessary to convert an institution for the relief of the sick into a mission for the dissemination of doctrines and tracts.'¹³⁰ He also dismissed 'lady nurses': 'The demand for ladies to take superintendence of hospitals ... is steadily increasing. For such a post, no lady is fit It is a common mistake to suppose that a very superficial knowledge of nursing is sufficient to enable a lady to undertake the work of superintendence.'¹³¹

Swete described the nurse's duties in extensive detail: ward cleaning and disinfecting, managing ventilation of the wards, preparing meals, reading prayers, preparing for the Medical Officer's round, washing patients, setting and maintaining fires, sanitising and washing bandages, preparing and rolling fresh bandages, making pillows, giving food and medicine, dealing with accidents and emergencies in the absence of the Medical Officer, preparing the operating room and meeting and greeting visitors.¹³² His list appeared to require a person with boundless energy but it should be noted that as shown above, the complement of beds in early hospitals were rarely continuously occupied and much of the medical treatment provided consisted solely of a good diet for several weeks in a clean, warm environment.

Based upon his experience as Medical Officer at Wroughton Cottage Hospital, Swete (unlike Waring) preferred to employ 'the homely, motherly woman of the neighbourhood', who had been sent to a county hospital for a few months where 'she will pick up a great deal of useful information.'¹³³ He excluded the trained hospital nurse as she will be 'far above the patients in manners and knowledge without having the education of a lady that would induce her to come down to the level of the patient.' He referred to Napper's experience of training a local woman, quoting Napper: 'she acts to the entire satisfaction of doctor and patients.'¹³⁴

Napper also set out the arguments for and against trained nurses:

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A most essential desideratum in an institution of this kind is a good nurse. There can be no question as to the superiority, in many respects, of one well-trained, and possessing a competent knowledge of her duties; but, on the other hand, these advantages are counter-balanced by an inordinate amount of conceit, and disinclination to conform to instructions that do not accord with her preconceived notions [...] I am not sure that a sensible, untutored woman, who will strictly carry out the directions given to her, will not often be found the more efficacious.¹³⁵

The background and training of Cranleigh's first nurse is unknown but she was almost certainly a local woman whom Napper had called upon to help him in his practice previously. He continued to employ unskilled women who he trained to his way of working. A leader in the *BMJ*, a year after Cranleigh opened, which praised its success, quoted the hospital's rule that 'The establishment shall consist of a regular nurse and another woman for the work of the house', commending its simplicity. The leader continued, 'Mr Napper is satisfied with a staff of two old women, and consequently the cost of Cranley Village Hospital is small' and advised 'Our parting word to Mr Napper is to keep his two old women.'¹³⁶ In this regard, it seems that the *BMJ*, keen to promote the concept of cottage hospitals, chose to stress how cheaply that could be achieved and had no interest in the quality of nursing support provided.

Despite Napper and the *BMJ*'s opinion, by 1878 the Cranleigh Annual Report noted that 'the experiences of the present Nurse, who was nurse for five years in St Thomas's Hospital, is found most valuable; and the arrangement by which the Nurse is boarded and found in everything works well.' She was not named. It had only taken twenty years for Napper to recognise the advantages of a professional nurse.¹³⁷

Henry Burdett, writing in 1877, described at length and tabulated in considerable detail the various nursing structures which had been adopted by cottage hospitals. He described a number of organisations which included a Matron or Lady Superintendent supervising one or more nurses, either reporting to the (male) Hospital Committee or its subservient Ladies Committee, and one in which a head nurse had full control including expenditure.¹³⁸ Burdett

favoured cottage hospitals employing trained nurses, taking issue with Napper's preference for a local woman he had trained himself. He dismissed the case for a village woman with limited training in a powerful paragraph:

This class of nurse was at first highly extolled for the cottage hospital. But what are in reality these country women [...] A common sort of monthly nurse (all monthly nurses are common) who has spent her life in learning, by the art of 'simples' what is 'good for' every disease under the sun [...] has not the least idea of method or regularity [...] and the moment [the doctor's] back is turned has recourse to her infallible herbs.¹³⁹

He preferred a nurse or assistant nurse from the county hospital: 'This class of nurse [...] in our opinion [...] is a likely sort of person for the post. [...]S]he would probably be from the same district [as the patients], belong to the same rank of life as the patients themselves, and be, therefore, able to sympathise and converse with them in their own peculiar county dialect.'¹⁴⁰ In other words, although he did not approve of partially trained local women, he also objected to 'lady' nurses trained in large metropolitan teaching hospitals.

Burdett lamented the shortage of nurses, which affected both general and cottage hospitals, and the private nursing sector, his solution being that cottage hospitals had to train their own: 'If the farmers' and tradesmen's daughters are to be utilised they could be sent to the county infirmary [...] as a sort of finishing school', he suggested.¹⁴¹ Burdett proved his point by placing an newspaper advertisement aimed at the daughters of farmers and tradesmen, which, he claimed, netted 'a large number of competent young women.' Consequently this 'has proved beyond doubt that in nearly every village [...] this class of person [...] is to be found. By such a system, the homeliness of the cottage would be secured, for the nurse would be well-known, and respected for her parents' sake by the patients.' He concluded that as parents were willing to let their daughters become pupil teachers in the local school, they would be as likely to approve of them taking up nursing locally rather than train away from home.¹⁴²

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The records of Moreton Cottage Hospital contained a handwritten account by Rebecca Horne, dated 1920, recalling how she came to be appointed Matron of that hospital when it opened in 1873.¹⁴³ Hospital co-founder Dr Lionel Yelf, had been impressed by her long-term nursing of a sick friend and had intimated that there would be a place for her in his cottage hospital if he were successful in obtaining funds, and suggested she obtained some training. She approached the Matron of St. Thomas's Hospital who recommended she attend Hampshire County Hospital in Winchester where the 'Nightingale Fund' was training a group of nurses, which she did. She was subsequently appointed and remained Matron at Moreton for many years, an example of a single middle-class woman with private means attracted by the opportunity to escape the cloistered home environment.¹⁴⁴

Evidence for the employment of professional nurses by the end of the century can be inferred from the records of Chorley Cottage Hospital, which employed Miss Noble as Nurse Matron at an annual salary of £14 11s 8d.¹⁴⁵ She lived in the hospital and had responsibilities for ordering provisions, keeping the household accounts and presenting them to a monthly management committee, supervising a night-nurse, an assistant nurse, who also visited patients in their home, and several servants.¹⁴⁶ The 1894 Annual Report noted that 'The District Nursing which was commenced at the end of last year has been continued. It is difficult to over-estimate the value of this work, and it is pleasing to note that it is so fully appreciated by the patients themselves.'¹⁴⁷

Whilst there were a few references in Annual Reports to the nurse visiting patients in their homes, it was not common practice as in most hospitals the nurse was in charge for much of the day, as the Medical Officer was tending to his fee-paying patients. As noted earlier, Honorary Medical Officers at Chorley made home visits to check progress, presumably following discharge of an in-patient, so it is possible that the nurse was also deployed for similar purposes where less medical skill was needed.

¹ Cottage Hospital Database.

² In some Surrey villages, Pound Day took place in June at which individuals contributed either £1 or one pound weight or equivalent of dry goods such as sugar and flour to the hospital or other local charity.

³ For discussion of the increasing involvement of women in charitable work connected to public institutions see for instance, Frank Prochaska, *Women and Philanthropy in 19th Century England*, (Oxford: Clarendon Press, 1980); Martha Vicinus, *Independent Women, Work and Community for Single Women 1850-1920* (London: Virago Press, 1985); Joan Perkins, *Victorian Women* (London: John Murray, 1993); or Simon Morgan, *A Victorian Woman's Place: Public Culture in the Nineteenth Century* (London: Tauris Academic Studies, 2007).

⁴ For a discussion of women and hospital management see Keir Waddington, 'Subscribing to a democracy: management and voluntary ideology of London hospitals, 1850-1900', *English Historical Review* 118 (2003), pp. 357-79.

⁵ Both men were well-established in the district: in the 1861 census, John Bradshaw was described as 'Landed proprietor and magistrate', and in the 1871 census James Elmes was described as 'Farmer of 150 acres employing 6 men.'

⁶ In the 1861 census, Alice Pocklington, age 28, was living with her sister in Cranleigh. They were the daughters of a deceased vicar, and both were described as fundholders, implying some level of independent wealth. Miss Crewdson could not be identified in the 1861 or later censuses.

⁷ See Chapter 1. *Cranleigh Village Hospital, First Annual Report, 1860*. Surrey History Centre (SHC). John Sapte provided the building at an annual rent of £5 which he donated to the hospital.

⁸ *Building and Reconstruction accounts of Cranleigh Village Hospital, 1903*, SHC ref DCH/9/4/4. One of the trustees, Pandeli Ralli, gave £1,000 as a memorial to his sister and five other prominent locals gave £100 each including Lord Alverstone. The Building Fund reached £1983 and the new wing cost c£1700, the balance transferred to the hospital.

⁹ *Cranleigh Village Hospital Annual Report for 1906*, SHC.

¹⁰ The hospital opened in 1859 with four beds which within a year had increased to six. The reference to 'practically four' may be understood to mean average bed occupancy. *Building and Reconstruction accounts of Cranleigh Village Hospital, 1903*.

¹¹ The new organisation from 1906 consisted of the six Trustees, a General Committee of twenty-three which included the three Medical Officers, from which an Executive Committee of five was appointed and the post of Secretary/Treasurer had become two separate positions.

¹² Prochaska, *Women and Philanthropy*.

¹³ Sir George became a trustee in 1907.

¹⁴ Either Julia or Alice James, both spinsters living on own means. Their house was next door to the Napper family home. The other members of the Executive Committee were Frank Naumann, coffee merchant, the Rector, P. Cunningham, James Holden, major local builder and Dr Arthur Napper, son of the founder. Sources: 1901 and 1911 census.

¹⁵ *Cranleigh Village Hospital, 48th Annual Report*, pp. 6 and 9, SHC. A donation of £25 had been made by Executive Committee member Frank Naumann, a wealthy coffee merchant who lived in Cranleigh.

¹⁶ William Stenson, 'Gent.', William Kendall, solicitor and James Ashwin, local farmer of 250 acres who employed nine men and 3 boys. 1861 census, Bourton-on-the-Water, District 1.

¹⁷ One of the Trustees, William Snooke Stenson had given the land for the new hospital. In the late century his widow, Mrs Stenson, is described as the 'Lady of the Manor' and principle landowner in Bourton on the Water. *Kelly's Directory (Gloucestershire)*, 1897.

¹⁸ *Cranleigh Village Hospital Annual Report, 1876*, SHC.

¹⁹ *Bourton-on-the-Water Cottage Hospital, 25th Annual Report*, p.6, Gloucestershire Archives. Crawford was the local rector.

²⁰ *Bourton-on-the-Water Cottage Hospital, 33rd Annual Report*, p.2, Gloucestershire Archives

²¹ Rebecca Horne, aged 40, single, is recorded in the 1881 census as Honorary Matron of the Cottage Hospital. In 1881 census, Frederick was recorded as employing 13 hands and his brother, Thomas Horne, who lived just a few houses away, was also identified as a farmer of a large farm, which employed 12 labourers. Judging by the size of their enterprises it would appear the Hornes were a family of some stature in the village.

- ²² Steven Cherry, 'Change and Continuity in the Cottage Hospitals c. 1859-1948: The Experience in East Anglia', *Medical History*, 36 (1992), p. 276.
- ²³ The hospital was named after Henry Rous, MP, Lord of the Admiralty and Jockey Club Steward. It was built on land conveyed by Sir Richard Wallace and was intended for the care of those employed in the racing industry. Cherry, 'Change and Continuity'.
- ²⁴ Cherry, 'Change and Continuity', p. 276.
- ²⁵ Cherry, 'Change and Continuity', p. 275. For a discussion of the relationship between charity and social status see for instance, Peter Shapely, 'Charity, status and leadership: charitable image and the Manchester man', *Journal of Social History* 32/1 (1998), pp. 157-77.
- ²⁶ Annual Reports for 1880 (Bourton) and 1881 (Moreton), Gloucestershire Archives.
- ²⁷ Rules of Bourton Cottage Hospital published in each Annual Report, Gloucestershire Archives.
- ²⁸ *Chorley Cottage Hospital and Dispensary, 1893*, p.5, Lancashire Record Office.
- ²⁹ Shapely, 'Charity, Status and Leadership'.
- ³⁰ 1891 England census. Ellen Hertslet was a woman of some substance, on her death in 1926 she left over £13,000 in her will. Ancestry, England & Wales National Probate Calendar, 1858-1966.
- ³¹ *Bourton Cottage Hospital, Annual Report 1876*, Gloucestershire Archives.
- ³² Such records will form the basis of discussions in Chapter 4.
- ³³ Chapter 1 described the first patient admitted to Cranleigh in November 1859, Ruth Shaw, wife of an agricultural labourer from the nearby parish of Ewhurst. From her details given in the Annual Report for 1860 she was quickly identified in the 1861 census. The Annual Report for Cranleigh Village Hospital for 1869 has not been found.
- ³⁴ After 1904, patients ceased to be identifiable in the Annual Reports.
- ³⁵ Almost certainly a tubercular condition.
- ³⁶ *Cranleigh Village Hospital Annual Report, 1871*, SHC.
- ³⁷ 1871 census. Patients admitted immediately before, during, and following a census year can be identified reasonably quickly.
- ³⁸ *Lydney Cottage Hospital Annual Report, 1901*, Gloucester Record Office, and 1901 census.
- ³⁹ *Cranleigh Village Hospital Annual Report, 1878*. For reading on medical ethics in the late 19th century see: Angus Ferguson, *Should a Doctor Tell: the evolution of medical confidentiality in Britain* (London: Routledge, 2016), pp 29-54.
- ⁴⁰ *Lydney Cottage Hospital Annual Report, 1904*, Gloucester Record Office.
- ⁴¹ *Lydney Cottage Hospital Annual Report, 1904*, Gloucester Record Office.
- ⁴² Chapter 1 described how receipt of the first Annual Report of Cranleigh led to the *BMJ* publishing the hospital's rules and encouraged other rural surgeons to follow Napper's example.
- ⁴³ Henry C. Burdett, *Cottage Hospitals: General, Fever and Convalescent: their progress, management and work*, 2nd Edn (London: J & A Churchill, 1880). Preface, p. x. The importance of Burdett's three editions of *Cottage Hospitals* is discussed in Chapter 1.
- ⁴⁴ As late as 1938, Cranleigh continued to publish the names of subscribers and donors. *Cranleigh Village Hospital, 88th Annual Report*, SHC.
- ⁴⁵ Galvanism was a form of therapy by which a mild electric current was applied to an affected body part with the aim of stimulating remedial nerve action. Napper may have used it on patients suffering rheumatism and arthritis but there are no references to its use in the Cranleigh records.
- ⁴⁶ The Cranleigh Village Hospital League of Friends has recently donated £400,000 towards the installation of X-ray equipment in the hospital along with associated facilities and furniture.
- ⁴⁷ Cranleigh patient records for the years 1887-8 do not show any patient discharged to a sanatorium.
- ⁴⁸ *Cranleigh Village Hospital Annual Report, 1887/88*.
- ⁴⁹ *Cranleigh Village Hospital, First Annual Report, 'Rule 7'*, SHC.
- ⁵⁰ *Bourton Cottage Hospital, First Annual Report, 'Rule 13'*; *Moreton Cottage Hospital, First Annual Report, 'Rule 9'*, Gloucester Record Office.
- ⁵¹ Anne Digby, *Victorian Values and Women in Public and Private in Victorian Values*, ed. by T. C. Smout (Oxford: Oxford University Press, 1992), pp. 195-215.
- ⁵² *Moreton Cottage Hospital Second Annual Report, 1874*, Gloucester Record Office.
- ⁵³ Prochaska, *Women and Philanthropy*, p. 143.
- ⁵⁴ *Chorley Cottage Hospital Annual Report, 1899*, p. 6, Lancashire Record Office.
- ⁵⁵ *Cranleigh Village Hospital Annual Report, 1894*, SHC.
- ⁵⁶ *Braintree and Bocking Cottage Hospital Annual Report, 1895*, p. 4. Essex Record Office.

- ⁵⁷ For further discussion of the roles undertaken by middle-class women in public institutions see for instance, Ann Summers, 'A Home from Home: women's philanthropic work in the nineteenth century' in *Fit Work for Women*, ed. by Sandra Burman (London: Croom Helm, 1979) pp.33-63; Andrea Tanner, 'Too Many Mothers? Female Roles in a Metropolitan Victorian Children's Hospital' in *The Impact of Hospitals, 300-2000*, ed. by John Henderson, Peregrine Horden and Alessandro Pastore (Oxford: Peter Lang, 2007), pp. 135-66.
- ⁵⁸ Edward John Waring, *Cottage Hospitals: Their Objects, Advantages and Management*, (London: Savill, Edwards and Co., 1867) p. 30; Horace Swete, *Handy Book of Cottage Hospitals* (London: Hamilton, Adams and Co., 1870), p. 80.
- ⁵⁹ Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century: the quest for independence* (Abingdon: Routledge, 2010).
- ⁶⁰ Burdett, *Cottage Hospitals*, p. 186.
- ⁶¹ *Ibid.*
- ⁶² See also Tanner, 'Too Many Mothers?'
- ⁶³ Amanda Vickery, *The Gentleman's Daughter*, (Newhaven and Yale: Yale University Press, 1980; Martha Vicinus (ed.), *Suffer and be Still* (Bloomington: Indiana University Press, 1973); Anne Witz, *Professions and Patriarchy* (London: Routledge, 1992).
- ⁶⁴ Carrie Howse, 'From Lady Bountiful to Lady Administrator: women and the administration of rural district nursing in England 1880-1925', *Women's History Review*, 15/3 (2006), pp. 423-442.
- ⁶⁵ Shapely, 'Charity, Status and Leadership', p.161.
- ⁶⁶ *Chorley Cottage Hospital Annual Report, 1894*, pp. 5-6, Lancashire Record Office.
- ⁶⁷ *Moreton Cottage Hospital First Annual Report, 1873*, Gloucester Record Office. ref. HO30.
- ⁶⁸ *Ibid.* The Loyal Rose of England was one of many similar fraternal organisations loosely modelled upon the Masonic Order, such as The Oddfellows, Royal Antediluvian Order of Buffaloes, Loyal Order of Ancient Shepherds, the teetotal Rechabites and various Orange Lodges. Like Masons, only men were admitted, they practised arcane rituals and some wore distinctive vestments at their meetings. Their principal objective was to support members in times of need and were a type of Friendly Society.
- ⁶⁹ Keir Waddington, 'Grasping Gratitude; charity and hospital finance in late Victorian London' in *Charity, self-interest and welfare in the English Past*, ed. by Martin Daunton (London: UCL Press, 1996), pp. 135-51.
- ⁷⁰ *Cranleigh Village Hospital, Twentieth Annual Report, 1879*, p. 7-9, SHC. Among this group identified in the 1881 census were George Grinstead (road surveyor), Edwin Thirkell (grocer and postmaster), Frederick Ansell (farmer and coal merchant) and Stephen Rowland (draper and grocer).
- ⁷¹ A small number were partly supported by an employer and/or weekly contributions by employees. As an example, Swindon Cottage Hospital was established and part-funded by the Great Western Railway Company.
- ⁷² Annual Reports of the hospitals in Moreton, Cranleigh and Bourton. By the end of the nineteenth century the listing of individual subscriptions had ceased.
- ⁷³ *Moreton Cottage Hospital Annual Report, 1889*, Gloucestershire Archives.
- ⁷⁴ Burdett, *Cottage Hospitals*, pp. 87-9.
- ⁷⁵ Keir Waddington, *Charity and the London Hospitals, 1850-1898* (Suffolk: The Boydell Press for the Royal Historical Society, 2000), p. 62.
- ⁷⁶ Burdett, *Cottage Hospitals*, pp. 63-8.
- ⁷⁷ See Chapter 1 for a discussion of patients' payments.
- ⁷⁸ Supplement to *British Medical Journal (BMJ)*, 15 December 1906, p. 323.
- ⁷⁹ Admission principles and exclusions are discussed in Chapters 1 and 4. See also Sally Sheard, 'Getting Better, Faster: convalescence and length of stay in British and US hospitals' in *Hospital Life: theory and practice from the medieval to the modern*, ed. by Laurinda Abreu and Sally Sheard (Berne: Peter Lang, 2013), pp. 299-331.
- ⁸⁰ Derived from analyses of patient records, discussed in Chapter 4.
- ⁸¹ Burdett, *Cottage Hospitals*, p. 81.
- ⁸² See Chapter 4.
- ⁸³ Bourton was the second cottage hospital to open in March 1861.
- ⁸⁴ W.C. Coles, *An Account of the Bourton-on-the-Water and Cotswold Village Hospital* (London: Taylor & Co., 1877), p. 19.
- ⁸⁵ *Cranleigh Village Hospital Annual Report, 1861*, patient no. 12, SHC; *Bourton Cottage Hospital Annual Report, 1886*, patient no.14, Gloucestershire Archives.
- ⁸⁶ Coles, *Bourton Village Hospital*, p.19.

⁸⁷ Admission dates showed that both hospitals were open for 365 days per year. 1862 was selected for Cranleigh. In its first full year, 1861, bed numbers increased from four to six but it was not recorded when in the year that happened. Cranleigh in 1862 had six beds, an annual capacity of 2,190 bed days. Patients were resident in the hospital for a total of 1,397 days giving a 64% utilisation. Moreton with seven beds had an annual capacity of 2,555 bed days which in 1875, its second full year, were occupied for 1,566 days or a 61% utilisation. The second full year was chosen as representative as it was assumed that in the first full year the most serious cases would have been admitted, staying for longer periods. These values are averages across the year and do not show peaks and troughs in bed occupation. Chapter 4 discusses hospital 'stays' and bed occupancy in more detail.

⁸⁸ Burdett, *Cottage Hospitals*, p. 79.

⁸⁹ *Bourton and Cotswold Village Hospital, 1st Annual Report, 1861*, Gloucestershire Archives.

⁹⁰ *Moreton Cottage Hospital 1st Annual Report, 1873*, Gloucestershire Archives.

⁹¹ *Moreton Cottage Hospital 9th Annual Report, 1881*, Gloucestershire Archives.

⁹² *Cranleigh Village Hospital 2nd Annual Report*, SHC. The only year in which the nurse's salary, of £21, was shown as a separate item was in the First Annual Report, for 1859-60.

⁹³ Coles, *Bourton Village Hospital*, p. 7.

⁹⁴ In the London training hospitals ward nurses earned in the region of £16 and £18 per annum in the mid-1860s rising to £20-£25 per annum by the end of the century (plus their board and lodging), so this salary seems quite generous for a rural hospital. Compare this with the reported salary of £12 pa for Miss Noble, as head nurse at Chorley Hospital. For a discussion of the wages of hospital nurses in London see Hawkins, *Nursing and Women's Labour*, pp. 109-39.

⁹⁵ *Bourton Village Hospital Annual Report, 1864*, Gloucestershire Archives.

⁹⁶ *Braintree and Bocking Cottage Hospital Annual Report, 1886*, Essex Record Office.

⁹⁷ *Braintree and Bocking Cottage Hospital Annual Report, 1900*, Essex Record Office.

⁹⁸ *Braintree and Bocking Cottage Hospital Annual Report, 1886 and 1900*, Essex Record Office.

⁹⁹ Burdett, *Cottage Hospitals*, p. 81.

¹⁰⁰ Burdett, *Cottage Hospitals*, pp. 77-109.

¹⁰¹ Burdett, *Cottage Hospitals*, pp. 79-80. Burdett also calculated the cost per unoccupied bed which showed that cottage hospitals had similar cost advantages using that measure, compared to voluntary hospitals.

¹⁰² *Ibid.*, p. 81.

¹⁰³ Cherry, 'Change and Continuity'.

¹⁰⁴ *Moreton Annual Report, 1877*, p. 5, Gloucestershire Archives.

¹⁰⁵ *Bourton Annual Report, 1878*, p. 10, Gloucestershire Archives.

¹⁰⁶ *Bourton Annual Report, 1876*, p. 1, Gloucestershire Archives.

¹⁰⁷ *Cranleigh Annual Report, 1911*.

¹⁰⁸ *Bourton Annual Report, 1885*, p. 3, Gloucestershire Archives.

¹⁰⁹ Jonathan Reinartz, 'Charitable Bodies, The funding of Birmingham's voluntary hospitals in the nineteenth century', in *Financing Medicine, the British experience since 1750*, ed. by Martin Gorsky and Sally Sheard (London: Routledge, 2006), p.53-4.

¹¹⁰ *Chorley Dispensary and Cottage Hospital Annual Report, 1894*, Lancashire Record Office.

¹¹¹ *Chorley Cottage Hospital and Dispensary Annual Report, 1902*.

¹¹² Discussed in Chapter 1.

¹¹³ John N Moore was the son of George Moore, local surgeon and general practitioner, recorded as Consulting Surgeon to the hospital. George was born in Tewkesbury, Gloucestershire as was John Moore who founded the earlier nearby Bourton Hospital and they were probably brothers. John junior no doubt obtained his position in the new cottage hospital through his father's influence.

¹¹⁴ *Cranleigh Village Hospital Annual Report, 1860*, patient nos. 14 and 8, SHC. Henry Sharp Taylor, MRCS, LSA, was surgeon to the Royal Surrey Hospital in Guildford, and, of more relevance to this case, Medical Officer for the Guildford Union, which probably explains his willingness to be involved in this case.

¹¹⁵ *Chorley Cottage Hospital and Dispensary Annual Report, 1894*, p. 6, Lancashire Record Office.

¹¹⁶ *Chorley Dispensary Report, c1851*, Lancashire Record Office.

¹¹⁷ *Chorley Dispensary and Cottage Hospital, Rules and Regulations, 1894*, p. 6-7, Lancashire Record Office

¹¹⁸ Steven Cherry, 'Change and Continuity', p. 274.

¹¹⁹ *Medical Register (1895)*, p. 255.

¹²⁰ *Chorley Dispensary and Cottage Hospital Annual Report, 1893*, Lancashire Record Office, p. 7.

¹²¹ A previous House Surgeon, Septimus Farmer had over many years argued strongly for a cottage hospital in Chorley. In the Dispensary Report for 1884, Farmer wrote: 'I cannot too strongly point out the great advantages a Cottage Hospital would be attached to the Dispensary. Many valuable lives have been lost by want of proper nursing, which might have been saved, had there been a properly managed Cottage Hospital in the town.' It was another seven years before the hospital was built. *Chorley Dispensary and Cottage Hospital Annual Report*, 'Reports of the House Surgeon for 1884 and 1893', Lancashire Record Office.

¹²² *Medical Register* (1895), p. 1117.

¹²³ *Ibid.*, pp. 124-68.

¹²⁴ In 1945, Cranleigh Village Hospital medical staff consisted of two Honorary Consulting Physicians, three Honorary Consulting Surgeons, three Honorary Medical Officers and an Honorary Dental Surgeon.

¹²⁵ Waring, *Cottage Hospitals*, p. 32.

¹²⁶ *Ibid.*, p. 33.

¹²⁷ Barry Doyle and Robina Dixon, 'Voluntary Hospital Finance in North-east England: the case of North Ormesby Hospital, Middlesbrough, 1900-1947', *Cleveland History*, 80 (2001), pp. 5-19.

¹²⁸ Anon, *The Tablet*, 14 January 1899, p. 19.

¹²⁹ Swete, *Handy Book of Cottage Hospitals*, p. 93.

¹³⁰ *Ibid.*, p. 94.

¹³¹ *Ibid.* pp. 95-6. For a discussion of the relationship between doctors and lady superintendents see Sue Hawkins, 'I must remind you that the nurse is not the doctor; that she never can be': gender and hospital nursing in 19th and 20th century England', *Historia Hospitalium*, 30 (2016-17), pp. 41-64.

¹³² Swete, *Handy Book of Cottage Hospitals*, pp. 93-107.

¹³³ *Ibid.*, p. 96.

¹³⁴ *Ibid.*, p. 97.

¹³⁵ Albert Napper, *On the Advantages Derivable to the Medical Profession and the Public from the Establishment of Village Hospitals* (London: H K Lewis, 1864), p.9.

¹³⁶ *BMJ*, 20 October 1860, pp. 820-1.

¹³⁷ *Cranleigh Village Hospital Annual Report, 1878*, SHC. The 1861 census records Elizabeth Smith, a widow age 54, as the village hospital nurse. Smith when married had been a governess in a day school in east London. The 1871 census records Sarah Tanner, age 34, as nurse of the village hospital. She had been born in Cranleigh, but ten years previously had been working as a cook in nearby Dorking. Napper may well have known her and trained her. In the 1881 census, the nurse was Edith Purton, age 31, born Alcester, Warwickshire. She was the daughter of a gentleman and it is possible she was the nurse recruited from St Thomas's. Napper was close to retiring and handing the hospital to his son Arthur, who may have persuaded his father to appoint a trained nurse.

¹³⁸ Burdett, *Cottage Hospitals*, pp. 172-196.

¹³⁹ *Ibid.*, pp. 190-91.

¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.*, p. 177.

¹⁴² *Ibid.* It is unclear why Burdett was seeking trainee nurses and it has not been possible to locate the advertisement. This was during his time as Secretary to the Seaman's Hospital at Greenwich, so he may have been looking for nurses for that hospital.

¹⁴³ 'Reminiscences about foundation of the hospital by Miss Rebecca Horne, the first matron, 1920', Gloucester Record Office, HO30/21/1.

¹⁴⁴ The accounts show she was unpaid for the first two years of the hospital.

¹⁴⁵ This is a very low salary for a matron. By the end of the nineteenth century staff nurses in large voluntary hospitals were earning at least £20 pa with board and lodging added to that. Hawkins, *Nursing and Women's Labour*, p. 121.

¹⁴⁶ In 1896, she left to become Matron of Macclesfield General Infirmary, replaced by Miss Dawson from Wigan Royal Infirmary.

¹⁴⁷ *Chorley Dispensary and Cottage Hospital Annual Report, 1894*, Lancashire Record Office.

Chapter 4: The Patients

Introduction

This Chapter discusses the factors which influenced the admission of patients to a cottage hospital, including social status, sponsorship and the severity of disease or accident. Datasets of patient records from three rural and three town-centred hospitals have been examined to determine if gender, age or occupation affected decisions to admit, which diseases or types of accidents were most prevalent, the duration of hospital stay and the medical or surgical treatment provided. The results provide new insights into how poverty and industrial mechanisation affected the health of poor agricultural and industrial workers between 1860 and the early twentieth century.

Establishing the social status of patients admitted to three rural cottage hospitals (Cranleigh, Bourton, Moreton) was key to understanding why these hospitals were founded and which segment of the population was served. This proved problematic as occupation was only reported in the surviving records of Cranleigh Village Hospital for its first nine years, commencing 1860, and intermittently thereafter, but fortuitously was illuminated by a pamphlet written by Albert Napper, the hospital's founder and Medical Officer, in which he reviewed his first 100 patients. When analysed and compared with patient datasets from the two other hospitals, it was clear that, as discussed in Chapter 1 the three populations shared many similarities, being poor and pauper agricultural labourers and their dependents, and could therefore be discussed collectively.

Admission records for the three town-centred cottage hospitals (Lydney, Chorley and Braintree) although later in foundation than the rural hospitals were selected for comparative purposes with their rural counterparts. Analyses of these records showed that patients were drawn from a similar social stratum to their rural counterparts, poor and pauper industrial workers and their dependents; however, their three populations were too dissimilar in the types of

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patient occupations and the gender mix of patients to aggregate. However, there were commonalities in the causes of admission and patient age ranges between the three town hospitals and their rural counterparts.

Cottage hospital admission processes

As discussed in Chapter 1, cottage hospitals had rules which specified who could be admitted and for what duration, but in practice the patient's good fortune in being sponsored by an annual subscriber and the severity of their illness or accident determined admission and length of stay. Cranleigh Village Hospital (opened in 1859), simply stated in its rules that it was 'designed for the accommodation of the Poor when suffering from disease, or from accident'. At Cranleigh were admitted on the authority of the Manager (in this case the Reverend Sapte) in consultation with Albert Napper, the Medical Officer (or by Napper alone if an accident or emergency).¹ In some cottage hospitals, recommendations were also assessed by a Committee. The patient's sponsor was required to submit a written recommendation, a practice in general use at that time in voluntary general hospitals as a means of limiting access to the 'deserving poor'. Sponsoring a patient implicitly carried a responsibility for paying the weekly fee; as Napper observed 'Friends, relatives, or employers are ever ready to provide the means when under the influence of anxiety and fear ... in the case of destitute persons, the amount is always guaranteed by the relieving officer of the Union.'²

Most cottage hospitals had a rule which required an accident or emergency patient to obtain subscriber sponsorship retrospectively. There was no evidence that this rule or the requirement to make a weekly contribution was enforced with rigour; in fact hospital accounts typically showed that patient receipts only contributed between 15 and 20 per cent of annual income as already discussed in Chapter 3.

In its first two years, the rules for admission at Cranleigh cottage hospital were vague, but by 1864 the rules were amended to exclude those 'suffering infectious, incurable and consumptive diseases', and those who could be 'efficiently treated at their own homes', which probably referred to patients living within easy reach of Napper's house, in the centre of the village.³ From its

beginning in 1861, Bourton hospital also excluded anyone suffering from 'pulmonary consumption and infectious disease, excepting enteric fever' and Moreton followed the same pattern, additionally excluding the 'incurable'. Similar rules, some with local variations, can be found in many cottage hospital annual reports. At Epsom and Ewell Cottage Hospital in Surrey, (opened 1873), in addition to the exclusions described above, its rules added that 'none can be received who are not free from fits, and from any association with infection'.⁴ Exceptionally, Charlwood and Horley Cottage Hospital (opened 1872) included a rule that 'convalescents [were] also admitted when there is room in the wards', presumably for the income.⁵

Sponsorship and the requirement for a weekly financial contribution from each patient also featured in the rules of the later town-centred cottage hospitals along with similar exclusions to those applied by the early rural hospitals. For example, Chorley Cottage Hospital barred 'Infectious cases, persons suffering from consumption or any incurable disease or who are of unsound mind, and cases of advanced pregnancy, ...'.⁶ Chorley alone of the three town-centred cottage hospitals studied had a rule which specifically excluded those receiving parish relief, and had in place a complex set of admission rules.

The hospital's income was listed under various headings, for example by individual business name or as 'Workpeople's Collections' from separate factory departments such as the Spinning, Weaving and Card Rooms of Messrs. George Brown & Co. It seems likely that employees and their dependents who had contributed directly, or indirectly through an employer's annual subscription, were preferentially admitted and the extensive financial details were published to show the benefit of subscribing and act as encouragement to others to participate in hospital funding.

Whether the rules which required a Governor's recommendation for admission to Chorley Cottage Hospital and which specified a weekly income limit to control access to the dispensary were ever strictly enforced is not known, but unlikely. The system was too unwieldy to be used consistently. It was more likely that rules of such complexity were established and published to reassure subscribers that there was a sound process to manage admissions, exclude the perceived undeserving and have in place a set of exclusions to apply should the necessity arise, as is the nature of bureaucracies.⁷

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In addition to exclusions already discussed, Lydney Cottage Hospital also excluded 'hopeless cases', those for whom no cure could be envisaged, and would risk becoming long-term patients. Unusually, a statement of purpose preceded its extensive set of rules:

The object of this Institution is to afford prompt surgical aid in cases of accident, and to supply skilled medical treatment, combined with good nursing, pure air, and suitable diet to patients who cannot obtain these advantages in or near their dwelling – For lending linen, and necessary articles to poor persons during sickness; and, as opportunity offers, for providing a nurse.⁸

The statement provides ample evidence to support common reasons for the establishment of cottage hospitals, particularly the reference to 'prompt' responses in cases of accident and the benefit of 'good nursing' and 'diet' to aid recovery. The last sentence referring to the loan of clean linen and other 'necessary articles' is striking and places the Hospital at the centre of its community. It was the only cottage hospital in the research sample which claimed to provide this service.

Notably, the statement did not specify which sections of the population would be admitted or excluded.

Chapter 1 discussed how some dispensaries had added a small number of beds which later developed into cottage hospitals, citing Chorley as an example. Others, such as Bourton, included a dispensary from the beginning, attendance at which had also to be recommended by a subscriber, although it too provided for emergency access.⁹ In 1877, Bourton treated 171 out-patients which included measles, scarlatina and diphtheria, non-malignant tumours, various digestive system illnesses and parasitic infestations. Rule 20 stated: 'Out-patients being necessitous persons who apply for relief without a Subscriber's Ticket, will, if supplied with medicine at the Hospital, be required on their first attendance to make a payment of two shillings and sixpence which will entitle them to a supply of medicine for a month, or they may receive gratuitous advice, and provide their own medicine as heretofore.'¹⁰

Patients' social status

Cranleigh alone of the three rural hospitals included patients' occupation in its Annual Reports from 1860 to 1868 (176 patient records), which provided a good source of information on their social background. These reports included details of illness or accident, age, gender, treatment, length of stay, outcome and sponsor's name.¹¹ Most patients at Cranleigh Hospital were either agricultural or general labourers, their wives, widows or children. A few servants were recorded, along with some carters, bargees and railway navvies. Only five tradesmen were admitted in the nine-year period: one shoemaker, two carpenters, a blacksmith and a wheelwright. Bourton and Moreton did not state occupation but given that both were agricultural villages like Cranleigh their patients probably comprised a similar demographic.

In 1864 Napper published a pamphlet reviewing the first four years of the Cranleigh Hospital (1860 to 1864), which included the records of the first 100 patients and a social profile of each.¹² From this record a clear picture of the type of patient being admitted to Cranleigh can be drawn. Firstly, they were poor: sixty-seven were categorised by Napper as parish paupers, sixteen 'in humble circumstances', ten had their fees paid by the Poor Law Guardians and seven were 'incapable of remunerating a surgeon'.¹³ Males predominated: 54 per cent of admissions were male, 22 per cent were female and, interestingly (given voluntary hospitals' reluctance to admit children) 24 per cent were children. While male patients continued to dominate admissions throughout the period of this study, the proportion of female patients rose slightly, while that of children declined. Analysis of the complete Cranleigh database between 1860 and 1902 revealed that of the total admissions of just under 1100 in that period, 55 percent were male, 31 per cent were female and 14 per cent were children under thirteen years old. From 1902 only summaries of numbers admitted by disease type were published. Only six patients died in the four-year period covered by Napper's report. His summary did not include occupation but as it had been individually recorded in each of the Annual Reports for the four-year period, all 100 have been identified.

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Table 4.1: Occupation and financial status, first 100 patients, Cranleigh Village Hospital, 1860-1864.¹⁴

	Parish pauper	Fee paid by Guardians	In humble circumstances	Unable to pay Surgeon	Total
Labourer Male	29	4	2	4	39
Labourer's wife/widow	8	1	1	1	11
Labourer's child male	12	1	1		14
Labourer's child female	6	1	2		9
Navy male	7	2		1	10
Servant male	1				1
Servant female	4		2		6
Others, both genders & ages		1	7	2	10
Totals	67	10	15	8	100

Table 4.1 clearly indicates the predominance of male admissions., and also provides insight into the social status of the poor of Cranleigh, most of the patients being labourers of one sort or another. The presence of 10 navvies is particularly interesting. Cranleigh railway station opened in 1865, and navvies, some with wives, resided in the village whilst the railway between Guildford and Horsham was being constructed. Railway construction was a dangerous business. Napper wrote in the *4th Annual Report*, 'the admission of many railway accidents, which could not have been successfully treated in the huts of the navvies [...] has made the Village Hospital instrumental in saving these lives as well as in alleviating the severe and protracted sufferings of the men in these terrible accident cases.' Two of the ten navvies admitted to the Hospital died. It is interesting to note that all appeared to be classified by Napper as paupers, perhaps rendered thus as a result of being unable to work because of their accidents.

As already discussed, Edward Waring (pamphleteer and campaigner for cottage hospitals) had defined the target patient group for which cottage hospitals were intended as the deserving poor, by which he meant not the parish pauper 'but [...] that large and deserving class – ratepayers [...] comprising small farmers, tradespeople, mechanics, and others who support their families by honest labour'.¹⁵ Cranleigh's admission practices were clearly at odds with this, based on Napper's report, with few if any (perhaps those 'in

humble circumstances') meeting Waring's definition. At Cranleigh, at least, provided they were sponsored, or their admission resulted from an accident or emergency, patients were admitted based upon medical or surgical need; most were paupers, or impoverished or had been referred by the Poor Law Guardians.

It was Napper's approach to admitting paupers which set the pattern most later hospitals were to follow. At Bourton, a rule stated that paupers suffering accident or disease were to be admitted for which the Poor Law Guardians were charged between 2s/6d and 5s/- per week for each; the rules of Lydney Cottage Hospital referred to an extra fee to be paid to the District Union Medical Officer upon admission of a pauper and at a fund-raising event for Totnes Cottage Hospital, Devon, the mayor was reported having said '.....the greatest help to their poorer neighbours was not by pauperising them but by rendering assistance in the time of dire necessity ...'.¹⁶ Conversely, Wrington Village Hospital (Somerset, opened 1864) declared in its first Annual Report that it was intended for the respectable working class and small tradesmen, a surprising statement from the founder and Medical Officer, Horace Swete, an active promoter of cottage hospitals who would have been familiar with Cranleigh's admission practices.¹⁷

Chapter 1 discussed the distinction between poor and pauper resulting from the Poor Law Amendment Act of 1834 and how attitudes and services provided to each differed, yet despite the rule that appeared to restrict admission to the Cranleigh 'Poor', eighty-five of Napper's first 100 patients were either paupers or had insufficient financial resources to contribute to their hospital treatment. Interpreting Table 4.1 was problematic as it is unclear on what basis Napper classified patients: each of his four categories probably included paupers. It is assumed that the category 'parish pauper' referred to those in receipt of outdoor relief, while those 'unable to pay the surgeon' were not, but could have been eligible. Those in 'humble circumstances' may have been able to pay the weekly fee of 5s/-. Of the fifteen in 'humble circumstances', eight were children whose fathers' occupations included labourer and pauper as well as farmer and wheelwright, so it is possible that some could have contributed. It is also likely

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that patients whose fees were paid by the Guardians were Workhouse inmates who could not be treated in the Hambledon workhouse infirmary.¹⁸

Further problems were posed in understanding the sources of the income from patient fees reported in the annual accounts. Fees contributed £659 to the Hospital's income in the four years covered by Napper's pamphlet (just under a quarter of the hospital's total income), this averages out at £6 10s per patient (a huge sum for most agricultural labourers), suggesting that the majority of patient fees came from parish or other sources and not from the patients themselves, as Table 4.1 indicates. The sources of patients fees are shown in Table 4.2.¹⁹

Table 4.2: Cranleigh Village Hospital: sponsorship sources of first 100 patients of both genders and children, 1860-1864.²⁰

Sponsor	Number of Patients 1860-64
Cranleigh Rector and hospital manager (John Sapte)	21
Other Anglican churchmen, local parishes	17
Albert Napper	16
Local gentry	11
Local farmers	11
Fee paid by Guardians	10
No sponsor named	14

Some patients' fees in Cranleigh were paid by private sponsors (the hospital's subscribers). While both Napper and Sapte were listed as sponsors of patients it is not clear that they paid the associated patient fees: Napper already gave his services gratuitously and Sapte provided the church-owned premises rent-free and there is no record that they provided further support through the payment of patient fees. Parish clergyman may have been able to contribute in some circumstances, but appeals through the pulpit may also have raised money for specific individuals. Local farmers and the gentry, though, would have contributed, and along with the Guardians they comprised about thirty per cent of sponsors. Of the fourteen unsponsored patients, six were local to

Cranleigh or a nearby village, two were Irish travellers or navvies and the parish of the remaining six was 'Not known', so may have been vagrants. Eleven of the fourteen unsponsored patients had been hospitalised following a violent incident (fractures, wounds, burns) and had very likely benefitted from Napper's authority to admit accidents and emergencies without an accompanying recommendation. Six of the fourteen were parish paupers, two of which had fees paid by the Guardians.

It is questionable whether Napper ever expected most patients would pay the weekly sum of between 3s/- and 5s/- and always expected it would either be paid by the sponsor or remain unpaid. Even employed agricultural labours would not have been able to pay such sums except, possibly, around harvest time when additional wages were paid for a short period. In 1860, Frederick Purdy, Principal of the Statistical Department of the Poor Law Board, published a comprehensive review of the earnings and expenditure of agricultural labourers. He estimated the average weekly wage of an agricultural worker in Surrey in 1860 as 12s/9d, which could rise to around 21s for two weeks around harvest time. Clearly, the payment of nearly half this in patient fees (with the accompanying loss of earnings) would put huge strain on the family finances.²¹ The only allowance Surrey agricultural labourers received was beer at harvest time, but Purdy noted that family earnings were often augmented by simple cottage-based manufacturing. He calculated the average weekly cost of food and clothing for a labourer's family with four children in 1860 as 20s/6d and, having noted the shortfall, commented, optimistically, that 'this leaves out of view the extra earnings which a man, with a wife and four children would receive from their labour'.²² If Purdy's calculation is correct, then it is clear that as many as possible of an agricultural labourer's family would be required to contribute to the household income; and that extras such medical fees, if either he or any of his family needed hospital treatment, would be a source of considerable financial pressure.

A similar analysis of agricultural labourers' wages in the West Midlands reveals that these workers would have been even less able to contribute to their care at

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the cottage hospitals of Moreton and Bourton.²³ There can be no doubt that most patients were unable to pay.

Cottage hospitals, both rural and town-centred, continued to be used mainly by the poor and paupers throughout the 19th century. For example, the 1896 Annual Report of Chorley Cottage Hospital noted that, 'Of the 117 Patients [...], 90 were allowed to be exempt from the payment; whilst the remaining 27 were asked to pay an average of 4s/10d, which sum falls far short of actual cost of their maintenance.'²⁴ Despite various attempts to prevent abuse of the system, it was still happening. In 1900, Braintree was forced to amend its admission rule, after difficulties in obtaining payment from servants: 'Owing to the difficulty of obtaining payment from those domestic servants who have been patients in the Hospital, the Committee have been obliged to make the following addition to Rule 1 "but any domestic servant being actually in service, shall be admitted at the amount of 7s/6d weekly".'²⁵ There was no explanation of the difficulty, but this does echo Napper's and Swete's complaints against voluntary hospitals, that the employers of domestic servants took advantage of free health care for their staff, by directing them to free hospitals, when they should have been paying for care, through their own private medical arrangements.²⁶

A significant finding from Napper's 1864 pamphlet was the number of Cranleigh patients sponsored by the local Rector and clergy from the surrounding parishes, just under 37 per cent of this sample of 100. An analysis of the complete Cranleigh database (1860-1902) showed the importance of a recommendation from the local parson: in the records which named a sponsor, half were clergy.²⁷ Some Moreton Cottage Hospital records also named sponsors between the years 1883 and 1892 of which about 27 per cent were local clergymen and in many other surviving Annual Reports, local clergy were prominently listed as governors, trustees and hospital managers.²⁸ The parson was a key member of the rural hierarchy of landowner, clergy and professional men, farmers and a landless impoverished agricultural majority.²⁹ It was clearly essential for the poor to maintain good (and deferential) relations with those in control of their livelihood and welfare; the advent of the cottage hospital with its

requirement of a recommendation for admission therefore provided a further instrument of social control.

The rest of this chapter investigates questions about the patients, their diseases and treatments, in these six rural and town-based hospitals based on analysis of the Patient Records Databases which has been constructed from the admission records for the six hospitals under study.

Rural cottage hospital patients

Patients records have survived for the twenty-year period, 1875-1894, for the cottage hospitals in Cranleigh, Moreton and Bourton. Cranleigh records cover the full twenty years' sequence, Moreton seventeen years and Bourton sixteen years. All three hospitals served small agricultural communities: Cranleigh farms were arable, dairy and sheep; Moreton and Bourton, about fifteen miles apart, were arable and sheep. No industrial or mining activities have been identified in any of the localities served by the three hospitals. Annual admissions to Cranleigh averaged between twenty-five and thirty patients of both genders and all ages, while Bourton admitted between forty and fifty each year and Moreton fifty to sixty. In total, there were 1,956 patients over the twenty-year period of the study (see Table 4.3).

Table 4.3: Admissions by gender, three rural cottage hospitals, 1875-1894.³⁰

Hospital	Male (Age 13 and over)		Female (age 13 and over)		Child (12 and under)		Total Admissions³¹
	Admissions	%	Admissions	%	Admissions	%	
Cranleigh	283	52	192	35	68	13	543
Bourton	310	48	239	37	101	16	650
Moreton	327	43	295	39	141	118	763
Total admissions	920	47	726	37	310	16	1956

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Causes of admission: Male patients in three rural cottage hospitals

Adult male patients accounted for 47 per cent of all adult admissions at the three hospitals (see Table 4.3). The most common cause of admission of adult male patients at all three hospitals was accidents, classified in the category 'Violence' (see Table 4.4). Accident cases were highest at Moreton (accounting for over a third of male adult admissions), and lowest at Bourton (about 26 per cent of all male admissions). At Cranleigh accidents accounted for 30% of admissions, and half of these were 'young adults' aged between thirteen and thirty years old, suggesting that lack of experience may have been a contributory factor, and that younger men, perceived as being stronger, were more likely to be given hazardous or strenuous tasks resulting in injury. Most were work-related accidents and the causes were similar in all three hospitals. Fractures and other injuries to lower limbs predominated, some life-threatening or requiring amputation. Head injuries and wounds to the face and scalp, and crushed fingers and hands were also common presentations.

Table 4.4: Male admissions by Disease Group, as per cent of total admissions of male adults, at three rural cottage hospitals, 1875-1894. ³²

	Cranleigh	Bourton	Moreton
No. Admissions Males over 13	282	309	326
Violence	29.8	26.2	35.6
Joints Bones & Muscles (JBM)	14.2	9.1	12.0
Diseases of the Skin	10.3	6.5	7.7
Respiratory System	7.4	5.8	8.3
Reproductive System	7.1	2.9	2.5
Digestive System	6.7	12.3	7.7
Circulatory System	4.3	6.5	7.7
Nervous System	1.4	5.8	1.2

No doubt many of the accidents were caused by agricultural machinery but the records were insufficiently detailed, other than those of Cranleigh, to state this

definitively. However, Napper alluded to this explanation in his 1864 pamphlet when he wrote of the London hospitals' '[failure] to meet the requirements of the rustic and mining population ... when machinery has become so generally in use.'³³

The Cranleigh records for 1860 to 1868 provided detailed reasons for admission to the hospital, many of which support the argument that such injuries were the result of industrial accidents arising from the serious impact of agricultural machinery and equipment coupled with unsafe working practices. In one such case, J.F., a 53-year-old farm labourer, was admitted in December 1859 (as the hospital's second patient) 'with compound fractures of both bones of his leg caused by accidentally slipping his leg into the drum of a steam threshing machine'. There are no notes on how he was treated except to say he was confined to his bed until 20 January and that 'on the 22nd, he got down stairs, and was discharged with a good straight leg'. He was discharged on 6 February, 'able to walk well' but only with the aid of a stick.³⁴

In another case, patient W.S., a 17-year-old farm labourer was admitted on 21 June 1864 with compound fracture of the arm. The Annual Report reproduced a considerable level detail of both the injury and his progress whilst in hospital. On admission, 'the bone [was] protruding through the skin about two inches, and resting in the arm-pit'. The man had been run over by a horse and waggon.³⁵ Napper described in detail the operation which he undertook to reconstruct the young man's arm. 'As the bone was denuded of its lining membrane', he recorded, 'I removed it with a saw an inch and a half of it before returning it to its proper position.' Four days later, he was recovering well, 'and feeling much better for some port wine which was ordered the day before'. A month later, he could move the arm about freely and was discharged, cured, on 27 September.

J.S., a 21-year-old navy, was not quite so fortunate. He was admitted on February 1863 with 'severe compound comminuted fracture [where the bone shatters into two or more fragments] of both bones of the right leg, and a similar injury of the left thigh, caused by the wheels of a laden truck having passed over him'. Napper records that he had 'lost a large quantity of blood but was

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quite sensible. [I tied] the femoral artery of the left leg, but he died from exhaustion, before anything more could be done'.³⁶

These cases are typical of the types of those which presented to Cranleigh Cottage Hospital. J.S., the navy who died, was unlucky: according to Napper's report only thirteen of the 203 accident cases (6.4%) treated at the hospital, in the period 1859-1868, died.

The reports of admissions of male patients to Bourton and Moreton Cottage Hospitals were less detailed but recorded mostly identical causes. Here too, patients presented with injuries resulting from workplace accidents: cases of 'severe concussion of brain', 'laceration of hand with amputation', 'laceration of arm by machinery', 'crushed fingers', 'severe burns from explosion of mineral oil', 'traumatic gangrene arm' and 'fractured thigh and pelvis' all resented to the two hospitals. Almost all admissions in this category had resulted from injuries caused by agricultural equipment, accidents involving carts and horses, burns, scalds and building and excavation works.

In 1877, Sir Henry Burdett published a second edition of *Cottage Hospitals*, which included data on amputations carried out in a range of cottage hospitals in England & Wales. In addition to the types of accident described above, he found all manner of injuries directly related to local industry: these included a male railway accident victim treated at Malvern Cottage Hospital whose right leg was 'torn off above knee'; an example from Bourton Cottage Hospital of a nineteen year old male whose leg had been caught and held in a waterwheel; and from Grantham Cottage Hospital, a triple fracture of both bones and a 'crushing soft parts' of the legs of another nineteen year old male. There were a small number of female accident victims listed, including one (from South Lincolnshire Cottage Hospital) whose comminuted fracture of the leg was caused by a 'thrashing' machine'.³⁷ These limited statistics suggest that serious accidents resulting from the use of machinery were a common cause of admission to the rural cottage hospitals and support the findings in this thesis that one of the primary stimuli for the opening of cottage hospitals was to deal with the aftermath of increasingly violent workplace injuries resulting from

mechanisation. Burdett's study was carried out in order to compare success rates of dealing with fractures at cottage hospitals compared with voluntary hospitals. He chose University College Hospital in London as an example of the latter, and surveyed forty-four cottage hospitals. His result indicated that while nearly 26 per cent of amputations at University College Hospital resulted in death, that figure was only 19 per cent in cottage hospitals.³⁸

Railway construction was particularly hazardous, as shown by an example from Cranleigh of a twenty-one-year-old navvy, who presented with horrific injuries following an accident at work:

[he had] a fracture of the scapula the lower angle of which was torn from the parts beneath by a truck which had passed over him. Also with a wound of the scalp, extending from the left ear to the top of the head, the scalp being taken off so as to expose the whole of the temporal and left parietal bones. Also, a deep wound of about an inch and a half in length, at the back of the head, exposing the bone.³⁹

Astonishingly, despite these grave injuries, he was discharged 'well' after 105 days. The Trustees Report published in the Annual Report of Cranleigh Village Hospital, 1864, commented that:

the admission of many railway accidents, which could not have been successfully treated in the huts of the navvies, and which did not admit of removal to any great distance, has made the Village Hospital instrumental in saving lives as well as alleviating the severe and protracted sufferings of the men in the terrible accident cases.⁴⁰

Bourton Cottage Hospital Annual Report for 1876 also drew specific attention to the number and severity of railway accidents and their impact on hospital finances:

There were 17 males and 1 female admitted from the works in progress on the Banbury and Cheltenham

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Railway. Of these, many were cases of severe injury, requiring not only surgical relief, but much nursing, whilst from the very nature of the injuries, as well as from the constitution and habits of life of men of this class, there was a large demand in the way of extras, as Beer, Wine, etc.⁴¹

The railway was being built to give access to local ironstone mines and was described in *Grace's Guide* as exceptionally difficult to construct, comprised of tunnels, viaducts, bridges, deep rock cuttings and embankments.⁴²

The main causes of admission which fell under the general heading 'Joints Bones & Muscles (JBM)' at Cranleigh and Moreton included rheumatism, necrosis of various bones and various disorders of joints, which were possibly of tubercular origin (see Table 4.4). Such conditions were the second most common causes for admission at these hospitals. Skin diseases were also prevalent at Cranleigh, accounting for over 10 per cent of admissions; they included leg ulcers, abscesses and eczema which may have had a number of origins including limited diet, poor personal hygiene and inadequate living accommodation. At nearby Bourton admissions for dermatological conditions was lower (6.5 per cent), possibly because they were dealt with as out-patients at the hospital dispensary.

Unlike the other two hospitals, Bourton admitted a number of patients suffering from diseases related to the digestive system. Common complaints included rectal ulcers, abscesses and fistulas, constipation and haemorrhoids, and liver disease which may have been caused either by alcoholism or hepatitis. The numerous rectal abnormalities suggested dietary deficiencies were the cause, but the descriptions were too brief to be certain.

At all three hospitals, between 30 to 40 per cent of male patients in the Disease Groups above were discharged within twenty-eight days, and about 80 per cent after seven weeks, an indication perhaps that efforts were made to apply the 'discharge after four weeks' rule. A long duration of stay was not associated with any particular medical or surgical cause and no pattern could be discerned

between patients admitted for the leading three causes of admission. In fact, discharge statistics in this study indicate that effective recovery prevailed over arbitrary discharge after a fixed period (or medical need took priority over petty bureaucracy). Only c.3 per cent of patients remained in hospital for more than 100 days, the longest being 216. Most patients were discharged 'well', 'benefitted' or 'much benefitted'.

Causes of admission: Female patients in three rural cottage hospitals

Female admissions represented 37 per cent of all adult cases admitted to the hospitals (see Table 4.3). The profile of female patients, in terms of cause of admission, differs markedly from that of their male counterparts. Table 4.5 demonstrates the much wider spread of causes which brought women to the hospital, and there was more variety between the hospitals, in contrast to the close similarities seen in the hospitals' male patients, shown in Table 4.4 above.

Table 4.5: Female admissions by Disease Group, as per cent of total admissions of female adults, at three rural cottage hospitals, 1875-1894.⁴³

	Cranleigh	Bourton	Moreton
Admissions females over 13	187	241	293
Reproductive System	14.4	6.6	6.1
Joints Bones & Muscles (JMB)	13.4	9.5	7.5
Digestive System	12.8	11.2	11.9
Growth Nutrition & Decay (GND)	10.7	15.8	7.2
Diseases of the Skin	10.2	6.2	17.1
Circulatory System	6.4	5.8	14.3
Nervous System	4.3	12.9	9.6

The causes for admission of adult females are in stark contrast to those for male patients: the leading causes differ in some significant ways, most markedly in the absence of 'Violence' as a leading cause for admission for female patients; and unlike the male patients which showed some commonality between them in terms of cause of admission, the three hospitals differed quite markedly in terms of their female admissions.

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Analysis of the records of the three hospitals demonstrated very clearly the effect of poor diet upon health of women in these three agricultural communities, particularly those under twenty years old. Analysis of the reasons for admission to Cranleigh showed that diseases of the digestive system and conditions relating to nutrition (GND) accounted for nearly a quarter of patients. Descriptions of women's conditions included: 'gastrodynia by which she was reduced to a state of extreme exhaustion and debility'; 'disordered state of general health'; 'in a state of great debility'; 'anomalous dyspeptic symptoms', 'extreme debility and loss of muscular power of the legs'. Bourton and Moreton, problems with the digestive system also resulted in large numbers of admissions, and included cases of haemorrhoids, constipation, stomach ulcers, dyspepsia, tapeworm, liver cirrhosis and enteric fever. Nutritionally-related disorders (GND) caused the highest proportion of admissions at Bourton (16 per cent) but were significantly less important at Moreton at 7 per cent of total admissions (see Table 4.5) Nearly all admissions at each of the hospitals categorised as GND were described either as anaemia and/or debility, two thirds of which related to very young women (and girls) aged between thirteen and twenty years old.

It is perhaps not surprising that causes of admission of female patients centred on problems with nutrition. The period of analysis of this study (1875-1894) included the period of agricultural hardship which began in the late 1860s. The diet of much of the population was poor, in normal times, but periods of hardship would have been particularly felt by rural women. Food shortages would have exacerbated an unequal distribution of food within the family unit, with the breadwinner taking priority. Economic historians Ian Gazeley and Sara Horrell have observed that 'Nutrition ... emerges as central to any assessment of farm labourers' welfare', commenting that meat and protein were allocated to working men, while the women and children lived on bread, tea and leftovers.⁴⁴ Drawing upon a variety of contemporary sources, which included Purdy's 1860 article on agricultural labourers' earnings discussed above, Gazeley and Horrell examined the constituents of the diet of an agricultural labourer's household. They identified potential iron and vitamin B12 deficiencies, which could be the

cause of anaemia, fatigue and reduced resistance to disease particularly among young women. The number of cases of chlorosis and other conditions related to poor nutrition, which appeared in the hospital records, tend to confirm this. Furthermore, deficiencies in calcium, the vitamin B group and vitamins C and D are related to skin ailments, bone pain, bone and teeth loss and skeletal deformities such as rickets, all conditions with which women in this study presented.⁴⁵

As a result of their study, Gazeley and Horrell estimated that half of all agricultural labourers' households lacked three or more essential nutrients and concluded that 'there is a more consistent relationship between household size and [nutritional] deficiency... and that the majority of agricultural labourers' households suffered some degree of deficiency in most nutrients with the exception of protein.'⁴⁶ This conclusion supports the argument here that many of the women admitted to the three rural hospitals in this study were suffering various forms of malnutrition. Furthermore, at all three hospitals, the women patients were predominantly very young (in the thirteen to twenty age group), at the very point in their life cycles that, according to Gazeley and Horrell, they were most in need of good nutrition to thrive. The records of these three hospitals demonstrate very clearly the effect of poor diet upon health of women in agricultural communities.

Conditions relating to the skeletal system (Joints Bones & Muscles) also figured in the leading causes of admission Bourton and Cranleigh, but less so at Moreton hospitals. These included cases of chronic rheumatism; inflammation of the knee; bursitis; 'necrosis of the middle finger from thecal abscess'; 'painful swelling of the left breast, arising from acute periostitis of the first and second ribs'.⁴⁷ It is possible that many joint diseases were tubercular in origin; for example, a few patients were admitted suffering from Pott's Disease, now known to be spinal tuberculosis. Rheumatic admissions were skewed towards the winter months and almost certainly resulted from inadequate living and working conditions, additional confirmation that patients were drawn from the poorest in society.

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At Moreton, uniquely, there were admissions for spinal curvature, often associated with vitamin D deficiency, and which were treated by the application of a 'Sayres Jacket', possibly because the Medical Officer had acquired specialist expertise in treating the disease.⁴⁸

Cases of skin disease in female patients were particularly prominent at Moreton, accounting for largest proportion of admissions at 17 percent. Such causes of admission were relatively lower at the other two hospitals, but at all three they tended to be clustered around the 30 to 60 age group, although at Moreton there was also a small spike in admissions for the 13-20 year olds. Cases included eczema, leg ulcers and abscesses: '... deep and extensive ulceration of the leg, with sinuses extending from ankle to ankle'; 'chronic lumbar abscess'; 'chronic ulceration of the foot, of a severe character, and disordered state of health.' The overall admissions for skin diseases stood at 10 per cent at Cranleigh, 17 per cent at Moreton and only 6 per cent at Bourton, reflecting a similar pattern for male admissions and reinforcing the explanation that the availability of out-patient treatment through the Dispensary at Bourton was responsible for low admissions to the hospital.

One outlier in the analysis of female admissions was the comparatively high number of cases of reproductive system disorders at Cranleigh compared to the other two hospitals. These cases accounted for the largest group of admissions of cases at Cranleigh (14 per cent), and occurred mostly in women under thirty years old, whereas at Moreton and Bourton such cases were seen less often (6 per cent and 7 per cent, respectively). In the early years (1859-1870), little detail was available on the causes, the only examples being a 'cauliflower excrescence of the *'os uteri'* [related to the cervix] which was removed by an operation, the patient discharged 'well' after thirty-three days; and an ovarian tumour, treated 'by free application of leeches, iodine etc., [as a result of which] the tumour is much reduced in size'. This patient from Cranleigh was discharged after fifty-five days, 'much benefitted'.⁴⁹ In the period 1875-1894 the cause of admission was given in more cases and included many common gynecological problems including prolapse of the uterus, uterine tumours and menstrual problems such as amenorrhoea, menorrhagia and dysmenorrhoea.

The patients were mostly women under twenty, their conditions almost certainly the result of dietary and vitamin deficiencies discussed above. The few cases at Moreton were similar, including vaginal infections of unspecified cause. At Bourton, cases of amenorrhoea and menorrhagia, described as 'Special Female diseases', were treated as Dispensary out-patients.

At Bourton and Moreton hospitals between 13 and 10 per cent of female admissions were attributed to diseases of the nervous system such as chorea, neurasthenia, hypochondriasis and hysteria. The patients diagnosed with chorea (or St Vitus' Dance) were mostly aged between thirteen and seventeen; it is probable that they were suffering from Sydenham's chorea, a disorder which was often seen in children and young adults, and was closely associated with rheumatic fever.

Precisely what symptoms and causes led to the diagnoses of neurasthenia, hypochondriasis and hysteria (which in these records were only attributed to women), is a matter of debate. Which term was used probably depended on the doctor making the diagnosis. Cecilia Tasca and colleagues have described how over many centuries such illnesses were considered to be based in the uterus and outlined the various fashionable 'remedies' proposed as cures in the Victorian period, including marriage and 'pelvic manipulation'.⁵⁰ All three diseases attacked women of similar ages: those with neurasthenia and hysteria were aged between twenty-three and thirty-seven years old and those with hypochondriasis between nineteen and thirty-nine. Unfortunately, no details of treatment were given and they were usually discharged after about seven weeks, either 'well' or 'much improved'. It is interesting to note the very low occurrence of nervous conditions among the Cranleigh female patients.

Each of the three hospitals recorded different length of stay profiles for female patients (see Table 4.6).

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Table 4.6: Length of hospital stay, female patients, three rural hospitals, 1875-1894⁵¹

Duration of stay	Cranleigh %	Bourton %	Moreton %
Up to 28 days	63	33	41
29- 35 days	17	16	35
36- 63 days	13	30	19
Over 63 days	7	21	5

Cranleigh was assiduous in applying the 'four-week rule', over 60 per cent of its female patients were discharged within the time frame laid down, whereas Bourton and Moreton appeared to be more flexible, with the majority of their patients staying more than four weeks (see Table 4.6). It is not clear why the hospitals behaved so differently. The explanation may be simply that demand for beds was lower in Bourton and Moreton; if nobody was awaiting admission, and another day or two might help recovery, the patient may have been allowed to remain. Stays at Bourton were particularly long, over 50 per cent of patents stayed over five weeks (and 21 per cent stayed over nine weeks). At Bourton, the explanation may lie in the absence of a rule dictating maximum length of stay at that hospital. It is more difficult to find an explanation for the longer lengths of stay at Moreton, which may simply be due to a difference in medical practice between Napper and the medical officer at that hospital.⁵²

Child admissions rural cottage hospitals

Children under the age of thirteen comprised 16 per cent of patients in the research sample (see Table 4.3). Violent incidents (predominantly accidents) were the principle causes of admission of children at all three hospitals (see Table 4.7). The early Cranleigh records provided detailed descriptions of the injuries: a six year old (gender not given) was admitted with 'thumb crushed by machinery', resulting in amputation

Table 4.7: Child admissions by Disease Group, as per cent of total admissions of children, at three rural cottage hospitals, 1875-1894.⁵³

	Cranleigh	Bourton	Moreton
Total Number Child admissions	68	101	141
Violence	32.8	20.6	30.5
Joints Bones & Muscles (JMB)	29.7	11.8	24.8
Diseases of the Eye	4.7	1	2.8
Diseases of the Skin	4.7	5.9	5.7
Nervous System	4.7	12.8	5
Circulatory System	4.7	1	2.1
Digestive System	4.7	4.9	3.6
Respiratory System	4.7	1	2.8
Ear Nose & Throat	1.6	13.7	0.7
Congenital Disorder	0	6.9	5

and discharged after 121 days, 'nearly well'; a twelve year old labourer's son was admitted with a fractured forearm, discharged 'well' after forty three days; a labourer's daughter aged eight was admitted with both arm bones fractured; and an innkeeper's son, who had injured his hand in a turnip cutting machine.

An eleven-year-old labourer's daughter was admitted with a dislocated elbow and fracture of the humerus, about whom it was noted, after five weeks in hospital, that [she] 'can use the arm well but cannot quite straighten it. Extension is made daily by means of the screw splint.' She was also discharged 'well', after thirty-six days. At Moreton and Bourton cottage hospitals, causes of admission were similar: lower limb fractures, hand and arm injuries, facial and head wounds, burns and scalds. There were no admissions for childhood illnesses such as scarlatina and measles, mainly because all three hospitals excluded cases of infectious or contagious diseases. Brief details were given in the Moreton out-patient records (for 1883) which did include cases of measles,

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erysipelas and 'human parasites', although as patients' ages were not given it is not possible to identify these as children.

Diseases affecting the musculoskeletal system (JMB) were the second main reason for admission at Cranleigh and Moreton hospitals. The early Cranleigh records provided detailed descriptions of the cases. In May 1860 the son of a pauper labourer (age not given) was 'admitted with necrosis of the large bone of the leg; on admission was suffering from great emaciation and hectic fever'. On 10th of September he was looking well, 'his general health being quite restored [and] several pieces of bone had exfoliated'. He was operated upon on 14 September, under chloroform to remove the diseased portion of bone and Napper recorded that on 28th of the same month that, 'The wound is looking well, and healing fast. A further operation on 1 October removed a piece of shin bone which was necrosing. The boy was discharged, as a convalescent in April 1861 after spending 332 days in hospital.'⁵⁴

In another case, in August 1862, a twelve-year-old son of a pauper labourer was admitted with 'Chronic disease of the hip of seven months standing.' By the end of September Napper noted he had 'greatly improved in health, and is progressing most favourably'. This was a long process: on 4th November he was still in hospital although again Napper noted he 'had greatly improved in health, and the disease of the joint was fast healing.' The young boy was finally discharged in December, after 126 days, 'able to walk well, with a high heeled boot.'⁵⁵

It is probable that both patients were suffering from tubercular disease, although Napper did not identify this as the cause. Where an illness had been recognised as tubercular in origin, the detailed Cranleigh records often included the adjective 'strumous', or described the disease as 'phthisis'. In March 1862, a labourer's daughter, aged twelve, was admitted with, 'Strumous disease of the right knee (White swelling)'. Her general state of health was described as very bad, 'with hectic, and a strong tendency to phthisis.' Her knee joint presented with large deep ulcers, and 'a similar disease [had] attacked the cheek bone, and the bones of the left foot.' The patient left hospital after 318 days to go to

Margate Infirmary (a well-regarded hospital known for its 'sea cures'), 'nearly well, with the exception of a slight lameness.'⁵⁶

Cranleigh later introduced a rule excluding patients known to be suffering from tubercular disease; while from its opening in 1873, Moreton had excluded those suffering from pulmonary tubercular conditions. The brief entries from Moreton Cottage Hospital showed child patients with similar diseases to Cranleigh, including a five-year-old admitted with 'hip joint disease, first stage'; a boy aged eight suffering from 'disease of elbow joint' and another admitted with 'spinal affection'. Some cases had a more specific diagnosis, and were identified as being tubercular in origin such as the eleven-year-old boy admitted in with 'Strumous disease of the glands of the neck.'

Andrea Tanner has argued that the disease profile of patients at the children's hospital at Great Ormond Street was similar to that of their parents, the result of malnourishment and poverty: tubercular diseases, heart and lung complaints and infectious fevers all featured in both child patients and their parents.⁵⁷ A similar pattern has been found in the cottage hospitals in this study (with the exception of infectious fevers, which were rigorously excluded from cottage hospitals). She observed that at Great Ormond Street, 'Diseased joints, probably mostly tubercular, were the single most important cause of admission.'⁵⁸

Bovine tuberculosis (TB), transmitted in infected milk and meat, was a significant cause of the disease in rural populations, living in proximity to infected cattle and compounded by weakened immune systems resulting from poor living conditions and inadequate diet. Historian Anne Hardy has discussed the prevalence of human and bovine TB and found that human tuberculosis accounted for 70 percent of non-pulmonary cases, the remaining 30 per cent being derived from the bovine source.⁵⁹ From the number of patients treated in rural cottage hospitals for diseases of the joints and bone necrosis, many of which appear to have been of tubercular origin, it is likely that the incidence of bovine TB may have been higher in the countryside than Hardy estimated from her London research.

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Despite rules excluding patients with pulmonary tuberculosis, between 4 and 6 per cent of both male and female admissions were described as suffering a range of tubercular conditions, including 'strumous' conditions, tuberculosis or tubercular disease, and the supposedly banned phthisis (pulmonary tuberculosis).

Diverse other causes brought children to Bourton. The common childhood disease, tonsillitis (and other conditions affecting the ear, nose and throat), was seen regularly, mostly in patients under nine years old; while nervous diseases, particularly chorea, were seen in both male and female children along with several cases of paralysis, possibly polio. The early Cranleigh records described one case of chorea in detail.

In 1862 a girl, aged ten, was admitted with chorea 'of a very severe character'. On admission on 1 September she was walking with great difficulty and had 'but imperfect control of her limbs and actions.' After just 19 days in hospital her condition was improving, she 'is much steadier and has more command of herself', Napper records, and by the beginning of November she had completely regained control of her movements and was discharged. Sadly, Napper did not record how this recovery was brought.⁶⁰

Duration of stay of children did not reveal any particular patterns, within or between genders. Most of those admitted as a result of accidents and other acts of violence were discharged after four to six weeks, a few remaining for more than 100 days. Nearly all patients with musculoskeletal complaints had left after five weeks. There were some long stay patients; at both Cranleigh and Moreton, three such patients were kept for more than 100 days, the longest for 226.

Diet and treatment in rural cottage hospitals

It seems beyond doubt that many patients in all three hospitals were admitted for causes attributable to dietary deficiencies. This was clearly understood by

the Medical Officers and much emphasis was placed upon providing good quality, regular meals in a clean environment.

Diet was important to recovery as shown by the extensive details of individual treatments in the early Cranleigh Annual Reports. Diets of meat and wine featured, as in the case of an eight year old boy 'with strumous disease of the ankle joint ... and extremely cachectic state of health', who 'upon a diet of meat and wine, greatly improved' and was discharged after 119 days, 'perfectly recovered'. In another case a 23 year old labourer, 'much prostrated by pneumonia' had improved 'upon a liberal diet with wine and cod liver oil', and was discharged 'nearly well' after seventy nine days. A twenty seven year old labourer's wife, with 'strumous ulceration of the foot', received 'a generous diet', improved quickly, and was discharged convalescent after twenty eight days. Historians Sue Hawkins and Andrea Tanner, in discussing the therapeutic benefits of diet in the recovery of children in hospitals, noted that in many cases all that was required was good food, a warm bed and clean clothes, all of which were provided to cottage hospital patients irrespective of age.⁶¹

Napper published the four diets given to patients in Cranleigh Village Hospital. (see Figure 4.1). The early Cranleigh records emphasised the benefits of a generous diet and contained references to improvements which had resulted from a 'free exhibition of wine', from a 'liberal diet of meat and wine', and by the administration of cod liver oil, port wine and brandy to patients and older children of both genders. This was, especially the case for those admitted with various forms of debility, or suffering diseases of the Joints Bones and Muscles and Diseases of the Skin, and those recovering from amputations.

A large proportion of patients were discharged after between four and six weeks stay, their record usually annotated 'well', 'benefitted', 'greatly improved', etc., or occasionally 'convalescent'. It is unclear what was meant by those terms; at best the patient was in an improved physical condition from a good diet and fractures would have largely mended, but it must be questioned whether an underlying tubercular joint condition was in any way cured.

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Figure 4.1 Cranleigh Village Hospital Diet Tables

Milk diet: All kinds of light puddings, made with milk. Arrow-root, gruel, barley-water, tapioca or sago, boiled in milk, rice, etc. Tea and bread and butter.

Ordinary diet: Meat and vegetables for dinner. Bread, butter, cheese. Tea or coffee with milk and sugar. Daily allowance of meat - $\frac{3}{4}$ lb, uncooked, including bone. Bread as required.

Meat diet: Meat twice a day, average quantity about $1\frac{1}{4}$ lbs daily. Eggs sometimes substituted for breakfast. The rest, same as Ordinary diet.

Extraordinary diet: Meat, fish, poultry etc. Wine, brandy, porter etc., as specially ordered by the doctor.

Butter, $\frac{1}{2}$ lb per week. Cheese, as required. Tea, 2 oz. per week for adults, 1 oz. for children. Sugar, $\frac{1}{2}$ lb per week with extra allowed for puddings.

The quantity of Wine, beer, spirits etc., to be given to a patient is regulated by the special order of the doctor. None to be given unless ordered.

Mutton is the meat most invariably used; generally the leg, as more economical than the other joints.

Usual Meals

Breakfast: Bread and Butter	Dinner: Bread, Meat and Vegetables
Tea: Bread and Butter	Supper: Bread and Cheese

Bourton published a limited Dietary in its Annual Reports (see Figure 4.2), which was also displayed in the wards. The diets did not include fruit and eggs, and vegetables were not shown in Bourton's dietary, but would have been provided. Annual Reports contain many references to gifts of eggs, fruits in season, rabbits, poultry, wines and spirits, but not vegetables which it is assumed were bought or grown in the hospital garden. There were occasional references to the hospital having a garden but whether that was for therapeutic

reasons or vegetable cultivation remained unexplained. Visitors were prohibited from bringing food items to patients.⁶²

Figure 4.2 ‘Diet Table for Bourton. Ordinary allowance for each Patient per week.’⁶³

Male Adult	Articles	Female or Child
Three pounds	Meat	Two pounds
Six ounces	Butter	Four ounces
Eight ditto	Sugar	Eight ditto
Seven Pints	Milk	Seven pints
As Required	Bread, potatoes and rice or sago pudding	As Required
‘Extra diet: Beer, wine, or spirits, etc., etc. Allowed by special order of the Medical Officers. To be entered in the Diet Book, and on the Admission Card.’		

While neither Bourton nor Moreton Cottage Hospitals gave details of individual patients’ diets, in January 1885, Canon Wheeler of Welford, near Shipston on Stour, wrote to Lord Redesdale, President of Moreton Cottage Hospital, with a long list of complaints which was read into the minutes of the hospital’s Annual General Meeting and reported in the local paper. On the diet, he wrote, ‘the diet of the patients is extravagant ... each patient in 1884 cost weekly the sum of 17s/1d [...] it is also bad for the patients themselves to have to change suddenly when discharged from the high diet of the hospital to their own meagre fare.’ At a later meeting, the chairman read a rebuttal from the matron: ‘The sum of 17s/1d complained of by the Rev. G D Wheeler includes food, stimulants, wages, extra nurses, surgical instruments, gas, coal, printing and care of gardens. The cost of diet was 7s/0¼d, reckoning both patients and servants.’⁶⁴

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Edward Waring, an early advocate and promoter of cottage hospitals, observed that: 'A good diet was essential as an aid to recovery as the 'labouring classes' when overtaken by sickness are even less able to provide nourishing and regular food than normally so.'⁶⁵ A hospital provided wholesome food, properly prepared and regularly given and 'the port or other wine [...] is superior to anything which the patients could procure [...] and always equal to the demand'.⁶⁶ Waring also noted that the diet at Moreton was 'subject to such alteration [...] by the Medical Officer. With him rests the power of ordering extras, as eggs, poultry, fish, jellies, wine, brandy, ale or porter.'⁶⁷

Very little information was published in the Annual Reports on the surgical, medical and therapeutic processes used, other than occasionally noting provision of a healthy regular diet, as discussed above or reference to the use of anaesthetics, usually chloroform. The early Cranleigh records proved to be the most informative, but only included what Napper had considered to be the most interesting and/or unusual treatments, which demonstrated both his knowledge and skills.

The use of chloroform was emphasised in reports, probably to demonstrate Napper's skill in administering it safely and successfully. In June 1860, for example, the 14-year-old daughter of a labourer was 'admitted with a hare lip which rendered her a hideous object' and operated on 'under the influence of chloroform'. The operation, at which Napper was assisted by Mr Taylor of Guildford, was considered a great success and she was discharged after four weeks.⁶⁸

In Cranleigh's Second Annual Report, for 1861, Napper described an operation performed on a ten-day old baby (suffering from what sounds like an extreme umbilical hernia). The operation must have involved innovative surgery for a rural practice and probably not possible except in a hospital environment:

'Malformation of the integuments of the stomach, by which the bowels protruded through an opening at the navel of nearly 8 inches in circumference covered only by a thin

membrane. Performed the plastic operation by removing the membrane and uniting the pared edges of the skin, having previously replaced the protruded bowels. The child bore the operation well, but died on the following day.⁶⁹

Later in the same Annual Report, Napper demonstrated how his skills had improved the life of an agricultural labourer admitted with a large hydrocele which he had suffered for some twenty years. Napper 'extracted nearly a quart of fluid by tapping' and the patient was discharged well.⁷⁰

There is only limited information on the types of medication administered or equipment used in the early Cranleigh Annual Reports, but there were occasional references to the application of leeches, poultices and blisters; the use of catheters for urinary disorders; and injections of iodine following the draining of hydroceles and to treat abscesses. Lower limb fractures and knees were supported during recovery by leather splints, while a labourer with stomach cancer was 'given repeated hypodermic injections of morphia' for pain relief. A child with vitiligo, a skin disease which affects pigmentation, was eventually partially cured by 'frequent applications of creosote'.⁷¹

Most medicines were herbal, some containing narcotics such as heroin and cocaine and heavy metals, and may have been made up by Napper, a registered apothecary, although a chemist, listed in the 1861 Cranleigh census, may also have provided medicines.⁷² Early prescription books from the 1870s, held by the Thackray Medical Museum, contain recipes for eardrops, headache preparations, cough mixtures, scalp washes, liniments, enemas, eye drops, ointments, pills, suppositories and gargles, remedies which may (or may not) have been of any effect upon the illnesses and diseases of patients in the early hospitals.⁷³

Where operations and amputations were necessary, Napper was assisted by other surgeons, often based in Guildford, and occasionally by his son Arthur Napper who later took over his practice and the hospital when Napper retired.

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This may have indicated that nearby doctors lacked essential skills to assist or Napper wanted to retain sole rights over 'his' hospital domain.

Town-centred cottage hospitals

Three town-centred cottage hospitals of Lydney (Gloucestershire), Chorley (Lancashire) and Braintree (Essex) were selected for this study as comparators for the rural hospitals, each differing significantly from them and each other, both in terms of the industries and populations served and their geographical location. While the rural hospitals were considered as a single group, the differences found in the town-based hospitals required each to be analysed separately, although there were commonalities in the social status of patients and causes of admission, particularly males and children.

In the late nineteenth century Lydney was a busy port on the River Severn, well connected by railways serving industries which included coal, stone quarrying, tinsplate, timber and agriculture. Its hospital opened in 1882. The number of beds was not recorded, but it is estimated that it had between four and six based upon its annual admissions compared to hospitals where bed numbers were recorded. An out-patient service was provided, dealing with between five and eight patients each month, some or possibly all of whom were treated at home. Out-patient cases included an 'Infant suffering with acute bronchitis, attended occasionally and poulticed etc.'; and a case of 'Pneumonia – Visited frequently till patient recovered.'⁷⁴ Most out-patient ailments consisted of minor complaints such as ulcers, boils, cuts and contusions, but there was a good number of respiratory illnesses such as bronchitis, pneumonia and pleurisy in the winter months and some childhood diseases such as diphtheria and meningitis which proved fatal.⁷⁵

Chorley was an industrial town with a population of about 20,000 in 1893, when its hospital opened, located about twenty miles north of Manchester with extensive cotton and yarn mills, railway wagon manufacturers, calico printers, fabric bleachers, coal mines and quarries.⁷⁶ A dispensary had been established about 1828 which, in 1839, had served just under 700 patients.⁷⁷ The dispensary's Annual Reports provided an illuminating insight into the illnesses

and diseases of the inhabitants and the statistics were used by the House Surgeon, Septimus Farmer, to illustrate his plea 'that many valuable lives would be saved, had there been a properly managed Cottage Hospital in the town', a plea repeated each year with increasing vehemence. The final Dispensary report for November 1892, by which time Farmer had retired, extended congratulations to the people of Chorley on the erection of the cottage hospital. It noted that there had been an increase in attendances in that year, attributed to 'the depressed state of trade, and the severity of winter which caused outdoor labourers to be thrown out of work'. There had also been sporadic cases of measles, diphtheria, scarlet fever, typhoid and smallpox, 'but they never assumed anything like epidemic form'.⁷⁸

The hospital, illustrated on the cover of the *Annual Report* for 1894, was a substantial building, but only contained seven in-patient beds. It also incorporated the dispensary. It was financed by Alderman Henry Rawcliffe, a local brewer, (who became hospital President) in the tradition of Victorian civic pride and philanthropy on land donated by the Very Reverend Lennon, showing that the practice of Church involvement in hospital foundation was still very much alive in the early 1890s.⁷⁹

Braintree with Bocking in Essex was an agricultural and textile town with a good railway link to London which facilitated distribution of mourning crepe and silk from mills in Bocking and nearby Halstead owned by the Courtauld family and by Warner & Sons. Sydney Courtauld founded the four-bed Braintree & Bocking Cottage Hospital in 1886, a further example of industrial philanthropy.⁸⁰ In the 1880s Courtauld's mills employed about 1300 workers, most which were women, out of a population of about 5,000.⁸¹

Patient records for the three hospitals were analysed to determine their gender and age characteristics. (see Table 4.8).

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Table 4.8: Admissions by gender and age, three town-centred cottage hospitals, 1886-1907.⁸²

Hospital	Male over 12		Female over 12		Child under 13		Total admissions ⁸³
	Admissions	%	Admissions	%	Admissions	%	
Lydney	127	58	49	18	42	19	218
Chorley	350	52	144	21	179	27	675
Braintree	189	25	349	47	209	28	747
Totals	666	41	542	33	430	26	1639

The most striking difference between the town and rural hospitals was the much larger percentage of child patients at the former hospitals. In the rural hospitals children accounted for 16 per cent of admissions whereas at the town-centred hospitals they accounted for over a quarter of patients (see Tables 4.3 and 4.8). This difference was particularly the result of admissions to Chorley and Braintree, where child patients reached nearly 30 per cent of all admissions.

A second outstanding feature of Table 4.8 is the very high numbers of female patients at Braintree, and the comparatively low admissions for women at the other two town-based hospitals. At Braintree female patients represented nearly 50 per cent of admissions, in contrast to 25 per cent at both Lydney and Chorley Cottage Hospitals. (At the rural hospitals such admissions ranged between 35 and 39 per cent – see Table 4.3). Analysing young adult female admissions (13-30 years of age) between the three sites showed an even larger contrast; at Braintree these represented 65 per cent of all admissions, and about 30 per cent at the other two hospitals. Possible reasons for the difference in male/female ratio at Braintree is discussed below in a more general discussion of Female Admissions.

Social Status of patients at the town-based hospitals

At Chorley Cottage Hospital, patients of both genders and all ages were admitted. Children under thirteen were identified by the parent's occupation but not by gender. Table 4.9 shows the occupations of patients recorded between 1893 and 1903, during which there were 854 admissions.

Twenty-two per cent (184) of all admissions were male labourers or children of labourers, while at least 15 per cent were miners and quarrymen and their dependents.⁸⁴ The predominance of this latter group of workers is surprising as there were few references in the subscriber lists to mine and quarry owners and none to mining unions. Subscriptions were received, however, from colliery workplace collections: Ellerbeck Colliery in nearby Adlington collected £20 in both 1896 and 1897. The relatively low number of male mill workers and their

Table 4.9. Occupations of Chorley patients 1893-1904⁸⁵

	Males over 12	Child's parent		Females over 12
Labourer	139	45	Housewife	85
Collier/quarryman	95	33	Housekeeper/servant/ cook	49
Tradesman ⁸⁶	42	22	Weaver/cotton worker	22
Carter/bargeman/ driver	28	8	Charwoman	21
Weaver/cotton worker	20	35	Others ⁸⁷	15
Others ⁸⁸	122	51		
Total	446	194		192

dependents (7 per cent) was also surprising, given the financial contributions made by the workers' associations and the large number of weaving and spinning works in the town, although, given the tendency in the census to under-report women's work it is possible the same omissions took place in these records. It also possible that some of the 'housewives' treated were the wives of mill workers. The numbers of housekeepers, cooks and charwomen could indicate the presence of lodging houses, a feature of fast-growing industrial towns of that period which attracted incomers seeking work, and also a growing middle class with surplus income available to employ domestic help.

It is highly probable that many admissions were the very poor. In the *1st Annual Report, 1894*, patients' payments comprised just under £5 of the hospital's income of £521 and in 1899, fifty-nine of the eighty-six admitted paid nothing.

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As late as 1903, the income from patient fees was only £34 out of £888 total receipts.⁸⁹

At Lydney Cottage Hospital, as at Chorley, labourers and their dependents made up the largest group of patients (see Table 4.10). Analysis of 'Other' occupations identified waggoners, draymen, carters, gardeners, butchers, jewellers, grooms and masons amongst male patients and dressmakers and charwomen amongst the females. Schoolchildren were specifically identified as a category, contrasted with the practice in the early rural cottage hospitals and Chorley in which child patients were usually described as 'child of' followed by the father's occupation. There is little doubt that most patients were drawn from the poor working class but no paupers were identified.

Table 4.10: Occupations of Lydney patients, 1897-1904.⁹⁰

Occupation Male			Occupation Female		
over 12	No.	Child under 13	over 12	No.	Child under 13
Labourer/Ag. Lab.	45	6	Housewife	22	
Tin worker	18	2	Servant/domestic	13	1
Railway worker	9		None/widow	7	
Collier, quarryman	7		Schoolgirl		4
Sailor/fisherman	7		None	2	
None	8	4	Others	7	6
Schoolboy		15	Totals	51	11
Others	30	3			
Totals	124	30			

The Annual Reports for Braintree and Bocking Cottage Hospital for the period 1886-1907) contained nearly 700 records which listed occupation for patients, including that of the parent of a child admission. Unlike at Chorley and Lydney, where more than half of the patients were male and a quarter female, the proportions at Braintree and Bocking were significantly reversed. Here, female patients accounted for 46 per cent of all admissions, while males accounted for 26 per cent and children 16 per cent of cases.

Table 4.11. Occupations of Braintree Cottage Hospital patients 1886-1907⁹¹

Occupation – male			Occupation - female		
	No.	Child under 13		No.	Child under 13
Labourer/factory hand	87	25	Housewife or wife	118	28
Tradesman ⁹²	36		Servant and domestic	72	3
General workers	32	17	Mill hand/factory hand/weaver	42	
Farm workers	7		Dressmaker/needlewoman	14	
Schoolboy		46	Schoolgirl/at home	18	39
None	3	14	None	11	3
Other	8	5	Other including widow	33	5
Totals	173	109		308	78

As discussed in previous chapters, Braintree Hospital had been founded by the major local employer, Courtauld (a major textiles manufacturer), so it had been expected that a substantial number of patients would be female millworkers, yet there were few identified as such in the records. As discussed above, some of the ‘housewives’ might have been employed in the mills although simply described as spouse of a labourer, of which there were a considerable number.⁹³ The large number of servants and domestic servant, mostly under thirty years old, showed that the town had wealth with a substantial number of households able to provide employment and pay the weekly hospital fee.

Fewer than 2 per cent of all admissions were categorised as having no occupation at the time of admission and it has been assumed that when a male occupation was given the patient was employed at the time of admission and, probably, so was the husband of a housewife and/or parent of a schoolchild. If so, Braintree’s admissions conformed to Waring’s 1867 criterion of the ‘deserving poor’ and their dependents, quite different to the ethos of the rural

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hospitals and Chorley, where it seems a significant number of patients were supported by the poor law. Two thirds of male occupations were labourers, factory hands or general workers, the remainder employed in low skill jobs such as fish cleaner, gardener, railway porter, mat or brush maker and errand boy (grouped under 'Other' in Table 4.11). But, like other hospitals in the study, most patients could not pay the weekly fee; in 1886 their contributions comprised just under 10 per cent of the hospital's annual income, a proportion which varied little over the subsequent years. The conclusion must be that 'occupation' did not imply that the person was employed at the time of admission and so it is also likely that a large proportion of Braintree's patients were paupers or the very poor.

Of the female admissions at Braintree, 23 per cent were servants, nearly all aged under thirty. The substantial number of those described as wives, 17 per cent, were probably married to textile workers or were employed but not recorded as such, because they were married.

Male admissions, town-centred cottage hospitals

Violent incidents (mainly accidents) were the main cause of male admission in all three town-based hospitals, representing, on average, about 40 per cent of patients (see Table 4.12).

Analysis of reasons for admission published in the Annual Reports, showed a set of causes which closely mirrored those of the patients admitted to rural hospitals: lower limb fractures, some comminuted, rib and spine fractures, hand injuries, amputations following accidents, head wounds, burns and scalds, skull fractures, concussion and hernias. Some were clearly the result of industrial accidents such as eye injuries to an electro-plater, burns suffered by tin workers, carters who presented with crushed limbs and, at Chorley, colliers and datallers (causal labourers) admitted with serious injuries.⁹⁴ In 1894 Chorley's Medical Officer's report noted that 'We would especially draw attention to the large number of persons who have received treatment for injuries by machinery and other accidents, viz. 161. Thirty-one of these were admitted into the

hospital [*who*] previously would have had to be taken at great inconvenience and risk to Preston or Wigan.⁹⁵

Table 4.12: Male admissions by Disease Group, as per cent of total admissions of male adults, at three town-based cottage hospitals, 1886-1907.⁹⁶

	Chorley	Lydney	Braintree
Violence	46.8	34.9	30.7
Joints Bones & Muscles (JBM)	11.5	9.5	18.0
Digestive System	8.6	11.1	11.1
Respiratory System	8.3	4.8	2.1
Diseases of the Skin	6.6	7.1	8.5
Circulatory System	4.6	18.3	3.7
Cancer	2.3	0.8	9.0

Digestive System illnesses contributed on average 10 per cent of male admissions at all three hospitals. These included: ascites, hernias, haemorrhoids and anal fistulas, gastritis and gastric and duodenal ulcers. Some cases of alcoholism were recorded so it is possible that excessive drinking had contributed to other admissions, for example accidents.

Admissions relating to problems with the musculoskeletal system (JBM) were the second most common cause of admission at both Chorley and Braintree: including lower limb joint diseases such as exostosis, necrosis and synovitis, rheumatism and rheumatoid arthritis. Chorley recorded a few cases of gangrenous toes and fingers. This was a similar pattern as seen in the rural hospitals.

Lydney was only hospital in which Circulatory System diseases were significant, accounting for 16 per cent of admissions and representing the second most common cause for admission here. Conditions in this category included heart disease or 'rheumatism with heart disease'. A small number of tin workers were admitted suffering cirrhosis, cardiac dilation and anasarca (abnormal fluid retention affecting the whole body) today understood to be caused by liver

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failure and/or heart failure and severe malnutrition. Given these conditions were only seen in tin workers it is possible that the industrial process was causal, possibly related to repeated exposure to toxic fumes from the electrolyte used in the production process, sulphonic acid.⁹⁷

The relatively high proportion of admissions for cancer at Braintree is difficult to explain, perhaps relating to the admitting doctor's personal interest rather than a higher incidence of cancer in this part of Essex?

The periods of time spent in hospital varied between the hospitals. At Chorley and Lydney, about 60 per cent of patients admitted as the result of accidents (Violence) were discharged after a five-week stay, yet at Braintree this figure was only 25 per cent. It is conjecture, but this hospital, with only four beds, small even by the standards of the time, may only have admitted the most serious cases. Most patients staying more than five weeks were labourers; the longest being 148 days with a fractured femur, knee joint and metacarpal bones.

Female admissions, town-centred cottage hospitals

Unlike male admissions, which were dominated by accidents, there is no one predominant cause of admission for women at the town-centred hospitals (see Table 4.13). The sample size for Lydney Cottage Hospital was rather small to yield valid results (there were 49 records in the dataset, compared with 349 for Braintree and 144 for Chorley) and has therefore not been included in the following analysis. Causes of admission were similar to those discussed below.

Patients admitted with Diseases of the Skin at Braintree and Chorley hospitals suffered mostly from ulcers, particularly of the legs, and from abscesses, tumours and eczema. Half of these patients were under thirty years old and about one third aged over fifty. Chorley recorded similar ailments and, uniquely, had admissions for mammary abscesses. The median stay at Chorley was five weeks, the longest being 112 days.

Table 4.13. Female admissions by Disease Group, as per cent of total admissions of female adults, at three town-based cottage hospitals, 1886-1907.⁹⁸

	Braintree	Chorley
Joints Bones & Muscles	16.6	8.3
Diseases of the Skin	12.3	17.4
Circulatory System	14.6	6.3
Respiratory System	2.9	6.3
Digestive System	15.2	14.6
Reproductive System	7.4	7.6
Violence	4.3	11.8
Cancer	6.0	16.7

Admissions for musculoskeletal problems (JBM) were only significant at Braintree and included rheumatism and rheumatoid arthritis, spinal diseases and sciatica, hip and knee necrosis and synovitis, of which over 60 per cent were under thirty years old. No occupation predominated other than the generic description of housewife.

At Braintree and Chorley Cottage Hospitals, problems connected to the Digestive System were also prevalent, representing c15 per cent of female admissions each. At Braintree, patients mostly presented with gastric ulcers, gastritis and haemorrhoids; 70 per cent were under thirty years old. At Chorley, by contrast, hernias, some strangulated, were the main reason for admission in this category, most of who were aged over thirty. One surprising omission from leading causes of female admission at the town-centred hospitals were problems connected with nutrition. At the rural hospitals this had been a significant cause of admission for female patients (at Bourton for instance, nutritional problems were the leading cause accounting for 16 per cent of all female patients), but in the town-centred institutions such conditions were seen much less frequently: Chorley and Lydney admitted only one case each while at Braintree the figure was 6 per cent. This suggests (tentatively) that workers

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(and poor people's) diet in the towns under investigation may have been of better quality than that of the rural populations in this study.

Chorley alone recorded significant numbers of patients experiencing illnesses connected to their reproductive system such as metritis and endometritis, fibroids, uterine polyps and tumours, and post-natal complications. Cancers were mostly of the breast and all except two cancer patients were aged over thirty.

One key difference between female and male patients, in both rural and town settings is the frequency of accident admissions. While the 'Violence' category was the leading cause of male admissions in all six hospitals (see Tables 4.14), such causes were almost absent for the female patients.

Table 4.14. Accident admissions to six cottage hospitals, as per cent of admissions by gender.

	Cranleigh	Bourton	Moreton	Chorley	Braintree	Lydney
Male	30	26	36	47	31	44
Female	5	5	4	12	4	4

Child admissions, town centred hospitals

The sample size for Lydney Cottage Hospital was again too small to be subjected to detailed analysis. Reasons for admission were similar to those discussed below. Accidents were a major cause of admission for children at both hospitals. Types of accident were similar to those seen in the rural hospital: burns and scalds concentrated amongst the youngest indicating domestic accidents, wounds to feet and toes in older children, and lower limb fractures. The longest stay, 248 days, was a six-year-old admitted to Chorley suffering burns.

Table 4.15: Child admissions, both genders, by top five Disease Groups, at two town-centred cottage hospitals, 1886-1907.

	Braintree	Chorley
Joints Bones & Muscles (JBM)	18.7	16.3
Violence	14.8	29.8
Reproductive System	11.5	2.8
Ear Nose & Throat	11.0	5.7
Diseases of the Skin	7.2	11.2
Tubercular Disease	6.2	7.3

Children admitted at both hospitals with diseases of the musculoskeletal system (JBM) were suffering from rickets, spinal curvature and many occurrences of hip and joint necrosis and rheumatism, some of which may have been attributable to poor nutrition and some to tubercular infections. Skin complaints at Chorley, which could also have been connected to nutritional deficiencies, included eczema and abscesses while septic and suppurating neck glands were possibly tubercular in nature.

All but one of the Braintree child patients with problems associated with their reproductive system were male, admitted either for phimosis or to be circumcised. Ear Nose and Throat admissions were for removal of tonsils or adenoids.

Conclusion

Most early cottage hospitals were in agricultural communities, had between four and eight beds and admitted between twenty-five and sixty poor and pauper patients each year. Town centred cottage hospitals which began to appear from the late 1870s typically had between eight and twelve beds but the three analysed in the research sample were closer in bed numbers to the rural set and similarly admitted mostly the poor and paupers.

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The patient records of three rural and three town-centred hospitals provide insight into the diseases and accidents experienced by approximately 4,000 poor and pauper patients in the last quarter of the nineteenth century. The patients represented some of the most seriously ill in their communities, not forgetting that those whose conditions needed more sophisticated treatment were sent to the nearest voluntary hospitals. Hospitals' rules excluded ante-natal cases, those suffering from infectious and contagious diseases and (in theory) pulmonary tuberculosis, along with the terminally and mentally ill - even though a few patients suffering such illnesses were admitted.

Cranleigh Village Hospital patients were either paupers or very poor agricultural labourers and their dependents. Those at Bourton and Moreton were drawn from a similar rural demographic. Much of their disease burden was closely associated with poor diet and inadequate nutrition. The town-centred cottage hospitals at Braintree, Chorley and Lydney were occupied in the main by labourers (and their dependents) or those employed in low wage jobs, or who were unemployed through sickness. Annual accounts showed that at all six hospitals patient payments were very small, clearly indicating that most were unable to pay or, in the example of Chorley, had contributed indirectly through workplace contributions, shown as annual subscriptions.

The results of the analyses of the patient records of the six hospitals were very clear. Work related injuries caused by agricultural and industrial machinery were responsible for between 30 and 40 per cent of adult male admissions across both sets of hospitals and a further 25 per cent resulted from diseases and illnesses caused by dietary deficiencies, poor living conditions and non-pulmonary tuberculosis. Patient populations were also young, half were under thirty years old.

The results for female admissions were less consistent across the hospitals. About 40 per cent could be attributed to poor nutrition: the presence of maladies described as anaemia, debility, chlorosis, exhaustion, cutaneous ulcers and various joint diseases all suggest this. In two of the hospitals (Bourton and Moreton) admissions 'female complaints' such as 'nervous debility',

'neurasthenia' and 'hysteria' were in the leading group of causes of admission. Just under half such patients were under 30 years old.

Perhaps not surprisingly, a quarter of child patients were admitted following an accident, some of which had domestic causes such as scalds and burns but in children between nine and twelve, machinery was largely responsible. Diseases of joints, probably tubercular in origin, contributed another quarter of admissions in two of the hospitals but there were only a few cases of rickets, an indication perhaps that such food as was available was allocated to children (and the male breadwinner) to the detriment of the health of the mother. Childhood diseases such as measles and scarlatina were excluded but there was limited evidence that treatment was provided where the hospital had a dispensary.

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- ¹ *Cranleigh Village Hospital, 1st Annual Report, 1860*, Rules 1, 4 and 5. Surrey History Centre (SHC). In some early cottage hospitals, forms of recommendation were assessed by a Committee.
- ² Albert Napper, *The Advantages Derivable to the Medical Profession and the Public from the Establishment of Village Hospitals*. (London: H K Lewis, 1864), p.7.
- ³ *Ibid.* In the 1860s there were no paved roads in Cranleigh, and the outlying villages were often inaccessible in winter other than by horse when the local Wealden clay turned to deep mud.
- ⁴ *Epsom and Ewell Cottage Hospital, 1st Annual Report*, (SHC).
- ⁵ *Charlwood and Horley Cottage Hospital, 25th Annual Report*, (SHC).
- ⁶ *Chorley Cottage Hospital, 1st Annual Report 1893*, Rule 31, Lancashire Record Office. The Rules of Braintree Cottage Hospital, Essex (opened 1886) have not been found.
- ⁷ Chapter 3 discusses the financing of cottage hospitals.
- ⁸ Lydney Cottage Hospital Records, Gloucester Record Office.
- ⁹ *Bourton Cottage Hospital Annual Report, 1885*, Gloucester Record Office.
- ¹⁰ *Bourton Cottage Hospital Annual Report*, Gloucester Record Office
- ¹¹ Patients were identified by initials which enabled some to be located in the censuses for Cranleigh, providing further detail on their social status and family.
- ¹² An early version featured in the first two editions of the monthly magazine *The Medical Mirror*.
- ¹³ Napper, *The Advantages Derivable to the Medical Profession*.
- ¹⁴ The suffix 'Village Hospital' was Napper's preferred description and it is still in use today.
- ¹⁵ Edward John Waring, *Cottage Hospitals: Their Objects, Advantages and Management*, (London, John Churchill & Sons, 1867).
- ¹⁶ Elizabeth Earle, *A Noble Institution, Totnes Cottage Hospital*, (Totnes: Totnes Community Archive, 1977).
- ¹⁷ *Bristol Mirror*, 23 July 1864, quoted in *Wrington Village Records* (Bristol: University of Bristol, Department of Extramural Studies, 1965/66).
- ¹⁸ Cranleigh was included within the Hambledon Union, despite its great distance away. Peter Higginbottom, *The Workhouses*, <http://www.workhouses.org.uk/Hambledon/>
- ¹⁹ Cranleigh Village Hospital Annual Reports 1 to 4, (SHC).
- ²⁰ Identification of parish clergy, farmers and gentry was obtained from the 1861 census, Cranleigh History Society and from Annual Reports.
- ²¹ Frederick Purdy, 'On the Earnings of Agricultural Labourers in England and Wales, 1860', *Journal of the Statistical Society of London*, 24/3 (1861), pp. 328-373. Purdy defined earnings as consisting of weekly money wages to the labourer and his family or piecework paid to him alone plus additional payments at harvest time and, for some, part payment in food, fuel or ground to cultivate and/or a cottage free or at a reduced rent.
- ²² *Ibid.*, p. 348 and Table 17.
- ²³ *Ibid.*, p. 334 and Table 17
- ²⁴ *Chorley Cottage Hospital Annual Report, 1896*.
- ²⁵ *Braintree & Bocking Cottage Hospital, 15th Annual Report, 1900*, Essex County Archive.
- ²⁶ This problem is discussed in Chapter 1.
- ²⁷ The Cranleigh database (1860-1902) names 821 sponsors of which nearly 50% (401) were members of the clergy.
- ²⁸ The Moreton database named 620 named sponsors of which 167 (or 27 per cent) were clergymen.
- ²⁹ The role of the clergy in rural communities is discussed in more detail in Chapter 1.
- ³⁰ See Research Methodology (Appendix 5) for a description of the databases constructed from the hospital admission records, which form the basis of this table.
- ³¹ Total admissions for each hospital were higher than shown in this analysis as some records did not contain information on gender or age. Total admissions for the period 1875-1894 for each hospital were Cranleigh, 550; Bourton, 656; and Moreton, 786.
- ³² Patient Admissions Databases for Cranleigh, Bourton and Moreton Hospitals. The table includes the top five cause of admission at each hospital. The disease groupings used in this analysis are explained in the Research Methodology (Appendix 5). It should be noted that the term 'Violence' was used to denote any incident of unnatural injury including accidents and intentional injury. In almost all cases in this study cases coded as 'Violence' relate to accidents.

- ³³ Napper, *The Advantages Derivable to the Medical Profession*, p.1.
- ³⁴ *Cranleigh Village Hospital Annual Report, 1860*, patient no. 2.
- ³⁵ *Cranleigh Village Hospital Annual Report, 1864*, patient no. 21.
- ³⁶ *Cranleigh Village Hospital Annual Report, 1863*, patient no.13.
- ³⁷ Henry C. Burdett, *Cottage Hospitals, General, Fever, and Convalescent*, 2nd Edn (London: J & A Churchill, 1880), p.40.
- ³⁸ *Ibid.*, p.58.
- ³⁹ *Cranleigh Village Hospital Annual Report, 1863*, patient no. 7. He was discharged 'well' after 105 days.
- ⁴⁰ *Cranleigh Village Hospital Annual Report, 1864*.
- ⁴¹ It is interesting to note that the Hospital managers appeared to be prepared to indulge these 'habits'. *Bourton-on-the-Water Cottage Hospital Annual Report, 1876*. Gloucester Record Office.
- ⁴² *Grace's Guide to British Industrial History*, http://www.gracesguide.co.uk/Banbury_and_Cheltenham_Railway. (Downloaded 17 February 2017).
- ⁴³ Patient Admissions Databases for Cranleigh, Bourton and Moreton Hospitals. The table includes the top five cause of admission at each hospital. The disease groupings used in this analysis are explained in the Research Methodology (Appendix 5). It should be noted that the term 'Violence' was used to denote any incident of unnatural injury including accidents and intentional injury. In almost all cases in this study cases coded as 'Violence' relate to accidents.
- ⁴⁴ Ian Gazeley and Sara Horrell, 'Nutrition in the English agricultural labourer's household over the course of the long nineteenth century', *Economic History Review*, 66/3 (2013), pp. 757-784.
- ⁴⁵ *Ibid.* Table 10, p. 778. The nutrients quoted are from group (c) which referred to variables based upon household size.
- ⁴⁶ *Ibid.*
- ⁴⁷ *Cranleigh Village Hospital Annual Reports, 1861-1865*.
- ⁴⁸ The Sayres Jacket was pioneered by an American surgeon, Lewis Sayres, to correct spinal curvature, as an alternative to iron braces which were used at that time. Treatment consisted of suspending the patient by the arms to 'correct' the curvature whilst a plaster jacket was put in place to hold the spine after release. <https://cms.www.countway.harvard.edu/wp/?p=4610>, downloaded 17 February 2017.
- ⁴⁹ 'Early years' refers to the period 1860-1869, in which extensive patient details were printed in the Cranleigh Annual Reports.
- ⁵⁰ Cecilia Tasca, *et al*, 'Women and Hysteria in the History of Mental Health', *Clinical Practice and Epidemiology in Mental Health*, 8 (2012), pp.110-119.
- ⁵¹ The table includes the top five cause of admission at each hospital. The disease groupings used in this analysis are explained in the Research Methodology (Appendix 5). It should be noted that the term 'Violence' was used to denote any incident of unnatural injury including accidents and intentional injury. In almost all cases in this study cases coded as 'Violence' relate to accidents.
- ⁵² At Moreton, in contrast, Rule 5 stated 'No patient shall remain in the Hospital more than four weeks without a fresh letter or recommendation, or a special order of the Committee.' *Moreton Cottage Hospital Annual Report*, Rules of Admission.
- ⁵³ The table includes the top five cause of admission at each hospital. The disease groupings used in this analysis are explained in the Research Methodology (Appendix 5). It should be noted that the term 'Violence' was used to denote any incident of unnatural injury including accidents and intentional injury. In almost all cases in this study cases coded as 'Violence' relate to accidents.
- ⁵⁴ *Cranleigh Village Hospital Annual Report, 1860*, patient no. 11.
- ⁵⁵ *Cranleigh Village Hospital Annual Report, 1862*, patient no. 28.
- ⁵⁶ *Cranleigh Village Hospital Annual Reports, 1861-1868*.
- ⁵⁷ Andrea Tanner, 'Choice and the Children's Hospital' in *Medicine, Charity and Mutual Aid*, ed. by Anne Borsay and Peter Shapely (Aldershot: Ashgate, 2007), pp. 135-62.
- ⁵⁸ *Ibid.*, pp. 150-151.
- ⁵⁹ Anne Hardy, *The Epidemic Streets* (Oxford: The Clarendon Press, 1993), pp. 212-3.
- ⁶⁰ *Cranleigh Village Hospital Annual Report, 1862*.
- ⁶¹ Sue Hawkins and Andrea Tanner, 'Food, Glorious Food: the functions of food in British children's hospitals, 1852-1914', *Food and History*, 14/1 (2016), pp. 107-33.

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⁶² Jonathan Reinartz, 'Receiving the rich, rejecting the poor' in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting (Clio Medica: 86)* ed. by Graham Mooney and Jonathan Reinartz (Amsterdam/New York: Ridopi, 2009), pp. 31-54.

⁶³ *Bourton Cottage Hospital Annual Report, 1886*.

⁶⁴ Moreton Cottage Hospital Annual General Meeting, January 1885.

⁶⁵ Edward John Waring, *Cottage Hospitals: Their Objects, Advantages and Management*, (London: Savill, Edwards and Co., 1867), p.p. 9-10 and Appendix B, Dietary Tables.

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*

⁶⁸ *Cranleigh Village Hospital Annual Report, 1860*, patient no. 16.

⁶⁹ *Cranleigh Village Hospital Annual Report, 1861*, patient No. 14.

⁷⁰ *Cranleigh Village Hospital Annual Report, 1861*, patient No. 21.

⁷¹ *Cranleigh Village Hospital Annual Report, 1866*. patient no. 18.

⁷² As noted in the previous chapter though, there were no items relating to medicines listed in the annual accounts for Cranleigh, suggesting whoever provided the medicines did so free of charge.

⁷³ Penny Wainwright, *Opposite the Infirmary. A History of the Thackray Company, 1902-1990* (Leeds: Medical Museum Publishing, 1997), p. 7.

⁷⁴ *Lydney Cottage Hospital Annual Report, 1897*. The development of cottage hospital-based 'district' nursing is discussed in Chapter 3.

⁷⁵ *Ibid.*

⁷⁶ Chorley Population by Gender for 1891, *Vision of Britain through Time*, GB Historical GIS / University of Portsmouth (<http://www.visionofbritain.org.uk/unit/10027755/cube/GENDER>. Date accessed: 20th January 2017.

⁷⁷ The earliest reference to an operational Dispensary was the Report of the Committee for year ending 1839, Lancashire Record Office.

⁷⁸ Report of the Committee for the year ending ending December 1892, Lancashire Record Office.

⁷⁹ The Rev Lennon was rewarded by becoming a Trustee and a Vice-President.

⁸⁰ In 1921 following redevelopment, it was renamed the William Julian Courtauld Hospital and survived until 2013 when the site was sold for housing.

⁸¹ Braintree Population 1880, *Vision of Britain through Time*, GB Historical GIS / University of Portsmouth. http://www.visionofbritain.org.uk/unit/10235212/cube/TOT_POP. Date accessed 24 Jan 2017.

⁸² See Research Methodology (Appendix 5) for a description of the databases constructed from the hospital admission records, which form the basis of this table.

⁸³ Total admissions for each hospital were higher than shown in this analysis as some records did not contain information on gender or age. Total admissions for the period 1886-1907 for each hospital were Lydney, 235; Chorley, 845; and Braintree, 760.

⁸⁴ It has not been possible to determine in what trades labourers were employed so it has been assumed that they were dispersed amongst the wide spectrum of industries in the town and its surroundings.

⁸⁵ Patient Admissions to Three Town-based Hospitals Database, see Appendix 5 for a description of the databases used in the construction of this table.

⁸⁶ Tradesman includes: baker, butcher, blacksmith, tailor, shoemaker, shopkeeper. Patient Admissions to Three Town-based Hospitals Database, see Appendix 5 for a description of the databases used in the construction of this table.

⁸⁷ Including in 1902, two 'pit girls' age 24 and 30. The younger was admitted with parametritis, a pelvic inflammatory disease, the other with rheumatism.

⁸⁸ Others included: bargemen and canal workers, fire beaters and firemen, hawkers, painters and soldiers.

⁸⁹ The financing of cottage hospitals is discussed in detail in Chapter 3.

⁹⁰ Records had only survived for the years 1897 to 1904. Patient Admissions to Three Town-based Hospitals Database, see Appendix 5 for a description of the databases used in the construction of this table.

⁹¹ Patient Admissions to Three Town-based Hospitals Database, see Appendix 5 for a description of the databases used in the construction of this table

⁹² Tradesman includes e.g. blacksmith, boot and brush- maker, shopkeeper, miller and 'tradesman'.

⁹³ Forty-one (or 38 per cent) of the female patients were described as the wives of labourers. (Braintree and Bocking Patient Database)

⁹⁴ A dataller was a maintenance and service worker in a mine, employed on a casual day basis.

⁹⁵ *Chorley Cottage Hospital and Dispensary Annual Report, 1894.*

⁹⁶ The table includes the top five cause of admission at each hospital. The disease groupings used in this analysis are explained in the Research Methodology (Appendix 5). It should be noted that the term 'Violence' was used to denote any incident of unnatural injury including accidents and intentional injury. In almost all cases in this study cases coded as 'Violence' relate to accidents.

⁹⁷ <https://cameochemicals.noaa.gov/chemical/14564>, downloaded 17 February 2017.

⁹⁸ The table includes the top five cause of admission at each hospital. The disease groupings used in this analysis are explained in the Research Methodology (Appendix 5). It should be noted that the term 'Violence' was used to denote any incident of unnatural injury including accidents and intentional injury. In almost all cases in this study cases coded as 'Violence' relate to accidents.

Chapter 4: The Patients

Appendix 1: Database Technical Specifications

The Cottage Hospital Database 1860-1940 was created in Microsoft Access Version 2007-2016 and MS Excel 365.

Database Fields

Hospital name	Alpha by location name. Includes any later name and any synonym.
Historic County	As stated in the source record. These are known as Historic Counties as they predate the local Government reorganisation of 1974. If not given, the county was determined by reference to the Chapman Code, a superset of ISO 3166-2:GB and BS 6879 systems.
Wellcome	'Y' if recorded in the Wellcome Library cottage hospital database
Year opened	Earliest year stated by a reputable or contemporary source, such as Horace Swete or The National Archives. ¹
Year opened Burdett	Henry Burdett in various published works included foundation year. ²
Source	Sources which identified a facility as a cottage hospital.
Year closed	Physical closure as opposed to rebuilding or relocation to a new local site.
Opening bed numbers	Cots (for children) are identified separately. Additional information on bed numbers is included e.g. when beds are added following building extension or rebuilding.
Early medics	Names and qualifications of the first Medical officer(s) when known.
Nursing system	Burdett sometimes included a description of the nursing arrangements e.g. 'Trained nurse supervised by Ladies Committee.' Included as written.
Comments	Other features, often noted by a contemporary writer e.g. out-patient service, separate building for fever patients, separate mortuary.

Sources for Database are described in the Methodology section.

Appendix 1: Database Technical Specification

Cottage Hospital Patient Database

The patient record databases have been compiled from hospital annual reports. They are held in Microsoft Access and Excel 365. The reports have been transcribed verbatim, with the exception of the starred fields which contain added information.

	Bourton	Braintree	Chorley	Cranleigh	Lydney	Moreton
Date range	1860-1893	1886-1907	1893-1903	1860-1905	1886-1904	1873-1899
Number of Patient Records	672	760	844	1096	235	808
Fields in Databases						
Hospital name	Yes	Yes	Yes	Yes	Yes	Yes
Annual Report No	Yes	Yes	Yes	Yes	No	No
Year	Yes	Yes	Yes	Yes	Yes	Yes
Patient name/Initials	No	No	Yes	Yes	Yes	No
Gender	Yes	Yes	Yes	Yes	Yes	Yes
Age	Yes	Yes	Yes	Yes	Yes	Yes
Occupation	No	Yes	Yes	Yes	Yes	No
Residence	No	Yes	Yes	Yes	Yes	Yes
Reason for Admission	Yes	Yes	Yes	Yes	Yes	Yes
*Standard disease name	Yes	No	No	Yes	No	No
*Disease Class	Yes	Yes	Yes	Yes	Yes	Yes
Admission date	Yes	Yes	Yes	Yes	Yes	Yes
Discharge date	Yes	Yes	Yes	Yes	Yes	Yes
Length of Stay	Yes	Yes	Yes	Yes	Yes	Yes
Result	Yes	Yes	Yes	Yes	Yes	Yes
Recommended by	No	No	No	Yes	Yes	Yes

Sources for Database are described in the Methodology section.

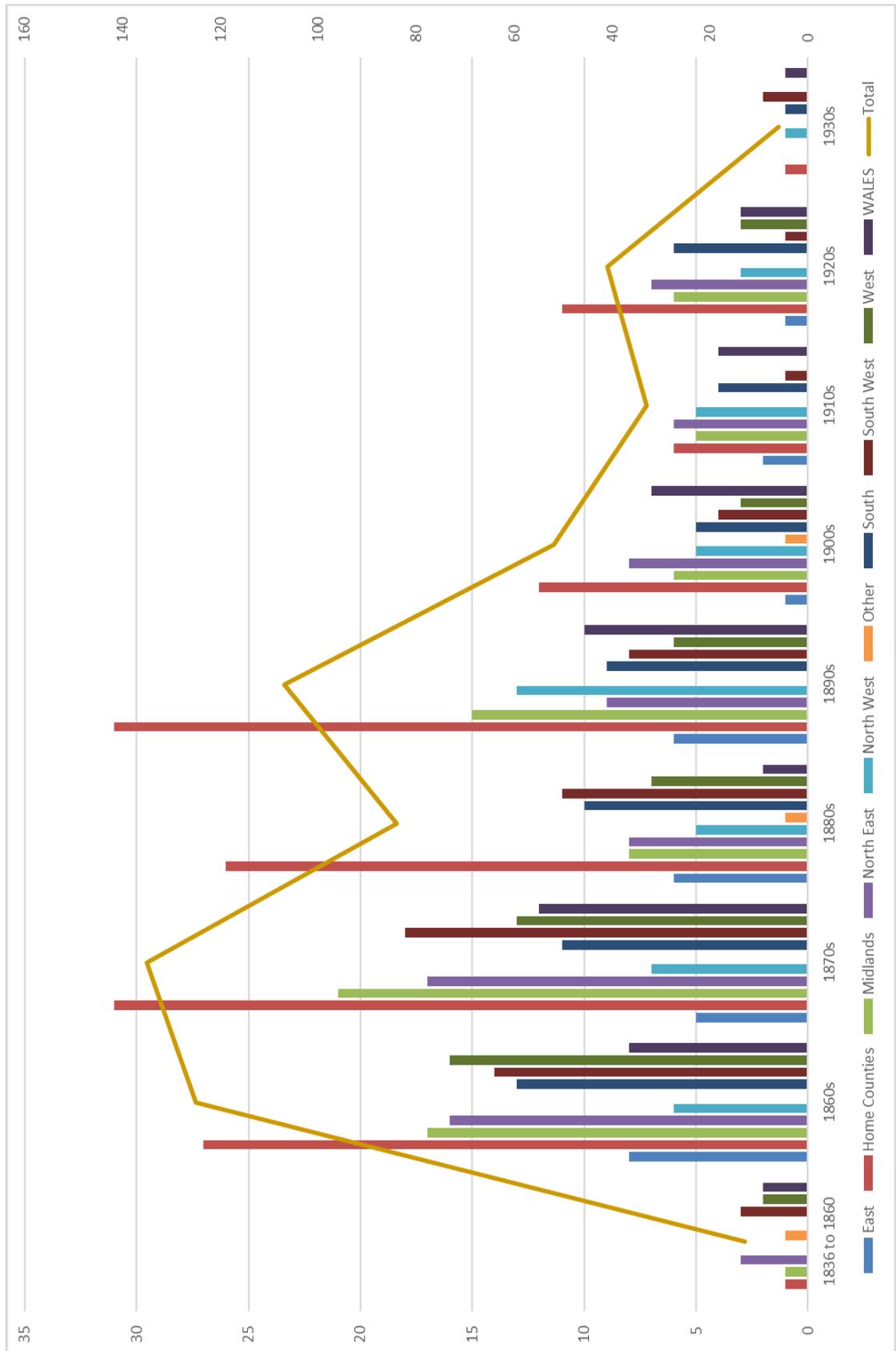
¹ Horace Swete, *Handy Book of Cottage Hospitals* (Weston-Super-Mare: Hamilton, Adams and Co., 1870), pp. 28-31.

² Not all foundation dates were identified with certainty and various authorities disagreed. Burdett included a number of hospitals in *Cottage Hospitals* published 1877 for which he had no information except that he believed they existed. Unless other reliable sources specified a date, then 1877 was entered in this field.

**Appendix 2: Analysis of Cottage Hospitals by County and Decade,
1859-1920**

	1859- 1870	1871- 1880	1881- 1890	1891- 1900	1901- 1910	1911- 1920	Grand Total
Bedfordshire		1		1			2
Berkshire	1	2	4	3			10
Buckinghamshire	2	3	1			1	7
Cambridgeshire		1	1				2
Channel Islands	1		1				2
Cheshire	3	1	1	4	2	4	15
Cornwall	3	3	1	1		1	9
Cumberland				3	2	1	6
Derbyshire	1	2	3	1		2	9
Devonshire	3	8	7	4			22
Dorset	4	2	2	1	1		10
Durham	4	3	1	1			9
Essex	4	3	4	6	1		18
Gloucestershire	8	6	3	1			18
Hampshire	6	6	2	4	2	2	22
Herefordshire	1	3	1	1			6
Hertfordshire	2	1	2	3			8
Isle of Man					1		1
Isle of Wight	2				2		4
Kent	5	9	5	2	1		22
Lancashire	2	6	4	9	3	1	25
Leicestershire		1		3	2		6
Lincolnshire	2	7	1	1	3	3	17
Middlesex	5	7	7	6	3	4	32
Norfolk	3	2	2	4	1		12
Northamptonshire	1	1		2			4
Northumberland	1	4	3		2	1	11
Nottinghamshire	4		2	1			7
Oxfordshire	2	3	1	1			7
Rutland							0
Shropshire	1	1	2	4	3		11
Somerset	5	5	1	2	3		16
Staffordshire	4	4	2	1			11
Suffolk	5	1	3	1		2	12
Surrey	9	6	3	11	7	1	37
Sussex	3	2	7	4	1	2	19
Wales	9	12	2	10	7	4	44
Warwickshire	2	2		2	1		7
Westmoreland	1						1
Wiltshire	6	3	1				10
Worcestershire	3	4		4			11
Yorkshire	11	10	4	5	4	4	38
Grand Total	129	135	84	107	52	33	540

Chart App 2.1 Growth of the Cottage Hospital Movement by Region, 1836-1940



Source for Table and Chart: Cottage Hospital Database

Appendix 3: Biographies of Key Characters

SIR HENRY BURDETT, 1847 – 1920

Philanthropist, hospital reformer and author. Burdett was a hospital administrator before joining the London Stock Exchange as Secretary, Shares and Loans Department where he developed *Burdett's Official Intelligence of Securities* which contained information on British and US financial securities. He had a lifelong interest in hospital administration and management (having never completed his medical training at Guy's Hospital), was a prominent supporter of and advocate for cottage hospitals and the author of major books and annual publications concerned with hospitals, their administration and statistics. Burdett was a combative figure, described as 'a little noisy' by some, and took disagreements personally (see Sue Hawkins, 'Catherine Jane Wood' in the ODNB, in press, for an example of Burdett's approach to people who opposed his views). But he was adept at attracting Royalty to various charities with which he was involved or had founded including the Hospitals Association, the Saturday Fund, the National Pension Fund for Nurses and the Prince of Wales' Hospital Fund for London, now (in 2017) the Kings Fund. He was knighted in 1897.

Significant medical publications included three editions of *Cottage Hospitals, General, Fever and Convalescent* (London: Scientific Press, 1876, 1885, 1896); *The Cottage Hospital, its Origin, Progress, Management and Work*, (London: J & A Churchill, 1877); four-volume *Hospitals and Asylums of the World: their origin, history, construction, administration, and legislation*, (London: J & A Churchill; Whiting & Co, 1891-1893); annual *Hospitals and Charities, the Year Book of Philanthropy*, (London: Scientific Press); 'The Hospital', a weekly journal of the Hospitals Association.

Sources: F. K. Prochaska, 'Burdett, Sir Henry Charles (1847–1920)', *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, in print and online 2004). <https://doi.org/10.1093/ref:odnb/38827>; Geoffrey Rivett, *The Development of the London Hospital System 1823-2015*, <http://www.nhshistory.net/burdett.html>.
Downloaded 10 March 2017.

Appendix 3: Biographies

ALBERT NAPPER, 1815 - 1894

Napper acted as sole Medical Officer at Cranleigh Village Hospital, Surrey from its opening until retirement in 1881. Born 1815 in Loxwood, West Sussex, he trained at St Thomas' Hospital and became a senior dresser. He qualified as Member of the Royal College of Surgeons (MRCS) and Licentiate of the Society of Apothecaries (LSA), spent a year in Edinburgh and a few months in Bonn, and practised in Guildford, Surrey from 1838, before acquiring the Cranleigh practice in 1854. The 1861 census records him as 'MRCS & LSA in General Practice' which in the 1871 census had expanded to 'Surgeon MRCS & LSA, Landowner of 120a employing 4 men', an estate inherited from his father Henry Napper in Wisborough Green, West Sussex, about ten miles from Cranleigh. He described himself as 'forceful advocate of village hospitals', was a speaker at medical societies, a pamphleteer and regular contributor to the correspondence section of *The British Medical Journal (BMJ)*.

In 1869 he was elected Associate of the Order of St John of Jerusalem in recognition of his services in having established the first cottage hospital and at the time of his death he was Senior Honorary Associate. In 1877, the Order, by then open to Christians of any denomination, set up the St John Ambulance to train members of the public in first aid, initially in workplaces and areas of heavy industry, and to provide an ambulance service. It is therefore possible, that Napper provided practical expertise to facilitate these developments.

Napper was an active supporter of the South–Eastern Branch of the British Medical Association (BMA), formed in 1856, and helped to organise its national system of districts within branches. He was also Honorary Secretary of the Royal Society for the Prevention of Cruelty to Animals (RSPCA) and contributed to the Meath Home for Epileptics.

Napper died in Surrey in 1894 at the age of 79.

Sources: *The British Medical Journal*, 24 November 1894, p. 1211. Obituary of Albert Napper MRCS, LSA., The Originator of Cottage Hospitals. The obituary included a lengthy encomium written by Sir Henry Burdett.

HORACE SWETE 1825 - 1912

Little verifiable information is known about Edward Horatio Walker (Horace) Swete MD, MRCS, LSA. In 1854, when a lecturer on Botany at Bristol Medical School, he authored *Flora Bristolensis* so it is possible that he trained there, one of the earliest hospitals outside of London, founded c1736. He was best known for his *Handy Book of Cottage Hospitals*, published 1870, an important source book for rural medical practitioners on the principles of the Cottage Hospital Movement. He wrote in the preface that 'it has been the intention of the Author to show how simply and inexpensively a Cottage Hospital may be managed.'

Swete founded one of the early cottage hospitals in Wrington, Somerset, which opened in July 1864 with five beds to serve the 'respectable labouring class and small tradesmen'. (Wrington 1st Annual Report) He left Wrington in 1867 to become Honorary Medical Superintendent of the West of England Sanatorium or Convalescent Home, Weston-super-Mare, but may have retained a link with Wrington for another two years as Honorary Surgeon. In an application in 1879 for the position of County Analyst he described himself as Public Analyst for Leamington and Medical Officer of Health, Droitwich Combined Sanitary Districts. Swete died in 1912 in Devon. A Death Notice stated he had been Worcester County and City Analyst for many years. (*Gloucester Journal*)

Sources: Wrington ARCHIVE, Dr Edward Horatio Walker Swete, MD <http://www.wringtonsomerset.org.uk/archive/swete/swete03.html> and <http://www.wringtonsomerset.org.uk/archive/swete/swete01.html>. Downloaded 10 March 2017; Horace Swete, *Handy Book of Cottage Hospitals*, (London: Hamilton, Adams and Co., 1870); First Annual Report of Wrington Cottage Hospital, July 1865. *Gloucester Journal*, 7 December 1912, p. 9.

EDWARD WARING 1819 – 1891

Edward John Waring, scientist and philanthropist, initially trained at Bristol, worked at Charing Cross Hospital and was awarded MRCS in 1842. He travelled extensively for the Emigration Commissioners, was employed by the East India Company in various senior medical roles and contributed articles to Indian medical journals. He authored a

Appendix 3: Biographies

number of books, notably *Practical Therapeutics*, 1854, *Bazaar Medicine*, 1860, *Indian Pharmacopoeia*, 1868, and contributed to *Bibliotheca Therapeutica* 1878/9. In 1867 he published *Cottage Hospitals: Their Objects, Advantages and Management*. He strongly supported Albert Napper and Horace Swete in their advocacy of 'village hospitals' and 'showed the great importance of such institutions and did much to popularise the idea which at that time was much favoured in very many quarters.' (*BMJ*) He lived in Uckfield, now East Sussex, about 30 miles from Cranleigh and would have known Napper through membership of the South-Eastern Branch of the BMA. As an influential and respected physician and surgeon, his words carried considerable weight.

Waring was appointed FRCS (Fellow of the Royal College of Surgeons) in 1863 and later MRCP and FRCP (Member/Fellow of the Royal College of Physicians). In 1881 he was made Companion of the Indian Empire (CIE) for his medical and charitable services. He died in London in 1891 at the age of 71.

Sources: *The British Medical Journal*, 31 January 1891, p.264. Obituary of Edward John Waring, MD, FRCP, FRCS, CIE.

Appendix 4: Geographical and Chronological Maps Showing Locations of Cottage Hospitals Recorded in the Cottage Hospital Database

SOFTWARE: GenMap UK, version 2.2 (2002-2007), Archer Software, 90 St Alban's Road, Dartford, Kent, DA1 1TY.

The suite consists of five maps each showing the physical location of a cottage hospital identified by a coloured circle within an historic county, named by its three letter Chapman Code:

Map 1: Cottage Hospitals founded in England & Wales between 1830 and 1870. 115 locations are shown.

Map 2: Cottage Hospitals founded in England & Wales between 1850 and 1880. 235 are displayed of which 120 were founded between 1871 and 1880;

Map 3: Cottage Hospitals founded in England & Wales between 1850 and 1890. 316 are displayed of which 81 were founded between 1881 and 1890;

Map 4: Cottage Hospitals founded in England & Wales between 1850 and 1900. 415 are displayed of which 99 were founded between 1891 and 1900;

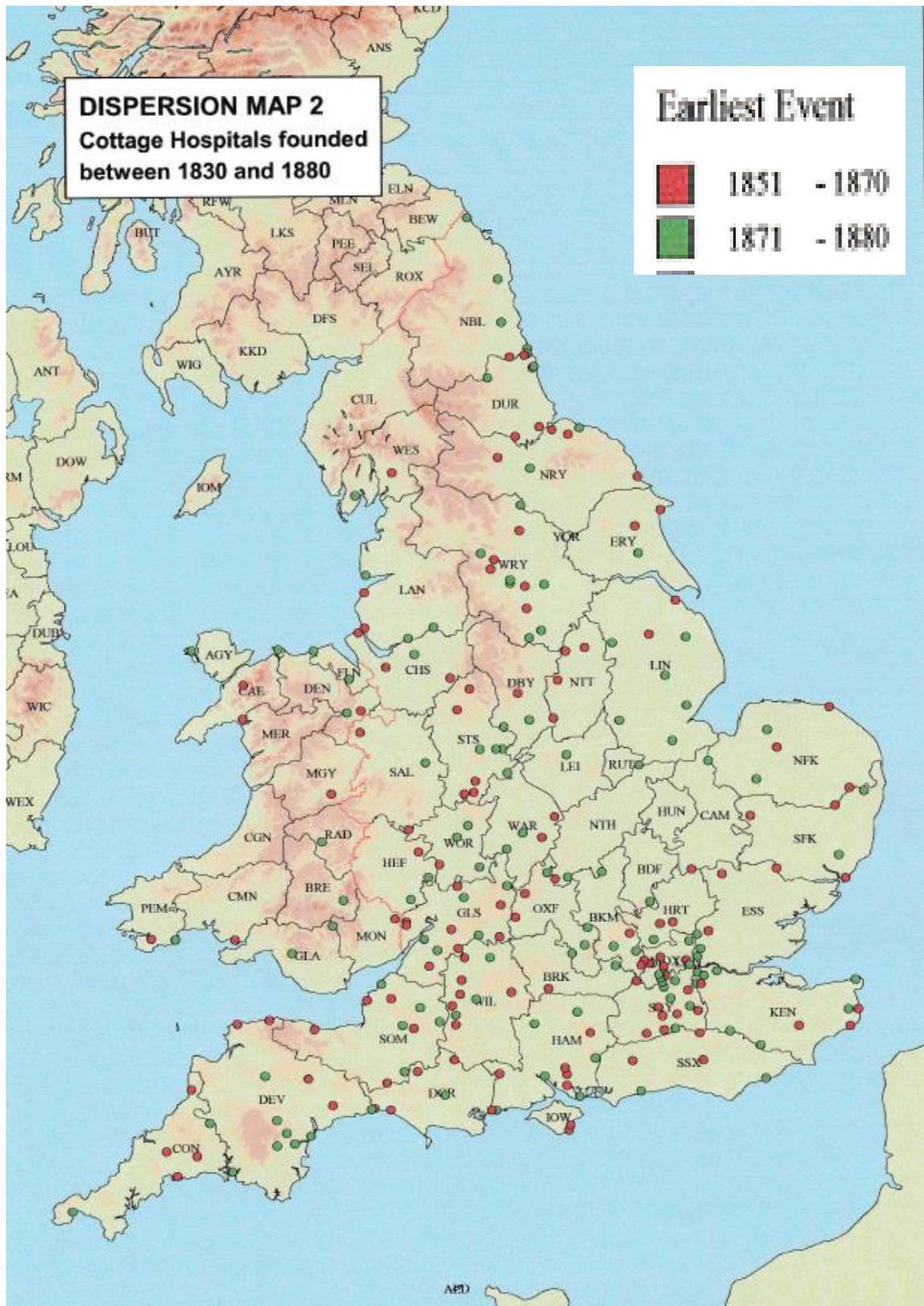
Map 5: Cottage Hospitals founded in England & Wales between 1850 and 1915. 471 are displayed of which 56 were founded between 1901 and 1915.

Appendix 4: Maps

Map 1: Cottage Hospitals founded in England & Wales between 1850 and 1870. 115 locations are shown

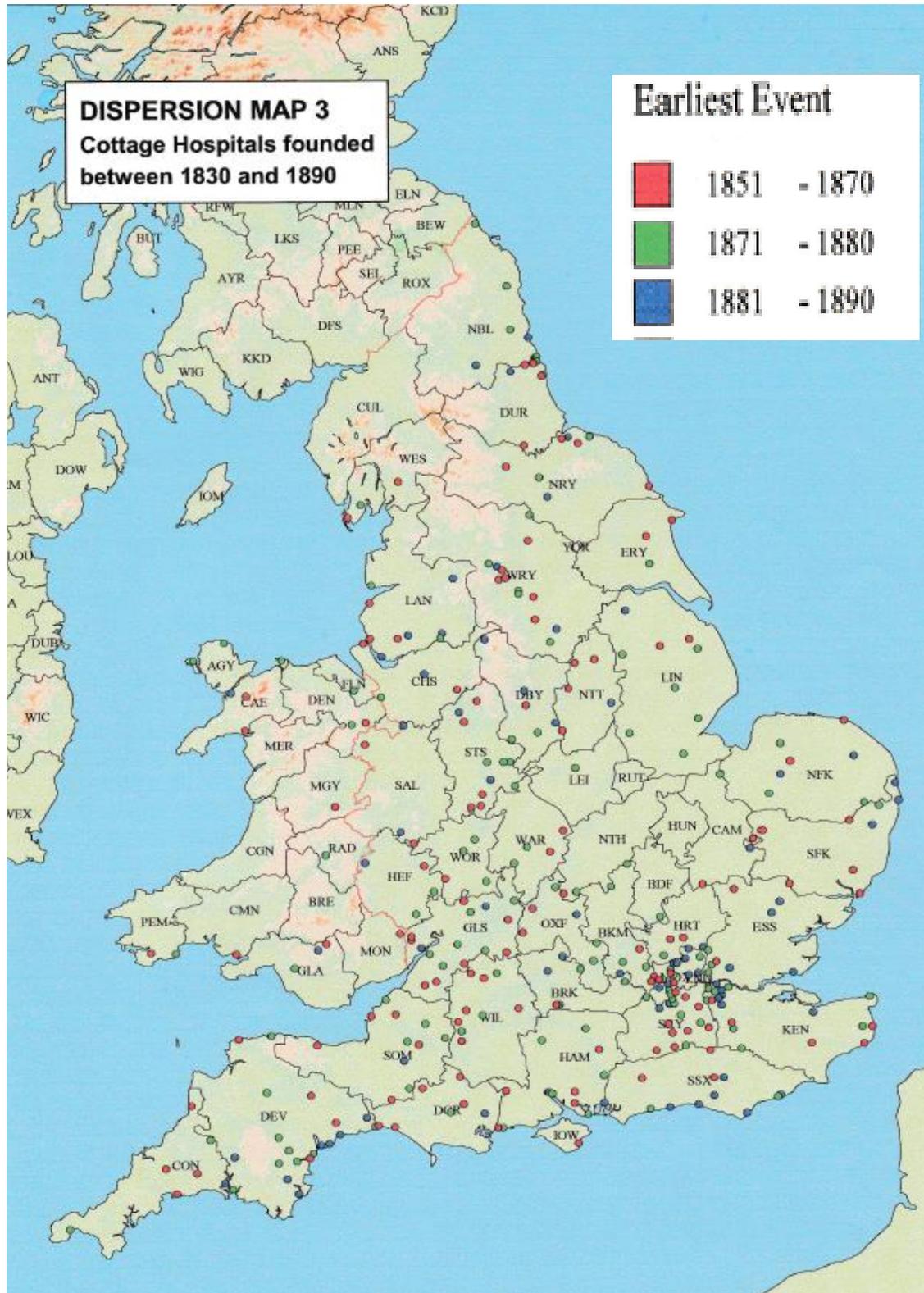


Map 2: Cottage Hospitals founded in England & Wales between 1850 and 1880. 235 are displayed of which 120 were founded between 1871 and 1880

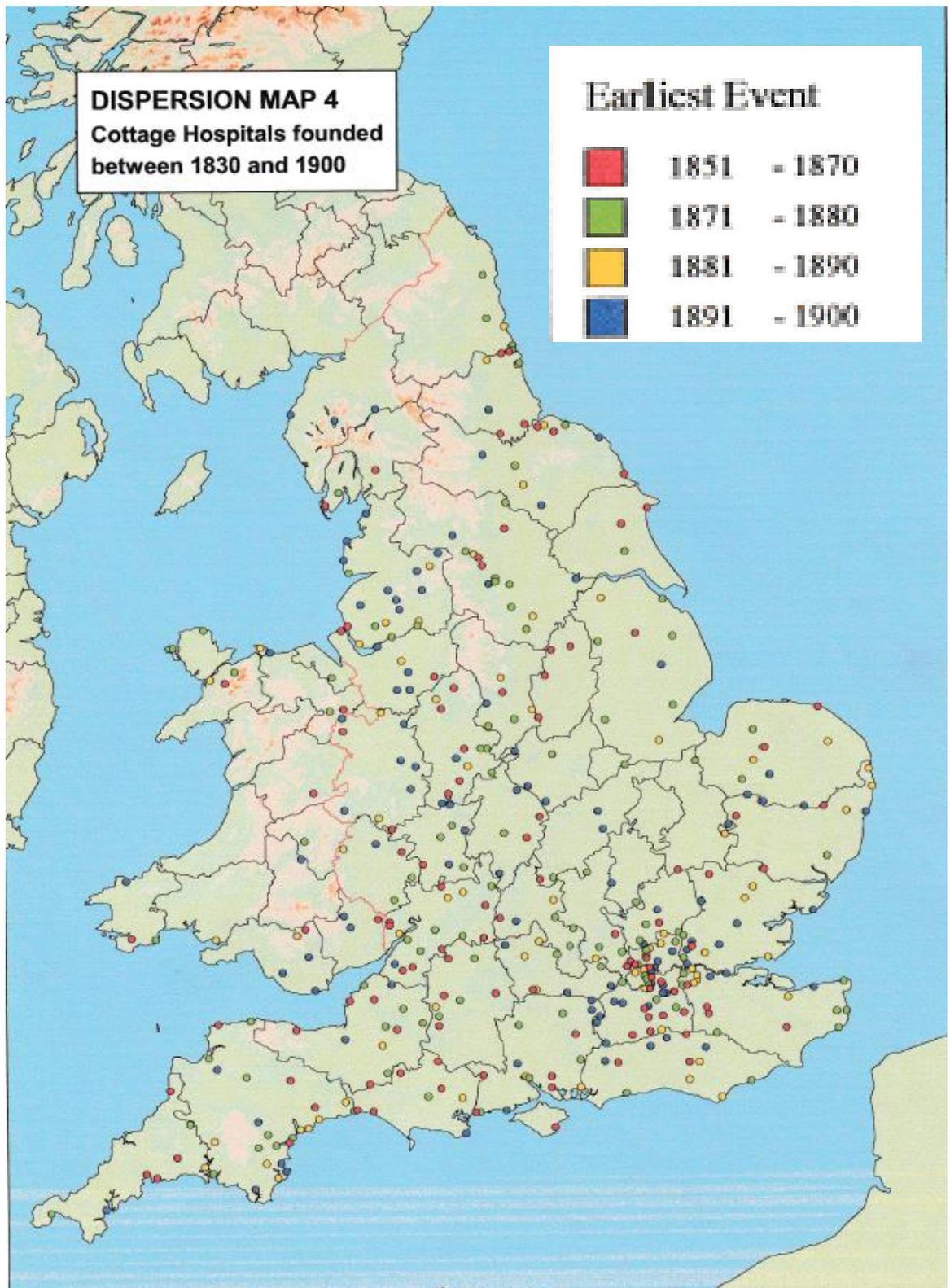


Appendix 4: Maps

Map 3: Cottage Hospitals founded in England & Wales between 1850 and 1890. 316 are displayed of which 81 were founded between 1881 and 1890

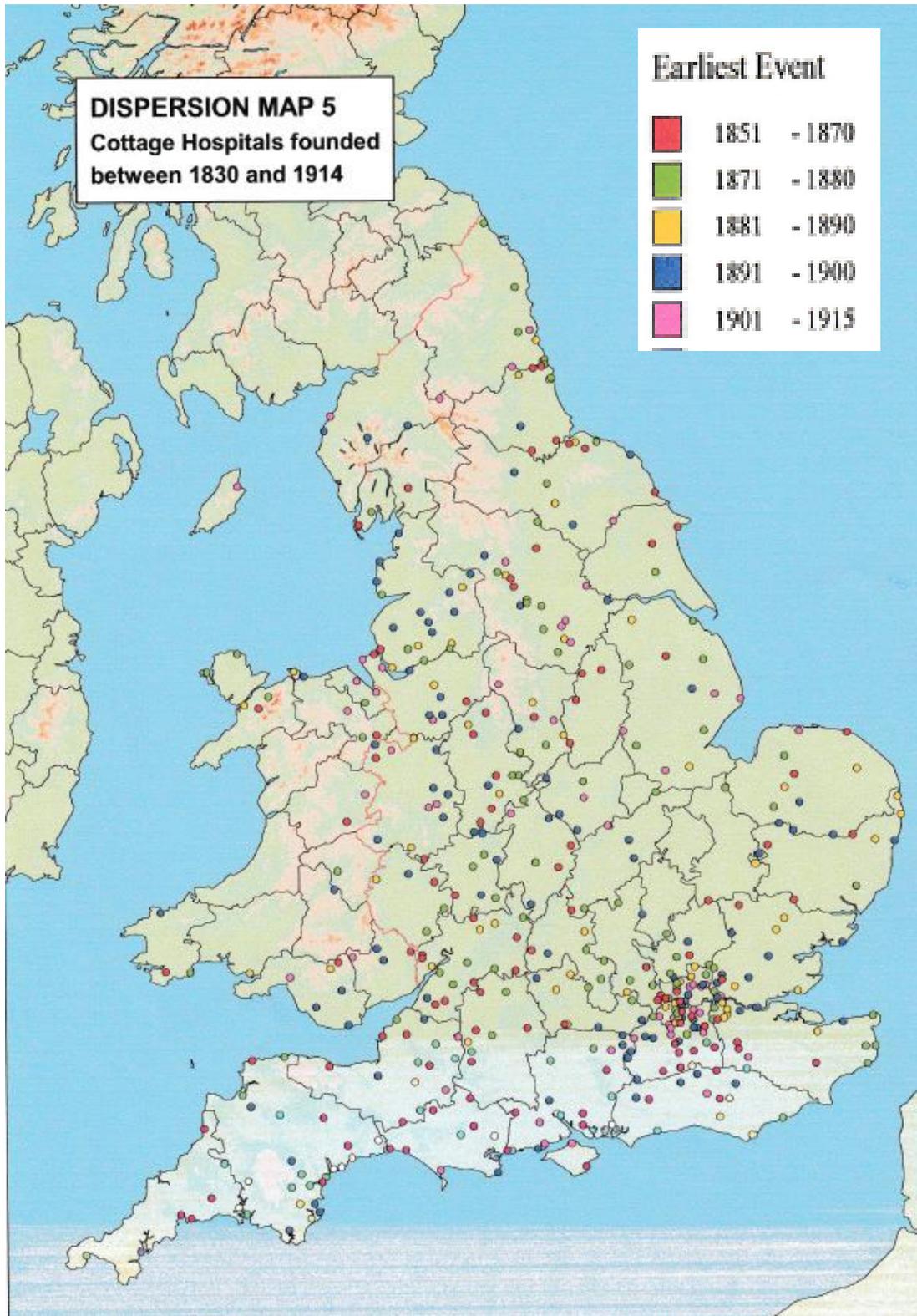


Map 4: Cottage Hospitals founded in England & Wales between 1850 and 1900. 415 are displayed of which 99 were founded between 1891 and 1900



Appendix 4: Maps

Map 5: Cottage Hospitals founded in England & Wales between 1850 and 1915.
471 are displayed of which 56 were founded between 1901 and 1915.



Appendix 5: Research Methodology

Introduction

Two major elements of research have contributed to this thesis. One major area of research aimed to identify as many cottage hospitals as possible across England and Wales, using multiple and varied sources. Its overall aim was to construct a database containing a definitive list as possible of cottage hospitals in England and Wales up to 1940. A second area of research aimed to identify a number of cottage hospitals where details of patients were available and to build a database of the admissions to reveal details of the patients these hospitals admitted and treated. The former revealed the chronology of the geographical spread and expansion of these small hospitals and contributed to Chapters 1 and 2. The latter provided data for Chapters 3 and 4 which discuss the patients, the causes for their admission and the financing, organisation and social structure of these important providers of healthcare to the poor (particularly the rural poor) much neglected by historians.

John Tosh discussed the scope of quantitative history and its transformative impact on historical enquiry, noting that ‘... not only is the main trend revealed but also the variations and exceptions which highlight the distinctive experience of a particular locality or group.’¹ That observation was especially apt when faced with the wealth of data contained in cottage hospital records. A cursory reading of patient profiles published in the hospitals’ Annual Reports revealed, for example, that some causes of admission occurred more frequently than others, that many of the patients, both male and female, tended to be under thirty years old, that children were admitted from the beginning, and that the time spent in hospital was surprisingly long by today’s standards, although not by nineteenth-century norms. Analyses of this data contributes to an understanding of the diseases prevalent in rural communities, the provision and outcomes of medical and surgical procedures available, and extends knowledge of the physical condition of the working poor in the second half of the nineteenth century. Practically, only a computer-supported analytical approach can extract with confidence findings of significance and as Tosh said, ‘In making

quantitative statements historians should take the trouble to count rather than content themselves with impressionistic estimates.²

COTTAGE HOSPITAL DATABASE

No complete publicly available database of cottage hospitals exists, and without such a source it is impossible to establish how many existed, the rate and time frame in which they opened, their geographical spread, the communities they served and their bed capacity. To answer such questions a resource has been constructed from scratch from a variety of contemporary sources, using The National Archives Hospital Records Database as the starting point, and supplemented by desk research. The resulting Cottage Hospital Database is the most comprehensive record available, containing details of 600 cottage hospitals in England and Wales, established between 1840 and 1940, of which 527 had been founded by 1914, the scope of this thesis.

Hospital administrator and author Henry Burdett also proved an invaluable source. His editions of *Cottage Hospitals*, published between 1877 and 1896, listed 351 cottage hospitals for which he had obtained information and which supplemented the records held by the National Archives.³ Along with those in England and Wales Burdett also recorded cottage hospitals in Scotland, Ireland, Canada, Australia and South Africa. The global influence of Napper's original idea is particularly evident in the forty-five cottage hospitals identified by Napper in the eastern United States in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont, which together comprised a further eighty-four records.⁴ These are outside the scope of the thesis but have been included in the database for completeness and later research.

Other sources for the Cottage Hospital Database include the Voluntary Hospitals Database⁵, the Wellcome Library catalogue, County Record Offices and Archives catalogues and references and descriptions in the contemporary writings of Edward Waring and Horace Swete.⁶ Other cottage hospitals have been identified in the *British Medical Journal*, *The Lancet*, *Medical Register*, *Medical Directory*, *Victoria County History* and the British Newspaper Archive.

Scholarly research on regional groups of cottage hospitals by Steven Cherry and Barry Doyle contributed valuable data and publications by local historians and enthusiasts helped to fill gaps and identified cottage hospitals which were not recorded in major sources.⁷

A hospital was included in the database if it met one or more of the following three criteria:

1. It was identified as a cottage hospital in one of the authoritative sources named above;
2. Cottage, Village or Rural and Hospital formed part of its name, preceded by a location, e.g. Moreton-in-Marsh Cottage Hospital, Cranleigh Village Hospital, Tewkesbury Rural Hospital. The majority were described in that manner. A few included the name of a benefactor or memorialised a deceased person, e.g. Lady Dunraven's Cottage Hospital (Clearwell, Gloucestershire), Grace Swan Memorial Cottage Hospital (Spilsby, Lincolnshire);
3. The number of beds and cots was twenty or fewer when the hospital opened. In the 1860s and 1870s, a cottage hospital typically opened with between four and ten beds. From the mid-1880s, as new hospitals opened, and existing hospitals were expanded or rebuilt, up to twenty beds became more common and, in a few examples there were more than twenty.⁸ Although Burdett considered hospitals which opened with more than twenty beds to be small general hospitals, cottage hospitals which had opened with fewer than twenty beds and later expanded beyond twenty beds and retained cottage in their name, and remain in the database. For about one quarter of the hospitals it was not possible to establish the number of beds when they opened so the earliest reference found was used, or the hospital was not included.

Some hospitals listed in editions of the *Medical Directory*, did not meet the preceding criteria but were recorded as having had a small number of beds and so may, or may not, have been cottage hospitals. These have not been included in the database but retained separately for later investigation.

Appendix 5: Research Methodology

Commemorating Queen Victoria's Jubilees of 1887 and 1897, a few existing and some new hospitals incorporated 'Victoria' in their name, occasionally also including 'Jubilee'; for example, Swaffham Victoria Jubilee Cottage Hospital (Norfolk) which opened in 1888. Others were simply named 'Victoria Cottage Hospital', for example, those in Romford (Essex), Kingston-upon-Thames (Surrey) and Morecambe (Lancashire). In populating the database, the convention adopted was to place the name of the locality first to facilitate analysis, e.g. 'Romford Victoria Cottage Hospital'.

From 1920, some new cottage hospitals included 'War Memorial' in their title e.g. Knutsford and District War Memorial Cottage Hospital (Cheshire) which opened in 1922 and existing hospitals were renamed. Andover Cottage Hospital (Hampshire) founded in 1876, expanded in 1926 and was renamed Andover War Memorial Hospital. Name changes have been included in the database.

A few specialist hospitals were founded, for example, Wokefield Cottage Hospital for Children (Berkshire), which opened in 1891, and Buchanan Ophthalmic and Homeopathic Cottage Hospital, St Leonards-on-Sea (Sussex) founded in 1881. Others were established for a particular community of patients such as the Powell Duffryn's Workmens' Cottage Hospital (Monmouthshire) which opened in 1910 and was later renamed as Aberbargoed Cottage Hospital.⁹ Dinorwig Quarry Hospital (Caernavonshire) was founded in 1860 specifically for employees of that quarry and (possibly) their spouses.¹⁰

A set of five colour-coded maps showing the locations of cottage hospitals founded in England and Wales was created from the Cottage Hospital Database, for the time periods 1850 to 1870, 1850 to 1880, 1850 to 1890, 1850 to 1900 and 1901 to 1914, the span of this thesis. The maps and conclusions and Inferences drawn from them are discussed in Chapters 1 and 2. The maps are reproduced in Appendix 4 along with details of the software used.

It is expected that the databases will be placed in the public domain. They will be held off line by the library and archive service of Kingston University, where they can be consulted, and possibly with the UK Data Archive, hosted by the University of Essex.¹¹ The databases were originally created in MS Access but

for technical reasons public access will be provided through a number of MS Excel spreadsheets. A description of the database fields can be found in Appendix 1.

DATASETS OF COTTAGE HOSPITAL PATIENT RECORDS

Cranleigh Village Hospital, recognised by contemporary writers as the first cottage hospital, opened in November 1859. A near complete series of its Annual Reports from 1860 to 1945 have survived of which those up to 1904 contained 1097 individual patient records. (From 1905, individual patient records ceased to be included, replaced by a table titled Cases under Treatment which only listed by cause and number, e.g. 'Hernia, 3', 'Rheumatism, 4'.) The patients records from 1860 to 1904 were transcribed into a Microsoft Access database (see Appendix 1 for details of the database structure). To determine if the Cranleigh patient records were representative of rural cottage hospitals generally (in terms of the patients), reasons for admission, treatments and outcomes, records of other cottage hospitals were collected. As, typically, in their early years, these small hospitals only admitted between twenty and thirty patients annually, a reasonably long chronological run of Annual Reports was needed to ensure that there was sufficient data from which reliable conclusions could be drawn. Based upon the Cranleigh records, it was concluded that a minimum series of ten years was needed.

The online catalogues of county archives were examined to identify other sets of cottage hospital Annual Reports for the research period 1850 to 1915; very few have survived in unbroken ten-year or longer runs, but Gloucester Record Office proved a rich source. It holds sets of Annual Reports for three cottage hospitals, Bourton-on-the Water (opened 1860) and Moreton-in-Marsh (opened 1873) and for Lydney (opened 1882), a town-centred hospital in a mixed light industrial and farming community. Bourton was of special interest as it opened about a year after Cranleigh in a similar small agricultural village, separated from it by about 100 miles. Its records covered the same period and an examination indicated the patients and their illnesses were much like those admitted to the Cranleigh hospital and therefore merited detailed comparative

Appendix 5: Research Methodology

analysis. Moreton, some fifteen miles from Bourton was of significance for a different reason: it was slightly larger than Bourton, opened thirteen years later during the agricultural depression and showed a high incidence of illnesses apparently resulting from malnutrition, especially in young females. Both Bourton and Moreton admitted considerably more patients in a year than Cranleigh, increasing the sample size.¹² Whilst only a short run of Annual Reports for Lydney had survived, its importance lay in being able to compare patients admitted to a small town hospital to those from the two villages in the same county.

To obtain a broader understanding of the patients admitted to town cottage hospitals and how their profiles differed from those of the rural communities, records were sought from two industrial areas. Essex Record Office held a sequence of Annual Reports for Braintree and Bocking Cottage Hospital (opened 1886) and Lancashire Archives for Chorley Cottage Hospital (opened 1893), both of which were town-centred hospitals situated in industrial communities. The availability of records for hospitals in industrial areas gave an opportunity to compare and investigate differences amongst patients and their reasons for admission between country and town and types of industry.

Cottage hospitals published Annual Reports which were distributed to their subscribers, local 'worthies' and the press. Typically, the Report opened with a Trustee's statement summarising the year's activity, described matters of interest and stressed the continuing need for funds and donations. This was usually followed by the hospital's rules, a named list of subscribers and financial donors and the individual value contributed, a list of gifts of food, alcoholic drinks, equipment and furnishings by donor, and a financial statement.

The six cottage hospitals all included tables of patients treated during the year. The tables gave the patients' forename or initial(s) and surname, or forename and surname initials, or initials only, and a clinical description of the reason for admission, age, date of admissions and discharge and outcome of stay. In some the duration of stay was given in days; otherwise (for database purposes) it was calculated from the admission and discharge dates. The convention

adopted was to include the day of admission and the day of discharge as days in hospital. Chapter 4 discusses the patients and presents a number of analyses of the causes of admission.

Cranleigh, Lydney, Braintree and Chorley also included the patient's domiciliary parish which established the catchment areas of these hospitals. Some records also named the patient's sponsor from which it was possible to gain an understanding of the social status of the supporters. Disappointingly, of the rural hospitals only Cranleigh included patients' occupations and only then for its first nine years, 1860 to 1869. Most were agricultural labourers, their wives or dependents. In the town hospitals of Lydney, Braintree and Chorley, by contrast all included occupation.

Some Annual Reports included a second table, showing, for example, the total number of admissions since opening, the number of patients who had 'benefitted' or died, and the number of admissions by parish of origin. Hospitals which had a Dispensary and/or an out-patient facility also published details of these activities, but these have not been included in the patient record databases: these datasets contain in-patient records only. Bourton occasionally published a table which gave total patients since opening and yearly averages by gender, surgical or medical case, outcome, average bed occupancy over time and total income and expenditure.¹³

This patient data was transcribed into Microsoft Access databases, one for each of the six hospitals.

By end of the nineteenth century, as patient numbers increased, admission data in the Annual Reports was reduced to simple statistical summaries of admissions by cause.

RURAL COTTAGE HOSPITALS

Near complete chronological sets of Annual Reports had survived between 1875 and 1894 for Bourton and Moreton, as well as for Cranleigh. This twenty-

Appendix 5: Research Methodology

year period was selected for all analyses of patient admissions as the records overlapped and gave good sample sizes, allowing comparisons to be made. Cranleigh contributed a sequence of twenty years, Bourton sixteen and Moreton seventeen.

Each hospital admitted 'the rural poor' of all ages, including children and both genders.

Table: App 5.1: 1871 census population, hospital admissions and database records, three rural cottage hospitals, 1875-1894.

	Opened	Popn., 1871	Annual Admissions	Records
Cranleigh	1859	1830	25 increasing to about 40 by 1900	1096
Bourton	1861	1011	25 increasing to about 45 by 1893	672
Moreton	1872	1450	30 increasing to about 90 by 1892	1089

The patients' domiciliary parishes were recorded for Cranleigh and Bourton from which it was possible to establish that the catchment areas of the two hospitals were similar, about a 10-mile radius with the hospital at its centre. From the 1871 census returns for some of the outlying villages and hamlets in Cranleigh hospital's catchment area it was estimated that the population served was about three times that shown in Table App 5.1 above.¹⁴

Town cottage hospitals

It was not possible to completely overlap the time periods for Braintree, Chorley and Lydney. The best 'fit' was Braintree 1886-1907, Chorley 1893-1904, Lydney 1897-1904. The three hospitals served very different communities. Braintree and its adjacent town of Bocking was an agricultural and silk weaving town, the major employers being Warner & Sons and Courtauld which founded the hospital. Their mills were largely staffed by women and it was expected that the records would therefore contain a high proportion of female millworkers. Although 46 per cent of admissions were women only 6 per cent were identified mill workers. Married women were only identified by their husband's occupation, so it was not possible to determine their employment, or if they worked at all. The difficulty of determining women's employment from census returns is discussed in Chapter 2.

Chorley was a cotton and mining town. Its hospital records usefully provided information on patients' occupation but not gender. For many patients their occupation or the reason for admission e.g. collier, mammary abscess was sufficient to establish gender so where it was possible to deduce gender from the reason for admission, the decision was made to apply that gender to all patients of the same occupational type, accepting that introduced some unknown degree of error, thought to be quite small. For example, 'weaver' was a common occupation in the patient records and many weavers were admitted with illnesses unique to women, such as 'mammary abscess', 'tumour of breast', or a 'puerperal' condition. Similarly, some occupations were male-only preserves such as 'overlooker', a male supervisor in a textile mill.

Lydney, for which only a short run of reports had survived, was a small port, had some mining, agriculture and manufacturing including an important tin-plate factory. The records reflected the diversity of employment which included tin plate workers, railway employees and seamen. Married women were described either as housewives or by their husbands' occupation'.

Across all six hospital admission databases there were c4900 patient records. Table App 5.2 summarises the breakdown of admissions and period covered for each hospital in the study.

Table App 5.2: No. of database records and years spanned for each hospital.

	Records	Years
Cranleigh	1096	1860 – 1904
Bourton	672	1875 – 1894
Moreton	1088	1875 – 1904
Braintree	760	1886 – 1907
Chorley	1041	1893 – 1904
Lydney	235	1897 – 1904

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The first nine Annual Reports of Cranleigh, 1860-1868, contained extensive descriptions of the diseases and treatments of two hundred and twenty patients. As an example of the level of detail provided in these early Cranleigh reports an entry is reproduced here:

24 April 1864. SW, female age 23, wife of a journeyman. [Admitted with] strumous disease of the elbow joint. Was about six months advanced in pregnancy.

2 May: Was improved in health, but the disease of the joint was increasing, ulcerous communication having formed with the joint.

10 May: The pain and discharge had much increased, and a probe could be passed through the joint.

20 May: Her sufferings had become daily more intense, the joint undergoing disorganisation, and the disease was extending up the bone of the upper arm. Hectic fever and perspirations indicated a break up of her health, and as she was within two months of confinement, I requested a consultation with some medical friends, and decided on removal of the limb without delay.

25 May: Assisted by Mr Thos. Smith, Dr Stedman, Mr Ross, and Mr Bond, I amputated the arm at the middle of the humerus, having previously placed her under chloroform. She bore the operation remarkably well, and with perfect unconsciousness.

3 June: Had good nights, free from pain, and the hectic fever subsided.

6 June: She was well enough to get down stairs, and on the following day walked in the garden.

27 June: The stump was quite healed, and she was in very good health.

29 June: Discharged. Four days after she gave birth to a daughter, and at the present time, both mother and child are progressing most favourably.¹⁵

This level of detail was not repeated in later Cranleigh Annual Reports or in the those of the other hospitals. In fact the level of detail in other Annual Reports varied, as discussed briefly above. One did not include gender, two did not identify the patient, some did not always specify occupation, and some stated the duration of stay in days whilst others gave the dates of admission and

discharge, from which the length of stay was calculated: the convention adopted for this calculation was to include the day of admission and day of discharge and to ignore leap years. It is not known what conventions were used by the authors of the Annual Reports who included duration of stay in their reports. The omissions, which totalled a few per cent, meant that not all data could be used in all analyses. Table APP 5.3 summarises the structure of the patient admission databases, noting where differences in information occurred. Uniquely, among this group of hospitals, the Cranleigh Village Hospital Annual Report for 1864 also included an additional table showing the payment status of the first one hundred patients which identified them as e.g. 'pauper', 'unable to remunerate a surgeon' etc. The Cranleigh database therefore contains an additional field, financial status, which is only populated by the named one hundred. The insert was later published as a pamphlet with additional explanatory text and is discussed in Chapter 4.¹⁶

Table App 5.3: List of fields contained in the Patient Admissions Databases

	Database fields in all Records
Hospital	Hospital name
Report No.	Annual Report no.
Year	Year of Annual Report
Patient No	Sequential patient number in year ¹⁷
Gender	Gender: M or F or Child or NK, Not Known
Age	Age in years or NK, Not Known
Date Admitted	Date admitted
Duration	Number of days in hospital
Disease	Original diagnosis
Disease Group	Disease group, added
Outcome	Outcome as given: cured, incurable, relieved, benefitted, not benefitted, died, sent elsewhere

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	Source-dependent database fields
Patient name	Patient's forename and surname initial, or forename initial and surname in full, or initials only. Missing in Bourton and Moreton .
Occupation	Occupation including none or widow or infant. Missing in Bourton and Moreton .
Residence	Home parish or residence identifier, all except Bourton.
Remarks	Updates of progress of illness and/or treatment e.g. 'amputation'.
Care of	Name of medical attendant.
Name of sponsor	Subscriber/sponsor's name.
Financial status	Financial Status of Patient, Cranleigh only.

To enable analysis of causes of admission, records were classified using a system developed by the HHARP project, a database of admissions to nineteenth century children's hospitals.¹⁸ The HHARP system categories diseases based on the major body system affected (based on medical knowledge at the time). There are a few exceptions to this: Infectious Diseases have their own category as do Parasitic Disease and Tubercular Diseases. For most patients, the stated 'reason for admission' to the hospital provided sufficient information to determine to which Disease Group the patient should be allocated. For example: a patient admitted with carditis would be assigned to 'Circulatory Disease' while one suffering tonsillitis would be classified as 'Ear Nose and Throat'. Some patients were admitted with multiple diseases e.g. double pneumonia and heart disease. The convention adopted was to classify using the first cause. In this example, the field Respiratory System was applied.

The categories in the HHARP classification system are:

Cancer	Infectious Diseases
Circulatory System	Joints Bones and Muscles
Congenital Disorder	Nervous System
Digestive System	Reproductive System
Diseases of the Eye	Respiratory System
Diseases of the Mouth	Tubercular Disease
Diseases of the Skin	Urinary System
Ear Nose and Throat	Violence
Growth Nutrition and Decay	Unclassified.

Analyses

The databases were used to conduct a number of analyses to study questions relating to admissions to the hospitals, to produce patient profiles which could be compared across the different institutions, looking for both similarities and differences. Four main analyses were conducted:

- 1 By Gender: An analysis of admissions by gender, within which further analysis reveals the similarities and differences in disease occurrence by gender and between adults and children (patients under thirteen of both genders). This analysis provided good size samples and enabled the major causes of admission to be readily identified. Typically, three or four Disease Groups were shown to predominate. The numbers of children ranged between 10 and 15 per cent of admissions, and one third of child admissions were female. With such small numbers, analysis of children's diseases by gender would generate such small datasets as to render the findings unreliable and analyses of child admissions were conducted on the whole subset. Male and female adult (over 12 years old) were analysed separately.
- 2 By age of patient.

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- 3 By Disease Group: to identify the most frequently occurring disease groups. Disease Groups were analysed in adult patients by age and gender and in children by age only. For children, two age bands were used: 0-5 and 6-12, the first band chosen to identify early childhood diseases or illnesses.
- 4 Duration of stay: to determine if and how gender, age or disease determined the length of stay in the hospital.

The results of these analyses are discussed in Chapter Four.

¹ John Tosh with Sean Lang, *The Pursuit of History*, 4th edn (Harlow: Pearson Education, 2006), p. 260.

² *Ibid.*, p. 258.

³ Sir Henry C Burdett, *Cottage Hospitals, General, Fever and Convalescent. Their Progress, Management and Work* (London: J & A Churchill, 1st ed. 1877, 2nd ed., 1880, 3rd ed., 1896)

⁴ Burdett, *Cottage Hospitals, General, Fever and Convalescent (1896)*. The foundation of these hospitals, especially in the United States showed that the Cottage Hospital Movement was not confined to the British Isles but had exerted an influence far beyond Napper's expectations.

⁵ The Voluntary Hospitals Database: <http://www.hospitalsdatabase.lshtm.ac.uk/>

⁶ Edward John Waring, *Cottage Hospitals: Their Objects, Advantages and Management*, (London: Savill, Edwards & Co., 1867); Horace Swete, *Handy Book of Cottage Hospitals*, (London: Hamilton, Adams and Co., 1870).

⁷ Steven Cherry, 'Change and Continuity in the Cottage Hospitals c1859-1948: The Experience in East Anglia', *Medical History* 36/3 (1992), 271-89; Barry Doyle, *A History of Hospitals in Middlesbrough*, (Middlesbrough: Gazette Media Company for South Tees Hospitals NHS Trust, 2002); John V Pickstone, *Medicine and Industrial Society*, (Manchester, Manchester University Press, 1985); John Hall, 'From cottage to community hospitals: Watlington Cottage Hospital and its regional context, 1874-2000', *Journal of Local Population Studies*, 88 (2000), pp. 33-49; Dr Meyrick Emrys-Roberts, *The Cottage Hospitals 1859-1990: Arrival, Survival and Revival*, (Motcomb, Dorset: Tern Publications, 1991); Veronika & Fred Chambers & Rob Higgins, *Hospitals in London*, (Stroud: Amberley Publishing, 2014); Charles Renton, *The Story of Herefordshire's Hospitals*, (Logeston, Herefordshire: Logeston Press. 1999); Edward Davies, *The North Wales Quarry Hospitals and the Health and Welfare of the Quarrymen* (Gwynedd: Gwynedd Archive Services, 1988).

⁸ Dorking Cottage Hospital (Surrey) opened in 1863 with 6 beds. Following rebuilding, by 1899, it had seventeen beds and three cots for children. Reigate Cottage Hospital (Surrey) founded 1866 with eight beds had, by 1899, expanded to twenty-one beds and four cots. Burdett, *Cottage Hospitals*.

⁹ From the 1830s, Powell Duffryn was a major South Wales mining company with interests in shipping and railways. <http://www.fundinguniverse.com/company-histories/powell-duffryn-plc-history/> (Downloaded July 2016.)

¹⁰ Davies included an extract (p.p. 69-70) from the *Caernavon and Denbigh Herald*, 17 May 1873, which described Dinorwig as 'a small cottage hospital containing two excellent wards' replaced with a new larger hospital by 1885. The original was exclusively for quarry workers but Davies included a reference to the Inpatient Book that a few women had been admitted to the new hospital. Davies, *The North Wales Quarry Hospitals*.

¹¹ UK Data archive is the largest repository of research data for the social sciences and humanities. At the time of writing we still have to discuss whether the UK Data archive would be a suitable place of deposit for the data created for this thesis. <http://data-archive.ac.uk/>

¹² In 1875, Bourton admitted 41 patients, Moreton 37 and Cranleigh 14 plus 3 remaining in hospital at 31 December 1874.

¹³ For example, *Bourton Cottage Hospital Annual Report, 1884*, Hospital Statistics of 23 years, p.16. Gloucester Record Office.

¹⁴ About three miles from Cranleigh lies the village and parish of Ewhurst from which patients were admitted to the hospital. In the 1871 census its population was 959. There were a number of other villages and hamlets from which patients were drawn such as Wonersh (popn 1561), Dunsfold (popn. 720) and Alfold (popn. 470). The Cranleigh hospital catchment area population was therefore estimated to be between 5000 and about 6000. In various of their publications both Napper and Burdett recommended that a cottage hospital contained one bed per thousand of its target population. Cranleigh opened with four beds and by the end of its first year, provided six. Bourton and Moreton were also surrounded by a number of villages and hamlets, so it conjectured that their catchment

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area populations were roughly triple that of the core parish. Bourton opened with six beds and Moreton with seven.

¹⁵ *Cranleigh Village Hospital Annual Report, 1864*, patient no. 17.

¹⁶ Albert Napper, *The Advantages Derivable to the Medical Profession and the Public from the Establishment of Village Hospitals*, (London: H K Lewis, 1864). Of these one hundred patients, sixty-seven were parish paupers, sixteen 'in humble circumstances', ten had their fees paid by the Poor Law Guardians, and seven were 'incapable of remunerating a surgeon'. Sixty-nine were 'cured', fifteen were 'relieved' ten were 'not benefitted' and six died.

¹⁷ The sequential patient number enables the individual to be identified when their stay spans more than one Annual Report. Gender was not always given for infants. Age was not given in a few cases, some of which were itinerant workers such as navvies. The subscriber's name is that of the person recommending the patient for admission, a requirement in cottage hospitals, except in the case of an accident where authority to admit was delegated to the Medical Officer.

¹⁸ Although the Registrar General's classification of causes of mortality was available, because its focus was on death it did not provide solutions for medical conditions which were not fatal. More information can be found on the classification system on the HHARP website: <http://hharp.org/help/diseases.html>.

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