

# FROM DISPENSARY TO HOSPITAL: MEDICINE, COMMUNITY AND WORKPLACE IN ANCOATS, 1828-1948

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**For medicine, as for most sectors of history, we know Ancoats from the outside-in. We would like to know it inside-out, but we do not; and we have very few materials for such a history. Instead, we have the reports of observers sent into Ancoats on surveys, or stationed there at the sites of charity — in the philanthropic institutions through which the working classes were serviced and recorded.**

A history of health and medicine from the inside-out would begin in the crowded housing courts by Loom Street or Spital Street, where filth and damp and cold sapped both bodies and souls. It would focus on the chronic diseases of gut and chest which were the life-experience of so many. It would focus on workplaces and accidents. It would follow the sick and injured as they sought assistance first, perhaps, from relatives or neighbours; then from the tradesmen and craftsmen whose shops lined the larger streets — say to the two surgeons and the eight druggists (or chemists) on Oldham Road.<sup>1</sup>

A history from inside-out would explore how patients and their carers chose between various kinds of remedies — from home or shop, informal advisers or qualified doctor. It would chart the financial, medical and social conditions under which patients or their friends would seek recommendations to a medical charity. Was it for the status of the doctors, or because the service was free? How did people feel about obtaining recommendations, via shopkeepers and local pubs, or from clergymen or middle-class supporters of the charity who lived in adjacent residential suburbs? What was the atmosphere in the waiting rooms of the Manchester Royal Infirmary or the Ancoats Dispensary (later Hospital)? How were choices made between one facility and another, and by whom? How did class-relations operate between patients in cellars and the doctors who made home-visits from a charity? How did patients view the prospect of a stay in a hospital ward? And when a worker was badly injured, who decided whether s/he should be taken home, or carried to the hospital?

Such a history is still a long way off, but we know it will need to place health and disease in the context of individual biography, family economy, social structure and community. It is in concerns with work, reward and fatigue, and with housing, food and drink that we shall find the materials for a patient's view of illness. And we will then need to explore when and how philanthropic and professional actions and vocabularies interacted with these biographies of hard-earned lives.

Meanwhile, we must write what we can: the history of the agencies which serviced Ancoats, especially here, the Ardwick and Ancoats Dispensary (and later, Hospital). Founded in 1828 to provide professional medical services to out-patients and home-patients, it was expanded in the 1870s to also include in-patients.<sup>2</sup>

The name gives the game away immediately. The Dispensary did not even claim to be an expression of 'community' within Ancoats; rather it expressed a dependence. Ardwick,

the largely middle-class suburb, was twinned in philanthropy with its poorer neighbour. The subscribers of Ardwick (and beyond), including those who owned factories and businesses in Ancoats, would fund a medical charity for the hand-loom weavers, the factory workers and the labourers of Ancoats. Ancoats was 'a very dependent district': meaning, of course, that the surplus value created there was returned, in part, as the gift of those who lived elsewhere.



*Ancoats Hospital today.*

## **Ardwick and Ancoats Dispensary**

Ancoats Dispensary, as we will call it for short, was the third such charity in the Manchester conurbation. Up to 1825 the Manchester Infirmary, situated in Piccadilly since 1755, had been the only medical institution in the city. From 1781 it had served home-patients as well as in-patients and out-patients. After about 1796 the home and out-patient services were organised as a Dispensary\*. Such a conjunction was anomalous, for in most small towns Dispensaries had been set up in the absence of a hospital; and in most comparable cities, Dispensaries had been established as new charities, independent of the older Infirmary.

The expansion of Manchester posed problems for the central Infirmary/Dispensary. Could the service-district be expanded? Should branch Dispensaries be formed in outlying districts? Or should one encourage the formation of separate charities? The third course was favoured, and relatively easily followed where districts had their own administrative machinery. Thus the Chorlton-on-Medlock select vestry, which administered the Poor Law in the southern suburbs, seems to have been instrumental in founding the Chorlton Dispensary in 1825-6. Similarly, leading citizens of Salford established a Dispensary there in 1827.

Ancoats, however, was not an independent township, or even a separate police district of the Manchester township. It was but a mass of mean streets and courtyards zig-zagged

\* The word 'Dispensary' is capitalised throughout to distinguish institutions from merely places where drugs are dispensed within hospitals.

amongst factories and canals. Establishing a Dispensary there had been strongly urged by the Board of the Infirmary, partly because the expansion of Ancoats meant that many inhabitants were now beyond the visiting area of the Infirmary. The Infirmary Board were unwilling to extend their boundaries; instead they sought to protect their finances. Many *patients* lived in Ancoats, but few *subscribers* to the Infirmary; the district cost far more than it paid for. It was peculiarly dependent. Presumably, a more *local* charity, especially one which included Ardwick, would stimulate more local participation and subscriptions.

We do not know who took the initiative in founding the Dispensary. The patron was Sir Oswald Mosley, Lord of the Manor of Manchester; the President was George Murray, one of Ancoats' largest manufacturers, and a Congregationalist. The Secretary (in 1831-2) was the Reverend Thomas Tate, and that post continued to be occupied by a succession of local ministers until 1872. One of the Secretary's tasks was to write the prefaces to the Annual Reports, variable mixtures of observations and exhortations.

Among the largest donors were other local industrialists, notably James McConnel of McConnel and Kennedy's, together with various members of the Kennedy family, self-made Scots who attended the affluent Unitarian Chapel in Mosley Street. Approximately 50 per cent of the other subscribers also came from the district; another 20 per cent had Ardwick addresses; 25 per cent were from Central Manchester, and the other 5 per cent were from elsewhere or are unknown.<sup>3</sup>

The medical staff (in 1831-2) comprised two physicians and two surgeons. Both the physicians were young men, raised in the region, and newly returned to Manchester after university education elsewhere. Dr. Pendlebury had studied in Cambridge and then gained clinical experience in Dublin and Paris. In 1828 he was 21 years old; he later moved to the Chorlton Dispensary, and in 1838 was appointed as a physician to the Manchester Infirmary. He died in 1842.

ambitious, Kay used the Dispensary post as a base for investigation and commentary, both medical and social. In 1830 he reported medical observations in a new periodical, the *North of England Medical and Surgical Journal*, which he had established with colleagues in Yorkshire. The next year brought cholera to Britain and Kay was appointed to serve on the Special Board of Health in Manchester. He surveyed the 'dangerous districts', and served at the emergency hospital at Swan Street, Ancoats, where riots broke out over the insensitive treatment of working-class victims. From such experiences he wrote his classic *Moral and Physical Condition of the Working Classes* (1832). And, in the aftermath of the epidemic, with his young intellectual and liberal friends he founded the Manchester Statistical Society to systematically examine the condition of the poor with a view to reform. When he was leaving Manchester, after a breakdown, he composed his parting shot, a major critique of Dispensaries as social instruments.<sup>5</sup> Through these publications, Kay becomes our major guide to health conditions and social ideologies in Manchester *circa* 1832: at a major turning point in British history.

The condition of the poor was then a major issue, and so were the rights and responsibilities of the urban middle-classes. Poor Law expenditure was threatening, so were epidemics and industrial and political unrest. Liberal ideologues diagnosed and prescribed, locally and nationally. Their framework was the political economy of Ricardo.

One key local issue was the causes and consequences of increased expenditure on medical charity. Did it mean that the poor of Manchester needed more and more medical care? Were their lives but one long disease, as some doctors maintained? Or was the fault to be located in their moral rather than their physical condition — in a failure of forethought bred from lack of education and encouraged by the availability of charity, including medical charity?

Kay took the latter position. Although well aware of how the poor struggled to survive on larded potatoes and tea, his major prescription was education, particularly national schooling of which he was to become a major proponent. He was already involved with new agencies set up around 1830 to penetrate working-class districts, spreading gospels both sacred and secular. Various churches, chapels and societies sent missionaries into Ancoats to save the poor. So, too, did the District Provident Society, the founding of which in 1833 was directly inspired by Kay. Such agencies preached the moral economy of *providence*: if working families would save a small sum each week, then they would not be so exposed to the economic consequences of trade depressions, accidents, or illness.

Kay would have preferred Dispensaries to operate on this same providential principle: medical care should be paid for on an insurance basis (a possibility much canvassed nationally at this time). Alternatively, the system of factory surgeons could be extended. Kay regretted that Dispensaries, as they currently functioned, failed even to ensure respect either for their subscribers or for their honorary medical staff. As he pointed out in his pamphlet on the *Defects of Dispensaries*, charity was being taken as a right rather than a gift, while doctors were overloaded, forced to cut corners, and generally unappreciated.

**ARDWICK AND ANCOATS DISPENSARY.**

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No. 78 *John Birkon* Admitted 28 July 1832

**DR. PENDLEBURY** is your Physician, and you are to attend him every *Wednesday and Saturday* at the DISPENSARY, exactly at Nine o'Clock in the Morning, during the continuance of your complaint; or until you have notice to be discharged. And you are, every time, to bring back all your Bottles and Gally-pots well Cleaned, together with this Paper, without which you cannot have any more Medicines.

When ordered, you must come to the Dispensary, to have a regular discharge from the House Apothecary, and bring this Paper along with you, that you may go to the Subscriber who recommended you, and acquaint him or her that you are discharged. You must demean yourself peaceably and respectfully during your attendance; and not commit any waste in disposing of your Medicines improperly. If you neglect to attend according to these directions, you will be discharged for **IRRREGULARITY**; and after that you cannot be admitted in future, to receive any benefit arising from this Charity, upon any recommendation whatever.

Any Out-Patient absenting him or herself from the Dispensary a ~~full~~ night, without the permission or knowledge of the Physician under whose care such patient may be placed, will be discharged for non-attendance; and notice will be given accordingly to the Recommender.

**Patients are to find their own BOTTLES.**

*Page in the Book,*

Printed by HENRY SMITH, St. Ann's-Square.

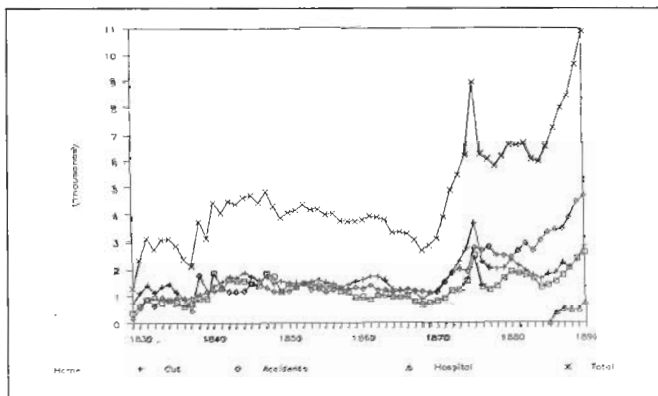
*Instructions to a Dispensary Out-Patient, 28 July 1832 (during the cholera epidemic).*

The second physician, who later became a notable civil servant, was James Phillips Kay (1804-77), raised in Rochdale, and a graduate of Edinburgh. He came to Manchester in 1827 and soon afterwards failed in his attempt to join the Infirmary staff; in 1828 he was 24 years old.<sup>4</sup> Like the industrialists mentioned above, he attended Unitarian chapels; indeed, he courted one of the Kennedy daughters, but was deemed unsuitable by the family. Industrious and

*The actual toil of attending the home-patients of Dispensaries at their own houses is very great — not to mention the repulsive character of the scenes into which the professional visitor is introduced. (But) . . . this system creates no permanent link of sympathy and gratitude between the different orders of society, and (it) undermines the virtues and independence of the poor. (pp.24-5)*

Kay's pamphlet was written in 1834, the year of the New Poor Law, designed by Edwin Chadwick. Like Kay, Chadwick was born in this region; unlike Kay he succeeded in marrying a Kennedy. He worked in London as a kind of civil servant, moving in the radical circles around the *Westminster Review*. Kay was already in touch with these groups when he left Manchester for a salaried post as a Poor Law Commissioner in East Anglia, so joining the Chadwick cadre as they set out to remodel pauper-relief and provide an institutional base for a national 'Public Health' programme. The Poor Law reformers' central ideology was close to Kay's: educate, but never give aid which could sap independence; remove the public causes of disease (e.g. filth), especially where these are independent of the economy and personal action, but do not give medical aid to anyone who could in principle pay for it.

The New Poor Law came to affect Dispensaries by separating statutory provision from charity service; Dispensaries such as Ancoats lost their subsidies from the Guardians. To a degree, they also lost some of their pauper custom: the Poor Law medical officer appointed to the Ancoats district in 1843 found that his work grew rapidly over the first two years as paupers discovered that it was simpler to obtain a medical relief order from the relieving officer than to get a letter of recommendation to the Dispensary.<sup>6</sup> Thus, despite the increasing extent of poverty and medical need in Ancoats, the number of patients treated at the Dispensary hardly changed over the next few decades (see graph).



Patients Treated by the Dispensary and Hospital, 1830-1890 (Note: the peak in the mid-1870s is attributable to an epidemic of smallpox.)

But the Dispensary continued nonetheless. In part this was because there were alternative ideologies, even in Manchester around 1840, and alternative projects into which medical charity fitted. Young doctors continued to need junior institutional positions, so they still queued up to be elected. Some of them did not share the animus against charity, nor the reductive view of disease causation which came to characterise the Public Health movement in the 1840s. Indeed, even in the reports sponsored by Chadwick, one could find a different tradition emphasising *destitution* (rather than filth) as the central cause of fever. Richard Baron Howard, the author of the Manchester sections of the sanitary inquiry of 1840,<sup>7</sup> had been doctor both to the Workhouse and the Ancoats Dispensary before becoming an Infirmary physician.

He stressed that the causes of fevers were extremely complex and 'interwoven with the perhaps unavoidably unpropitious position of the lower orders in densely populated manufacturing districts'.

To such men, charity was useful in off-setting destitution and the worst of its effects. Others would argue from different bases against hearts that were hardened by an 'avaricious philosophy'. Unsurprisingly, the Treasurer of the Ancoats Dispensary in 1845 was among those who would 'have nothing to do' with that

*imperfect philosophy which would repress promiscuous almsgiving, and which had dictated a false policy with regard to the poor . . . It is not adapted to a civilised, far less to a Christian community.*

But accompanying this appeal to Christian values was a medical threat:

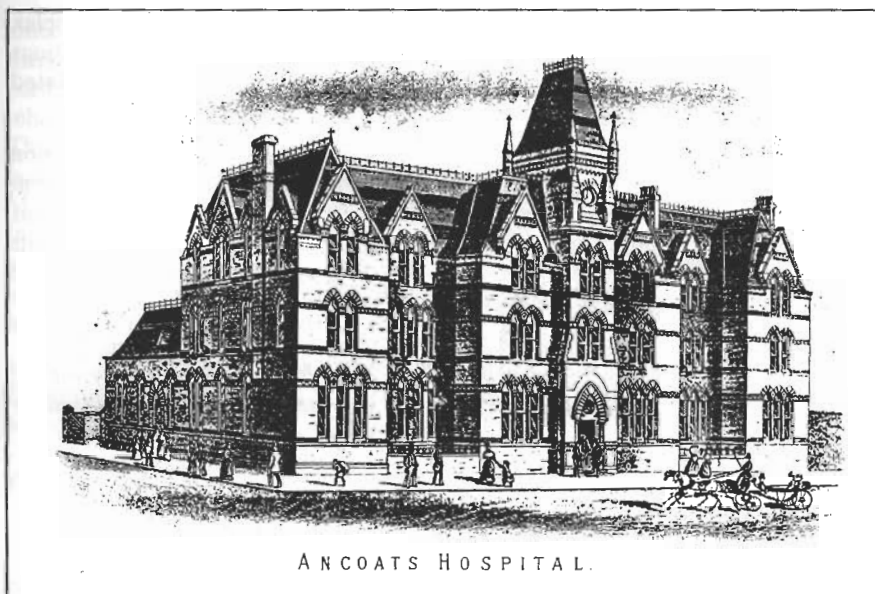
*disease neglected in such districts as Ancoats, especially if of an epidemic character, cannot be confined within the cellars of the poor, but may find its way to the dwellings of the rich, borne upon the wings of the freshening gale which the favoured inhabitants of a rural suburb may gladly inhale, all the while unconscious that the breeze may have swept along the deserts of Ancoats; and that the angel of death may have spread his wings on the blast.<sup>8</sup>*

From such mixed motives, subscribers to the Dispensary continued to subscribe. But, as the Treasurer's exhortation suggests, the tide of the 'imperfect philosophy' encouraged by Kay and his ilk was running strong against medical charity. Population, wealth and luxury in Manchester all increased, but subscriptions to the Dispensary decreased. Between 1830 and 1848, few new medical services were founded in Manchester.

### From Dispensary to Hospital

From around the mid-1850s, however, conditions began to change. Partly as a result of Nightingale's fame in the Crimea and the hospital movement she mobilised, a new enthusiasm for hospital-building emerged. In the 1860s, the suffering caused by the Cotton Famine and the 'success' of the relief operation further sapped utilitarian hard-heartedness. New medical charity, especially for women and children, was bestowed partly as reward for the 'good behaviour' of the working class. Much of the money that was left over from the relief fund was distributed to help provide hospitals.

But this is only a part of the backdrop against which we can explain the improved fortunes of the Ancoats Dispensary in the 1860s, and the fact that in 1869, for the first time, the managers were able to balance the books and think about transforming the Dispensary into a hospital. No less important — just as with the building of new infirmaries in such towns as Ashton-under-Lyne, Wigan, and Blackburn — was the growth of support from local employers and employees — the linking of hospitals and workplaces. Although the final decision to build the Ancoats Hospital depended upon a gift of £5000 in 1872 from Miss Brackenbury,<sup>9</sup> the daughter of a solicitor who had made his fortune in the railway boom of the 1840s, it was the grass roots support that encouraged the management committee to think about providing larger and more suitable premises. The new building at 24-28 Mill Street (on land purchased from the Manchester, Sheffield and Lincolnshire Railway Company) opened in January 1874 as a Dispensary; it was not until 1879 that the first six beds were made available for in-patients.



Ancoats Hospital, Mill Street, as first illustrated in the Annual Report of 1885.

Support for the Dispensary from local workers can be traced from the late 1840s. In 1848 the Annual Report remarked that

*A few donations have been received, and the Committee have much pleasure in stating that the operatives in the employ of Messrs. McConnel and Co., Murray and Co., Longden and Co., and Ireland and Co., have voluntarily subscribed to the Institution, which, as a proof of their appreciation of the benefits conferred by it, is exceedingly gratifying.*

In following years there appeared in the Annual Reports a separate section headed 'Subscriptions from Workpeople'. By 1852 the list of firms whose workpeople subscribed had risen from four to twenty, the amount collected exceeding £100. Although trade cycles greatly affected the amounts that could be gathered from shop-floor collections (in 1876 the sum fell to an all-time low of £14), the tradition was well established before the Hospital was opened, and it persisted through to the Hospital's absorption into the National Health Service (NHS) in 1948. By 1912, just before the National Health Insurance Act came into operation, the amount thus collected was over £800, with another £350 coming from the pooled shop-floor collections distributed by Manchester and Salford Hospitals Saturday Fund (established in 1872).<sup>10</sup> In all, this only amounted to around 10 per cent of the Hospital's ordinary income, but it surpassed that stemming from donations and was about a third of the total amount from all subscribers. In the interwar period, shop-floor collections rose from just under £1000 to well over £6000, though by 1939 all but 8 per cent of this sum was coming from the Saturday Fund.

Contributions from employers are less easy to determine since they were not separately entered in the Annual Reports. Indeed, in some cases the amount that a firm contributed was lumped together with that of its workpeople. From the annual list of subscribers, however (calculating on the basis of entries for 'Co.'s, 'Messrs', and 'Sons'), a conservative estimate of the number of employer subscribers lies between 35-40 per cent of the whole. Not all these firms were Ancoats-based, although those that were not, appear to have conducted business in the district and had employees (such as coal delivery men) who might have expected to make need of facilities for the treatment of accidents. Financially, their contribution represents between 40-50 per cent of the

sum from subscribers, and both this percentage and that for employer-subscribers appears to have remained much the same for the last three decades of the century. While firms like the Ancoats Vale Rubber Co, the Dukinfield Coal Co, Threlfall's Brewery, and Messrs P. & J. M'Gregor of the Falcon Iron Works regularly subscribed 2 or 3 guineas, others such as Midland Railway, or the Pendleton Alum Works of Holland Street subscribed two and three times this amount. Additionally, there were one-off donations, such as the 150 guineas from the Fine Cotton Spinners Association in 1900.

Although the combined contributions from workpeople and employers seldom amounted to more than 40 per cent of the Hospital's ordinary income,<sup>11</sup> such support was highly significant. In effect, it transformed the meaning of the

Dispensary-cum-Hospital from that of a charity intended for the 'deserving poor' to a kind of pre-payment medical service for wage-earners. In contributing to the Hospital, employers and employees expected to avail themselves of its services as and when they required, especially in relation to workplace injuries. (In some cases contributions came specifically from workplace 'accident funds'.)<sup>12</sup> Subscribers to the charity were of course entitled to a certain number of letters of recommendation — a system that was not to be abandoned at this Hospital until 1911. But it remains unclear if this entitlement operated in the case of group subscriptions from workers and firms, and, if it did, whether injured workers from contributing firms were expected to bear such letters in the event of seeking medical aid. The latter seems unlikely, for 'recommends' often bore the stigma of poverty. Our impression is that employers and employees who contributed to the Hospital (whether directly, or indirectly through Hospital Saturday Fund Collections) came to regard its services not as a privilege but as a right, and hence to prevail upon the medical staff more or less as servants in their employ. But however the system worked in detail, employers and employees, for their part, and the charity for its, were agreeing to mutual obligations which distanced both parties from the conventional relations of medical charity.

In essence, then, capital and labour's combined support for the charity involved a kind of providentialism, albeit largely independent of the rhetoric of the ideologues of the early 1830s. And this informal practice of medical insurance fitted well with the moral discourse around philanthropy that was emerging as dominant at the time the Hospital was being proposed in the early 1870s — the discourse exemplified and enshrined in the Charity Organisation Society (COS), which was established in London in 1869.

Although the COS was influenced somewhat by the evangelical reaction of the 1850s and early 1860s to the previous reign of hard-heartedness, it was essentially utilitarian in its outlook. The kind of efficiency that Chadwick had sought in the administration of state Poor Law, the COS endeavoured to apply in the sphere of voluntary welfare — by applying the same abstract principles of rationalisation that served to maximise profits by minimising 'waste' in business and industry. 'Indiscriminate' giving; of the sort favoured by evangelicals and sentimentalists as a result of

their individual encounters with poverty and illness was scorned by the COS. Instead, they urged co-ordinated, targeted welfare which could operate practically and ideologically to alleviate the causes of poverty.<sup>13</sup>

Of particular concern to the COS was the eradication of the so-called 'abuse' of medical charity by those persons who were deemed capable of contributing something towards their medical care. From the mid-1860s this rhetoric had been encouraged by general practitioners who were increasingly fearful of losing the custom of working people and their families to Dispensaries and hospital out-patient departments.<sup>14</sup> In the opinion both of doctors and the COS, hospitals that dispensed gratuitous medical aid to wage earners demoralised them by failing to inculcate thrift. Thus, in rhetoric strongly reminiscent of that deployed by Kay earlier in the century, the COS argued for Provident Dispensaries where workers would pay a few pence per week against the event of medical need, and in the process learn the virtues of self-help.<sup>15</sup>

The managers of the Ancoats Dispensary eagerly seized upon the COS-type rhetoric whilst planning their Hospital, even if, at the same time they benefited from expressions of more sentimental philanthropy.<sup>16</sup> At a meeting in December 1873 it was resolved that 'in order to encourage habits of self-help and independence in the working class, and to provide against the possible abuse of this charity, (the Hospital) recognises the necessity of adopting the Provident system'.<sup>17</sup> Such views were bolstered by the paper read to the Manchester Statistical Society earlier in 1873 by William O'Hanlon, the owner of a successful printing firm in Ancoats and a member of the District Provident Society. In the course of condemning the 'abuse' of local medical charities and calling for the formation of a local COS, O'Hanlon admonished 'those who can combine so successfully for the purpose of raising wages, and for the promotion of class interests, and pay so freely to obtain these objects, . . . (to) unite to provide for the contingencies of accident or disease.'<sup>18</sup> Interestingly, it was among the workpeople of Messrs. Parr, Curtis, and Co., machinists of Ancoats, that O'Hanlon found an ideal model of providentialism: through a penny deduction from wages (or a halfpenny from those whose wages were under 16 shillings per week), the workers provided a fund to help sick members, a portion of which went to the Ancoats Dispensary in payment for services rendered.<sup>19</sup>

The extension and formalising of this model was attractive to the managers of the Hospital. On the one hand, a provident system could be expected to generate some income for the institution; on the other, it promised to relieve the Hospital of the 'great and unnecessary burden' of gratuitously treating persons other than the 'really indigent and deserving'.<sup>20</sup> Although it was recognised that such a system might 'materially interfere with the private interests of (local) medical practitioners . . . and unfairly rob them of their patients',<sup>21</sup> this problem was to be solved by allowing those paying into the Provident Fund to 'employ their own doctors', who would, in turn, present their accounts to the Provident Institution.

Such was the system adopted by the Hospital in 1874, and it may be, as the managing committee proclaimed, that theirs was the first individual institution of its kind to introduce such a scheme.<sup>22</sup> Over the next few years great efforts were made to increase the number of Provident patients, in part by inducing patients who had been treated for one month 'to join the Provident Branch for the remainder of their sickness.'<sup>23</sup> Between June 1875 and June 1876, 5,240

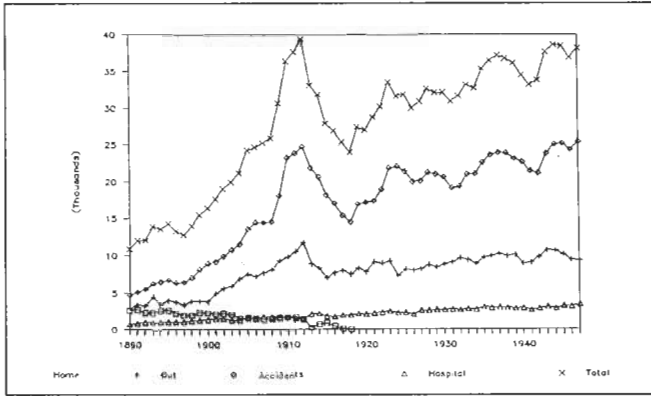
Year	Accident cases	% Accident Cases to total patient population
1828	169	13
1840	1215	26
1850	1189	28
1860	1270	32
1870	1145	36
1880	2429	40
1890	4694	48
1900	8939	54
1910	23279	64
1920	17177	62
1930	20598	64
1940	22683	66
1947	25398	67

Provident patients were seen, and between 1876 and 1877 this figure rose to 7,706. Thereafter, however, in the face of the depression in trade that lasted into the 1880s, the membership declined. While in 1879 it was claimed that there was no similar institution in Manchester where the Provident Branch worked 'better or more economically', it was also noted that 'instead of the movement increasing, it was decreasing'.<sup>24</sup> Eventually the Hospital's Provident Branch was allowed to be taken over and administered by the Manchester and Salford District Provident Dispensaries.<sup>25</sup> Pressure was back on increasing subscribers, especially from outside the borders of Ancoats.

However much the philosophy of providentialism may have suited the ideological interests of the managers of Ancoats Hospital, there were constraints on the extent to which a provident society sick club could serve as the Hospital's financial life line. 'Deserving' but 'uninsured' patients continued to make demands, and increasingly, the Hospital served as a station for accident cases. As in other charity or voluntary hospitals (in contrast to Poor Law infirmaries), accident cases were granted an automatic right of entry and were not therefore easily accommodated within providential schemes.

From the very beginning of the Dispensary accidents or 'cases of sudden emergency' were considered 'proper objects' of charity, and they figured prominently in the records of patients. Fortunately for us, they were listed separately in the admission records in order to distinguish them from patients who entered the institution in the usual way, via letters of recommendation. Quite how, and to what extent, such patients were re-entered in the books as 'home patients', 'out-patients; and/or (after 1879), as 'in-patients'<sup>26</sup> is nowhere indicated, but it is clear that their numbers steadily increased. By 1911 the Hospital was treating, on average, some 65 accident cases a day, and the number continued to rise.

Not all such accidents derived from industry; domestic injuries, especially to children (said to show 'the deplorable carelessness manifested by some mothers'),<sup>27</sup> and drunken street brawls also accounted for many. Exactly *how* many, is not clear, and in the absence of information on the age, gender, marital status, and occupation of patients it is difficult readily to distinguish rhetoric from reality in the Annual



Patients Treated by the Hospital, 1890-1947  
 (Note: The fall in all categories of patients after 1911 reflects the introduction of National Health Insurance for those earning less than £160 p.a. Those insured by the Act registered with 'panel' doctors from whom they obtained primary health care.)

Reports of the early 1880s, where repeatedly there were calls for more moral and domestic education. But by the late 1880s the Hospital's Annual Reports had dropped the moral rhetoric and were once again appealing for support directly



Out-Patients and Accidents 'Waiting Hall'. 1916.



Out-Patient Department, 1926.

from employers and employees on the grounds of the institution meeting the specific needs of industrial injury. Indeed, there is little reason to suppose that the Hospital was much different from several others established around this time specifically to cope with increases in cases of industrial

injury.<sup>28</sup> In part, such increases can be attributed to new risk factors in employment, but probably as important was heightened confidence in and appreciation of the medical, and more especially, the *nursing* skills available, vis a vis the kind of care possible in working-class homes. From 1880, when the category 'Fractures, Other Injuries and Removal of Deformities' (i.e., orthopaedic work) first appeared in the medical section of the Annual Report, acute cases within this category regularly constituted around 20 per cent of all the surgical cases. Wounds, burns and concussions made up another 20 per cent, whereas gynaecological cases (after a female ward was opened in 1887) accounted for only around 8 per cent. In 1890, shortly after a new accident room was built to render the treatment of these cases more efficient, a meeting of managers, foremen and leading men in the principal local firms was organised at the Hospital to reinvigorate workplace subscriptions. Under an elected Workmen's Committee, this new drive proved surprisingly successful. Until the turn of the century, when greater city-wide support was obtained, the Workmen's Committee was to provide a major source of revenue.

### ANALYSIS OF CASES TREATED IN THE HOSPITAL

June 25th, 1885, to June 24th, 1886.

#### MEDICAL.

Head—	Hepatic cirrhosis ... 2	Skin—Psoriasis ... 1
Concussion ... 4	Biliary calculi ... 1	Purpura ... 2
Compression ... 2	Hepatic carcinoma ... 1	Sycosis ... 1
Cerebral Irritation 1	Gastritis ... 1	Eczema ... 3
Chest—	Gastric ulcer ... 1	Nervous diseases—
Pneumonia ... 22	Metritis ... 1	Crutch palsy ... 1
Phthisis ... 20	Colic ... 1	Epilepsy ... 1
Bronchitis ... 18	Poisoning—	Neuralgia ... 1
Pleuritis ... 6	Sulphuric acid ... 2	Pseudo hypertrophic
Cardiac disease—	Belladonna ... 1	paralysis ... 2
Pericarditis ... 1	Gas ... 3	Infantile paralysis 1
Aortic ... 2	Rheumatism ... 8	Chlorosis ... 3
Mitral ... 8	Hysteria & hypochondria 5	Myxoedema ... 1
Tricuspid ... 3	Chronic rheumatic	Syphilis ... 3
Innominate aneurism 1	arthritis ... 1	
Abdomen—	Diphtheria and croup 3	
Morbus brightii ... 7	Typhoid ... 1	
Hepatic gumma ... 1	Tuberculosis ... 3	
		TOTAL ... 151

#### SURGICAL.

Burns ... 17	Morbus coxae ... 2	Adenitis ... 9
Fractures—Skull ... 1	Simple synovitis ... 7	Bursitis—Elbow ... 4
Jaw ... 4	Strumous ... 6	Prepatellar ... 2
Clavicle ... 1	Sacro-iliac disease ... 2	Hæmorrhoids ... 4
Ribs ... 4	Periostitis—Femur ... 2	Urebral stricture ... 6
Radius and ulna ... 1	Tibia ... 2	Hernia ... 3
Pelvis ... 1	Necrosis—	Orchitis ... 2
Patella ... 1	Nose (specific) ... 1	Empyema ... 2
Femur ... 13	Tibia ... 2	Strabismus ... 3
Tibia and fibula ... 8	Fibula ... 1	Lupus ... 2
Fibula alone ... 16	Metatarsus ... 2	Harleip ... 1
Dislocation—Shoulder 1	Phalanges ... 1	Blepharitis ... 1
Sprain—Elbow ... 3	Caries—Spinal ... 2	Genu valgum ... 1
Knee ... 1	Abscess ... 13	Ruptured perineum ... 1
Ankle ... 2	Perityphilitic ... 1	Intractable intercostal
Muscle of back ... 3	Ischio-rectal ... 3	neuralgia ... 1
Incised wounds of—	Psoas ... 2	Varicose veins ... 1
Face including eyes 4	Breast ... 3	Run over—no aftereffects 7
Scalp ... 17	Ulcers—Leg ... 3	Carbuncle ... 2
Body ... 2	Tumours—Ganglion 1	
Upper extremity ... 10	Epithelioma ... 1	
Lower " ... 5	Carcinoma ... 5	
	Sarcoma ... 2	
		Total ... 250

Total Medical Cases ... 151  
 Total Surgical Cases ... 250  
 —396

Annual Report, 1886.

### Medical Imperatives

Thus far we have said little about the role of the medical profession — deliberately so, since for the first fifty years of the institution doctors (as doctors) were at best secondary to its survival. Indeed, with regard to accident cases, the medical

officers frequently expressed frustration at their inability to deal properly with them 'owing', as was claimed in 1854, 'to . . . being compelled to attend them at (the workers') own homes, and entrust them to the care of (the patients') own friends'.<sup>29</sup> Already detectable within such a statement is concern with obtaining therapeutic space wherein surgical skills could be acquired and careers advanced. Although it was not until the 1880s that this space became available (when wards began to be opened and a new operating theatre installed), the Hospital increasingly served as a career stepping stone. Of the dozen surgeons appointed to the Hospital between 1880 and 1900, few stayed for more than a year. Two left to go into private practice, two became medical officers to the Board of Guardians, one obtained appointment at the Edinburgh Royal Infirmary, two at local special hospitals, and five took up appointments at the Manchester Royal Infirmary.

This relatively high turnover partly reflects the increasing incorporation of Ancoats Hospital into local and national medical education. House surgeons' posts were becoming more attractive to medical graduates aiming to be consultants, and hospital managers were able to reduce the salaries for these posts. The senior house surgeon's annual salary in 1875 had been £200, but was reduced to £80 in 1890, while the junior house surgeon's salary was halved from £120 to £60.<sup>30</sup>



*The Accident Room, 1916.*

In other ways, too, the interests of the Hospital managers were at one with those of organised medicine. As early as 1854, they concurred with 'the Medical officers . . . (in) thinking that the establishment of beds is a matter greatly to be desired'.<sup>31</sup> They appreciated that ultimately the reputation of the charity — and hence subscriptions — depended upon the development of medical provision and skills. For the same reason they were anxious to guard against overzealous junior surgeons experimenting on patients. Thus in 1862, it was ruled that 'no amputation, or other great operation, be performed without a previous consultation of a Physician and the Surgeons of the Institution'.<sup>32</sup>

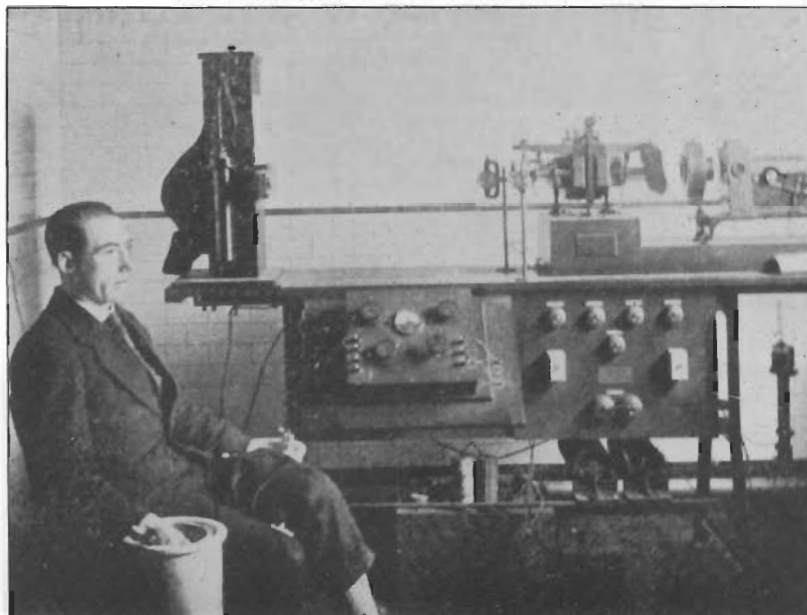
With the introduction of anaesthetics and, more importantly, antiseptic surgery in the 1870s, the prestige and commercial value of medical skills were enhanced. These could now be a direct source of income for the Hospital: in 1880 three private pay beds were brought into use, and in 1883, after witnessing the demand for osteotomies on children — the surgery for correcting bone deformities, often resulting from rickets — the Hospital began charging 2 guineas for this operation. By the 1920s, special services, such as X-rays and massage treatments, were bringing in over £3000 per annum.

Unsurprisingly, it was around the treatment of accidents in particular that careers were carved and the fame of the Hospital spread both regionally and nationally.

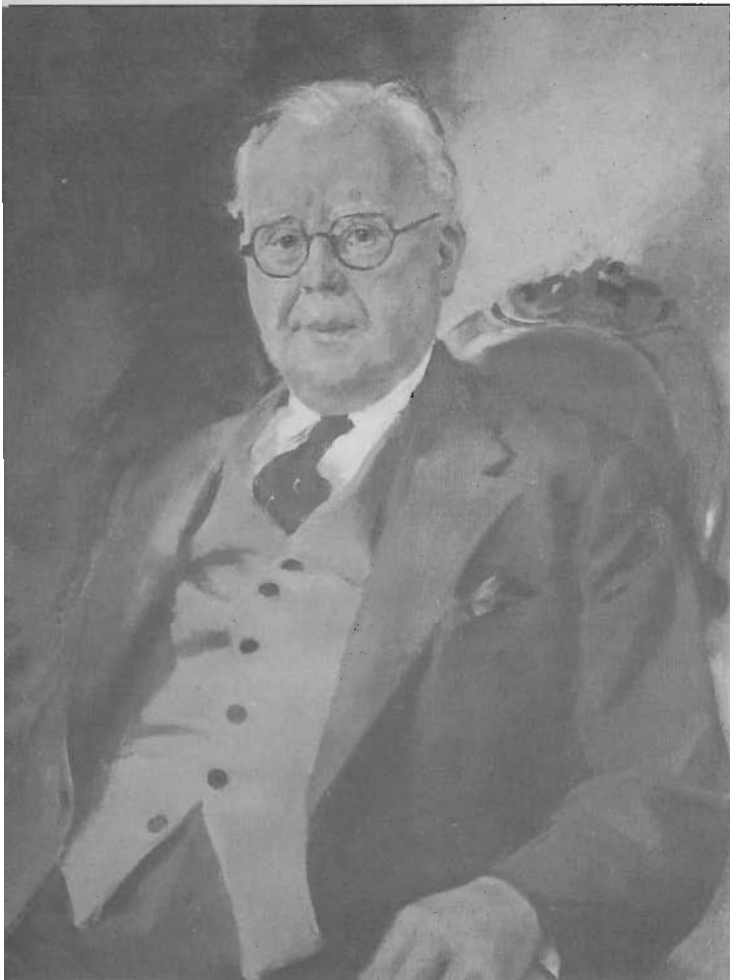
Although specialisation as such was not encouraged by the managers, it was difficult to prevent it. In April 1914 when the budding orthopaedic surgeon, Harry Platt (1886-1986) returned from training in London and in Boston, Massachusetts, to take up an appointment as Honorary Surgeon to the Hospital, he had had to promise not to indulge only in specialist work. Within months of his appointment, however, he was doing just that. In collaboration with the other two surgeons, W.R. Douglas (appointed in 1911, and later a renowned cancer surgeon at the Christie Hospital) and John Morley (appointed in 1912, and later Professor of Surgery at Manchester University), Platt began to segregate the incoming cases according to



*Operating theatre: plaster of paris; application for hip disease, 1923.*



*The clinical electro-cardiograph, 1923.*



*Sir Harry Platt, founder at Ancoats Hospital of the world's first fully segregated fracture service under the control of an orthopaedic specialist.*

specialisms, much as he had seen done in Boston. Thus he was able to establish therapeutic control over all incoming fracture and other orthopaedic cases.

The First World War interrupted Platt's work at Ancoats, but achievements in orthopaedics during the war, especially in relation to fracture treatment, greatly strengthened his commitment to the specialism. After the war, between 1919 and 1921, he established at Ancoats what has come to be regarded as the world's first segregated fracture service under orthopaedic control. His report on this service in the *Lancet* in 1921 laid the foundation for a series of reports by the British Medical Association and by government, which were ultimately woven into NHS policy.<sup>33</sup> In 1932 Platt was appointed the first orthopaedic surgeon to the Manchester Royal Infirmary.

Another notable figure in British medicine who similarly carved a reputation at Ancoats before gaining appointment at the Infirmary was the radiologist and physical medicine expert, A. E. Barclay (1876-1949).

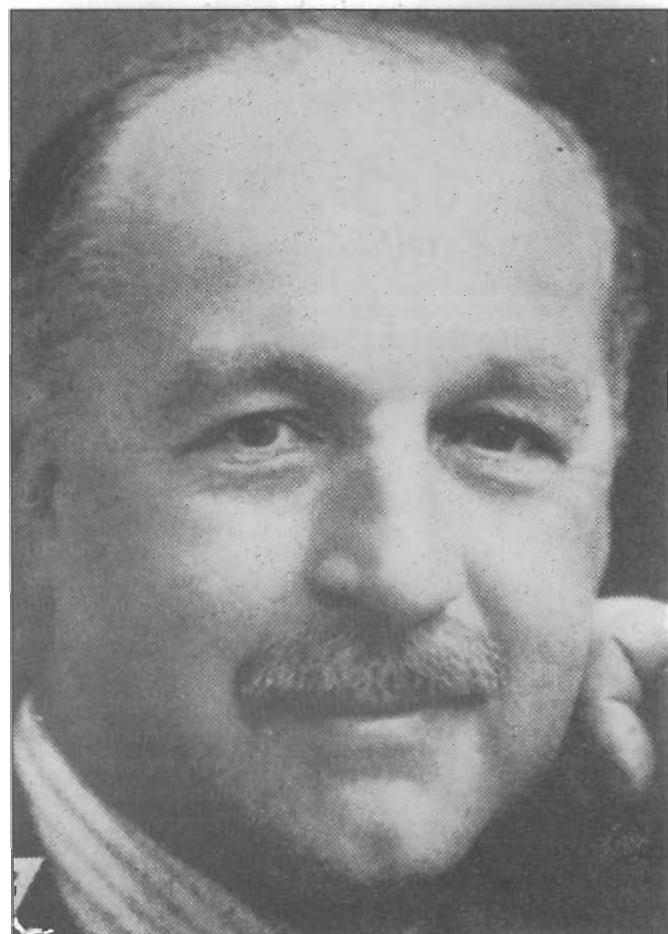
Like Platt, he was the son of a Lancashire industrialist; similarly, he began his medical education locally before proceeding to London to 'round it off'. In 1906 he returned to Manchester to set up in private radiological practice; in the following year he was appointed to Ancoats, where he established the first X-ray department in the city; in 1909 he was appointed to the Infirmary.<sup>34</sup>

Most of Barclay's work was concerned with fractures and with techniques for the rehabilitation of the injured. As such it served further to enhance the reputation of the Hospital as

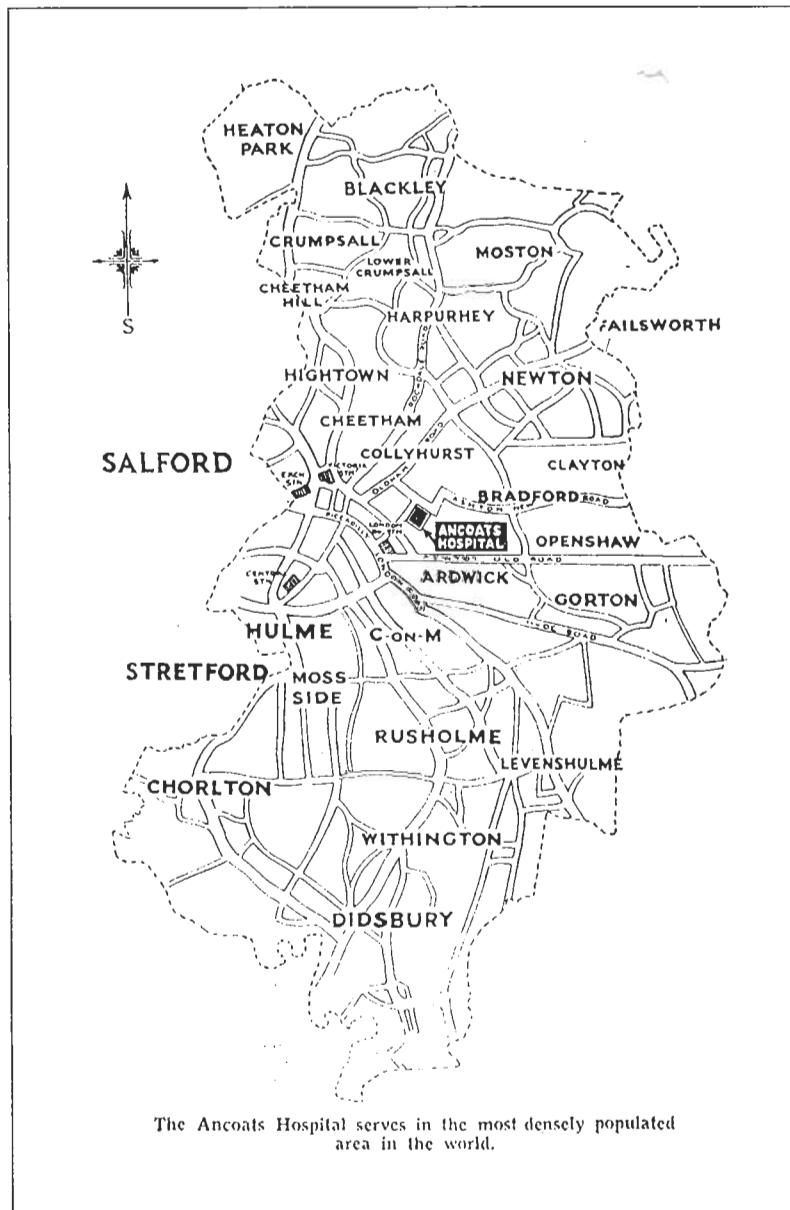
a place for the treatment of industrial injury — a reputation that by the turn of the century was drawing patients from as far afield as Bury, Oldham and Ashton-under-Lyne. Doctors and nurses who had trained at the Hospital began to be sought out by other hospitals with similar types of patients; at least one of its house officers obtained appointment at 'Labour's Own Hospital' — Manor House Hospital, London — in the 1920s.<sup>35</sup>

But the Hospital was not only for accidents; it also admitted medical in-patients. That it was able to do so was largely the result of a donation in the mid-1880s of £12,500 specifically for the opening of a male medical ward. The benefactor was James Jardine, an industrialist who had made most of his wealth in Ancoats and who was subsequently to serve as the Hospital President. Jardine's example was followed by others, enabling wards to be opened for both women and children. Thus by 1887 there were nearly as many medical in-patients (246) as there were surgical (258).<sup>36</sup>

From the mid-1880s, therefore, the Hospital could legitimately advertise itself as a *general* hospital; indeed, it was proclaiming itself 'next to the Royal Infirmary . . . the largest general medical institution in Manchester'.<sup>37</sup> After 1906, when the Infirmary moved from Piccadilly to its current site on Oxford Road, the Hospital could also present itself as the only city-centre hospital; by the 1930s it was projecting this image cartographically whilst claiming to serve 'the most densely populated area in the world'. By then, however, it was networked in various ways to the city and the region as a whole. Affiliated with both the Manchester and Salford Provident Society, and the regional Hospital Saturday and Sunday Funds, the Hospital in the 1920s joined the Hospital Council of Manchester and Salford, and the local Cancer Research Committee. From early on, regional interlockings



*Alfred Ernest Barclay, founder at Ancoats Hospital of Manchester's first X-ray department.*



*The map seeks to convey both a regional and global significance for the Hospital — an impression helped by the omission of the Manchester Royal Infirmary.*

were also required to enable sick children to be sent to the Pendlebury Children's Hospital; for transporting convalescents to Buxton, Cheadle and Southport; and for packing off tuberculous patients to various colonies. Several members of the management committee (eg Oliver Heywood and S.L. Helm) were themselves on the boards of other local medical charities, and it was rare for the managers to innovate in any way without first consulting the experience of other voluntary hospitals in the region. By the 1920s several of its medical staff also held appointments at the Infirmary and other medical institutions, and were involved with the Manchester Medical School. Among the latter was John Stopford, the Dean of the School. If, as was claimed in the 1930s, the Hospital was a 'pillar of the community', this was, at the very least, 'the Manchester and Salford Community'.<sup>38</sup>

Inevitably, too, there were links to national networks. In 1911, amid worry over the fate of voluntary hospitals following the passage of the National Insurance Act, the Hospital joined the British (Voluntary) Hospitals Association. Not unlike the COS and the Saturday and Sunday Funds, the British Hospitals Association sought closer co-operation and co-ordination between hospitals, partly for reasons of

economy and partly (thereby) collectively to fend off the takeover of the voluntary hospitals by the state. Yet, at the same time, the Hospital was increasingly locked into a range of poor law, municipal, and National Insurance-related services, from which it derived a portion of its ordinary income.<sup>39</sup> In 1922, over £900 came from such public bodies, £136 of which was from the VD service run through the new Ministry of Health. Furthermore, as a consequence of having on its medical staff persons who were central to the national planning for the rationalisation and regionalisation of hospital services,<sup>40</sup> the Hospital was to find itself in the late 1930s and early 1940s in the odd position of seeking to defend voluntarism whilst accommodating itself to some form of state medical service.<sup>41</sup>

### Community and Workplaces

In 1882 it was estimated that 31 per cent of the 2,515 heads of families in Ancoats (representing some 10,559 persons in 230 different occupations) were 'very poor', that is, 'those who are always face to face with want'. Another 14 per cent were reckoned as 'poor' or as having 'a hand-to-mouth existence'.<sup>42</sup> In 1889, when the population of the district was around 50,000 (or 201 persons per acre), the death rate was claimed to be well in excess of the 28.7 per 1,000 for the city as a whole.<sup>43</sup> Over half the deaths were among children under five years of age.<sup>44</sup> In 1929 it was estimated that the death rate within the 360 acres of Ancoats was as high as 20.9 per 1000 inhabitants, as compared with 13.77 for Manchester as a whole.<sup>45</sup> No less than at the time the Dispensary was founded, Ancoats was identified with poverty.

Dispensary doctors, making home-visits had known these acres of poverty from the inside. By the end of the century this kind of exploration had become the mission of 'Settlement' workers. By living amongst the poor in this alien world, settlement workers sought to understand and/or create community. Such was the project of young graduates, many of whom became 'social scientists'. Occasionally it was also the mission of a family: Francis Crossley and his wife moved from Bowdon to Ancoats, back to the neighbourhood of the factory which provided their wealth.<sup>46</sup> But this kind of vocation was rare, even among philanthropists or 'socially-minded' professionals. By the late nineteenth century the hospital doctors, the managers, and the lay supporters resided in the leafy suburbs; when they went to Ancoats it was to a place of work. They were not explorers or creators of community, they serviced a population. It was local; they belonged to regional or national networks.

For the Hospital managers the image of a closed-off world of poverty and ill-health was unacceptable. For them it was more important to open up the insides of the community to the outsides, so that the needs of the community and the work of Hospital could not be ignored by the general public. Indeed, from the mid-1880s they repeatedly spoke of cutting major passageways through the district, in part to expose it to the view of potentially wealthy subscribers.<sup>47</sup> While the Hospital needed to be seen as close to the population it served, it could not afford to be suffocated by the surrounding 'community' of poverty.



*The importance of convalescent homes was appreciated throughout the nineteenth century, but few were available for charity patients before the end of the century. Pressure on hospital beds meant that patients usually had to be discharged well before their health was restored. By the late nineteenth century fresh air and good diet were seen as crucial to the recovery process, especially for children suffering from tuberculosis of the bones and joints. The Ancoats Hospital convalescent home at Alderley Edge was typical in providing such care. Organised by the Ladies Committee in 1891, it was initially only for women and children. Twelve beds for men were added in 1900 through the generosity of the wife of Francis Crossley.*

Many of the philanthropists now lived in Bowdon, Wilmslow and Alderley Edge. Like the Crossleys and Jardines, they had made their money in Ancoats, and this continued to be the site of their charity. The Armitages, the Olivers and the Daffornes — several generations of whom all served on the management board and contributed considerable sums to the Hospital over the years — kept up commitments to the Hospital long after the men had retired from their businesses. Typically, Philip Milner Oliver (1884-1954), the son of J.R. Oliver of Bowden, continued as the honorary treasurer of the Hospital in the 1920s (succeeding his father in the post) whilst serving as the Liberal MP for the Blackley division of Manchester.<sup>48</sup> To this closely-knit philanthropic elite the Hospital was a 'family', if distant, enterprise.

Intriguingly, from the turn of the century, not only were the philanthropic elite able to visit Ancoats to perform their charitable duties, but the sick poor were able to visit them at Alderley Edge — not for tea, but for the open air, as convalescent patients at the Hospital's country branch. The Alderley Edge Convalescent Home, which was at first only for women and children, was in the hands of the Ladies Committee, and its management was soon delegated to the members who lived nearby in Alderley Edge. The Ladies Committee were thus able to conduct their 'good works' among the poor without having to traverse the geographies of class: the sick poor of Ancoats would now come unto them and be restored to health. As Ancoats became a philanthropic outpost for the middle class of Bowdon, Wilmslow and Alderley Edge, so Alderley Edge became an outpost for some of the poor of Ancoats.

But what of those who lived in Ancoats? Did they regard the Hospital as serving some kind of cohering community function? Did they share the conviction of the managers about 'the great boon brought into their midst'?<sup>49</sup> Did they acknowledge the managers' cosy perception of the Hospital as far more personal than the Infirmary because of its local position? Did they regard the institution as something to be proud of, to campaign for, to support. Or was it seen simply

as a medical workplace serving the demands of other workplaces? We can only guess, though in guessing there are certain features we should bear in mind.

First, it is likely that as the functions of the Hospital became more general towards the end of the century, and as its bed capacity expanded, there was less need for patients to go outside Ancoats when they required hospital care. Relations between patients and the hospital medical staff must have changed, too, as the latter ceased (completely in 1916) to carry out home-visits. Like it or not, the seriously ill of Ancoats would be hospitalised.

Secondly, as its departments became specialised in their functions, the Hospital served as a place to refer patients from outside the district, at least on an out-patient basis.<sup>50</sup> By the 1930s considerable income was generated by referrals of patients from other hospitals in the region, particularly to the massage, fracture, and radiology departments.

Thirdly, while after 1890 there was an increase in workplace subscriptions to the Hospital, after the First World War most workers seem to have contributed not directly to the Hospital, but to the Hospital Saturday Fund. The primary commitment may thus have been a pragmatic one to a system of medical insurance, not devotion to this particular Hospital. Some workers, such as those who headed the Workplace Fund Committee, obviously had a special commitment to the Hospital. These, perhaps, were aristocrats of labour, who may well have been seeking to ape the manners of philanthropy of the rich. Others workers, however, may have preferred to support more democratic, worker-managed medical institutions, such as Manor House Hospital, which by the 1930s as 'Labour's Own (and only) Hospital' was widely supported and used by industrial workers from all over Britain.

Such workers may even have been contemptuous of the Ancoats Hospital, with its employer patronage and its oligarchical board of managers drawn from the capitalist elite. The 'ragged trousered', as we know from Tressell, did

not 'believe in begging as a favour for what one is entitled to demand as a right', even if they did not succeed in smashing 'the idiotic system of society which these "charitable" people are determined to do their best to perpetuate'.<sup>51</sup> Although we have no such evidence from Ancoats, it is known that many workers in Lancashire were disappointed that the state had not taken over the voluntary hospitals after the Great War, as seemed then a possibility.<sup>52</sup> What is certain is that during the 1930s, when the Hospital managers sought to discountenance the opinion that 'the voluntary hospital system is finished, that it is bankrupt, and that the future lies entirely with municipalisation',<sup>53</sup> there were few new working-class recruits to be found for the Hospital's Workpeople's Fund Committee.<sup>54</sup>

## Epilogue

Indeed, the voluntary hospital system was doomed. The nationalisation of hospitals in 1948, as part of the NHS, meant that Ancoats Hospital would no longer depend on the district's workers and employers for their contributions, nor on the 'local' philanthropists for their subscriptions. The Hospital became part of a national, regional, and city-wide system, supported from taxes, and run, for the most part, by doctors and administrators.

Again, however, Ancoats was anomalous. Too small to have its own Hospital Management Committee under the NHS, it was twinned with Crumpsall, the huge ex-Poor Law, ex-municipal hospital several miles to the north. Its work was increasingly determined by planned divisions of labour between these sites. Ancoats was accessible and had a tradition of accident and acute work — it remained a major casualty station for central and east Manchester, but its importance declined as Crumpsall expanded its range of acute services and as the population around Ancoats declined.

The *rhetoric* of community would persist, but in new forms. There was now no need for workers to organise locally in support of hospital services, whatever that might have meant in terms of communal feeling. Nor was there need for philanthropists to seek identity and local cohesion by concentrating on a particular locality. The Hospital would no longer be advertised in terms of service to a defined community. Its community now, more clearly than before, was simply those who used its services, wherever they lived. 'Community' was no longer required for the support or governance of hospitals.

NHS hospitals met the needs of more or less local populations, but they did not depend on the mobilisation of those

populations, except to protest when plans were made to reduce services or render them less accessible. Such protests were often led by hospital staff, and a discourse of lived community — of residence — was taken up in defence of services and work places. But for Ancoats, as we have seen repeatedly in this essay, this residential aspect of community was always problematic. We have little evidence of community mobilisation as shared feeling; we have lots of evidence about different kinds of services and *workplaces*.

For doctors, the Ancoats Hospital (and Dispensary) was always a place on a career ladder, a temporary work-site. For philanthropists, increasingly, the site of charity was distant from the site of home. For employers, charity institutions were a means of producing cheap medical care for employees. When workers had been enrolled in support of the Hospital, it was through their workplaces, rather than their homes.

Initially, and especially via home-visits, the medical service had been linked to residences, but that link became attenuated after the Hospital was established. In the interwar period, if not before, the Hospital became one of the workplaces of central Manchester, increasingly detached from the population immediately around. It was maintained as a unit in a metropolitan network of medicine and philanthropy. The dependence on locality had always been problematic; the NHS allowed a divorce. Thereafter, for as long as required for the distribution of NHS services, the Ancoats Hospital stood among the factories and warehouses as an important, almost central service — one workplace among others in a district from which homes were being systematically removed. Whatever 'community' had once surrounded the factories, this was being dispersed. Whatever the relations of community to Dispensary and Hospital, and whatever the inwardness in relation to health and medicine, that community was now turned-out. Neither physically nor rhetorically did hospitals (or factories) require to be *communal* institutions. They were now, as in Ancoats they had always been, the product of much larger systems of power.

## Acknowledgements

The illustrations for this article are from the Annual Report of the Ardwick and Ancoats Dispensary and Hospital, and from other material in the Manchester Medical Collection, John Rylands University Library of Manchester. For permission to reproduce it, we are grateful to the Director and University Librarian. We also wish to thank Jon Agar for his help with the graphs, and Joan Mottram for her generous advice and assistance.

## NOTES

1. See Slater's *Directory of Manchester and Salford* (Manchester, 1848).
2. For useful, though celebratory, accounts, see *History of Ancoats Hospital, 1873-1900* (np., nd.); and John Dafforne, *Ancoats Hospital 150th Anniversary, 1828-1978* (n.p., n.d.).
3. *Annual Report of the Ardwick and Ancoats Dispensary* (hereafter AR), 1831-2.
4. See F. Smith, *The Life and Work of Sir James Kay-Shuttleworth* (London, 1923). Forthcoming is a new biography by R.J.W. Selleck.
5. *Defects in the Constitution of Dispensaries with Suggestions for Their Improvement* (London, 1834).
6. *Third Report from the Select Committee on Poor Relief*, 1844, pp.604-7, evidence of H.W. Ker of Ancoats. For the effect of the New Poor Law on other local Dispensaries at this time (some of which were forced to close), see J.V. Pickstone, *Medicine and Industrial Society: A history of hospital development in Manchester and its region, 1752-1946* (Manchester, 1985), pp.89-91.
7. Reprinted as *Report on the Prevalence of Disease Arising from Contagion, Malaria, and certain other Physical Causes, Amongst the Labouring Classes in Manchester* (London, 1840), p.29.
8. AR 1845.
9. The Hospital received a further £2000 upon her death in 1873.
10. Hospital Saturday and Sunday Funds (the latter becoming 'national' in 1873) were distributed to different institutions not simply on the basis of their need, but also, according to the extent to which they were seen to be operating efficiently. Like the Prince of Wales Hospital Fund, which was established in 1897 to bail out the increasingly impoverished voluntary hospitals in the metropolis, the Saturday and Sunday Funds were committed to a COS-like rationalising ideology. Not until 1895 were attempts made for working-class representation on the local management committees.

11. The combined receipts from other subscribers, investments, legacies, pay-beds, and the Manchester Corporation and Board of Guardians were always greater.
12. Seven guineas was thus subscribed in 1885 from the workers of Messrs John Hetherington and Sons, while the employers gave additionally 10 guineas.
13. For a fuller account of COS ideology, specifically in relation to its articulation in late nineteenth century Manchester, see Alan Kidd, 'Charity organisation and the unemployed in Manchester, c.1870-1914', *Social History*, 9 (1984), pp.45-66.
14. COS, *Report of the Sub-Committee Appointed to Consider the Means by Which the Abuses of the Out-Patient Department of General Hospitals May Best be Remedied* (London, 1870); see also I. Loudon, 'Historical importance of Outpatients.' *British Medical Journal*, 15 Apr, 1978, pp. 974-77; and Brian Abel-Smith, *The Hospitals, 1800-1948* (London, 1964), pp.153ff.
15. A full history of the Provident Dispensaries movement remains to be written; for a useful overview, which establishes some connections with the medical activities of friendly societies, see Ruth G. Hodgkinson, *The Origins of the National Health Service* (London, 1967), pp.241-49, 612-19. See also David Green, *Working-Class Patients and the Medical Establishment: self-help in Britain from the mid-nineteenth century to 1948* (Aldershot, 1985), and N. Kirk, *The Growth of Working-Class Reformism in Mid-Victorian England* (London, 1985). For some of the local medical and social sources of interest in the movement, see Pickstone, *Medicine and Industrial Society*, p.209 n.9.
16. The latter primarily through the receipt of new legacies and subscriptions (such as that from Miss Brackenbury), but also through takings from the church-gathered Hospital Sunday Fund. In the 1920s the amounts received from the Sunday Fund exceeded those from the Saturday Fund.
17. AR 1873, p.9.
18. W. O'Hanlon, 'Our Medical Charities and their Abuses, with some suggestions for their reform', *Trans. Manchester Statistical Society* (1872-3), pp.41-69 at p.66.
19. *Ibid.*, p.67. The employers acted as the treasurers of this sick-society, deducting subscriptions from wages. 'I am informed that all the workpeople, amounting to 2000, are members. Any person meeting with an accident receives 3s. to 7s. per week, according to age and subscription, or, in case of death, or loss of arm or leg, £20 to £30. In case of sickness, after six weeks, 10s. to 30s weekly are allowed. The society contributes twenty guineas yearly to the Infirmary, the Eye Hospital and the Ardwick Dispensary'. The *Annual Report* of the Dispensary for 1874 (p.21) indicates that £9 was subscribed by the workpeople of Messrs. Curtis, Sons and Co.
20. AR 1873, p.6.
21. C.H. Bazley, President of the Dispensary, quoted in AR 1873, p.9. Unfortunately, we have little information on the reaction of local practitioners; nor is it clear exactly how many GPs there were in Ancoats at this time. From the addresses of surgeons provided in *Slater's Directory of Manchester and Salford* (Manchester, 1858) it seems that there were no more than half-a-dozen. The balance sheet for 1878-9 of the Provident Branch based at the Hospital reveals only six doctors reclaiming for services rendered (the highest claim being for £31), while the Hospital charged the Fund £73 for the attendance of the resident Medical Officer, plus another £117 for drugs and rent (AR 1879).
22. Locally, at least, only the homoeopathic Dispensaries had introduced such provident schemes. See O'Hanlon, 'Medical Charities', p.59.
23. AR 1877, p.3.
24. AR 1879, p.8.
25. AR 1886, p.10.
26. During the first year in which in-patient facilities were available, 46 patients were admitted, 'the majority . . . accidents, some of them of considerable severity . . . , the remainder were admitted for the removal of serious deformity'. AR 1879, p.5.
27. AR 1879, p.5.
28. See Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: Macmillan, 1993), Ch 5 'Happenings by Accident'.
29. AR 1854, p.6.
30. AR 1891, p.6.
31. AR 1854, p.7.
32. AR 1862, p.4.
33. Platt, 'On the Organisation of a Fracture Service', *Lancet*, 17 Sept 1921, pp.620-1, and see Roger Cooter, 'the Politics of a Spatial Innovation: Fracture Clinics in Inter-war Britain', in J.V. Pickstone (ed.), *Medical Innovations in Historical Perspective* (London, 1992), pp.146-64.
34. W.J. Elwood and A.F. Tuxford (eds), *Some Manchester Doctors* (Manchester, 1984), pp. 126-30.
35. Neil McDonald, a house officer at Ancoats in the 1910s. See Samuel Woodall, *The Manor House Hospital* (London, 1966), pp.99-100.
36. Consistently, the greatest number of medical in-patients were cases of pneumonia and bronchitis, followed closely by cases of rheumatism. Gastro-intestinal and heart conditions also figured prominently.
37. AR 1883, p.6.
38. AR 1938, p.11.
39. One of the first of such services was that established in 1885 for vaccination. The local Board of Guardians paid the Hospital £10 a year for a vaccination room in the Hospital. Given popular hostility to compulsory vaccination, however, this may not have endeared the Hospital to the community.
40. Platt was active on the local Joint Hospitals Committee, and on the Advisory Committee of the Nuffield Provincial Hospitals Trust; John Stopford was also a key figure on the Joint Hospitals Board, and was the vice-chairman of the Ministry of Health's Inter-Departmental Committee on Medical Schools (the Goodenough Committee).
41. See, in particular, AR 1944.
42. F. Scott, 'The Condition and Occupations of the People of Manchester and Salford', *Trans. Manchester Statistical Society* (1882), pp.101-2.
43. Arthur Redford, *The History of Local Government in Manchester*, vol.II (London, 1940), p.421.
44. H. Whittly, 'Work and Cost of the Manchester Corporation Health Department', *Trans. Manchester Statistical Society* (1885-6), Table E.
45. 'Ancoats' Hospital' in *The Book of Manchester and Salford, written for the ninety-seventh Annual Meeting of the British Medical Association in July 1929* (Manchester, 1929), p.126.
46. Dafforne, *Ancoats Hospital*, p.23.
47. See, especially, ARs 1887, 1889, 1992. The need for such roadways was frequently legitimated in terms of 'ventilating' and 'lightening' Ancoats, even of restoring it to how 'they used to think about Ancoats . . . in the old days . . . (as) the land of Goschen', i.e., of light and plenty. (AR 1891, p.7).
48. Another notable member of the management board from 1906 was Arthur E. Gaddum (1874-1948) of Bowdon, the son of the JP, silk importer, and devoted local charity organiser, H.E. Gaddum (after whom Gaddum House is named). In 1915 A.E. Gaddum married the Hospital Matron, who in turn, became an active member of the Hospital's Ladies Committee and was to have a ward named in her honour.
49. AR 1892, p.7.
50. The Hospital was slightly unusual in restricting in-patients to only those from the Ancoats district. See AR 1924, p.37.
51. Robert Tressell, *The Ragged Trousered Philanthropists* (London, Panther edn., 1965), pp.288, 341.
52. There is considerable evidence for this among coal miners, for reference to which we are grateful to Eirau Eynon, who is currently completing a doctoral thesis on medical provision among Lancashire colliers, 1850-1948.
53. AR 1934, p.10.
54. See, for example, the report of the Workpeople's Fund Committee in AR 1932, p.24.