"Co-operate! Co-ordinate! Unify!" The 1920 Proposal to Amalgamate the Medical Charities of Bristol*

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Wars are often followed by a period of reconstruction and the First World War was no exception. Following the resolution of peace in 1918 there was a desire for new solutions to old problems. The establishment of the Ministry of Health is a classic example of this, and the same mood which brought about the new government ministry was also to be found at the local level and at the grassroots of society. However, there was also a conservative concern that revered aspects of British culture could be swept away in a frenzy of reform. Such fears were largely ill-founded but real. The 1920 proposal for the amalgamation of the medical charities of Bristol, which in essence was a plan to unify nine organisations including the six major voluntary hospitals of the city, offers an illustration of this tension between progress and tradition. This paper will examine the proposal and the debate it inspired. It will assess the role of politics and ideology in explaining the ultimate failure of the proposal. Furthermore it will consider what insight the scheme offers into the voluntary medical sector in early twentieth century Britain at the local and institutional level.

I

By the outbreak of war in 1939 there was a powerful movement for the regionalised co-ordination of hospital services in Britain. This became the basis for planning a National Health Service in peacetime. We know where the journey ended but where did it begin? We can trace the movement's history back to the work of the Nuffield Provincial Hospitals Trust, which worked at disseminating the formula it had constructed in Oxford over the late 1930s, and the King's Fund in London. However, before the Nuffield had even begun its Oxford experiment and when the King's Fund was little more than a fundraising body,

there were local hospitals' councils emerging. These councils, such as that which came together in Liverpool in 1927, brought those in the voluntary and municipal hospital movements around a common table. Bristol itself was included in the Gloucestershire Extension of Medical Services Scheme which was established in 1920 under the auspices of the Gloucestershire County Council.[1] However, the scheme's gradual decline was followed by Bristol taking on its own hospitals' council two decades later. It was, coincidentally, this same year of 1920 that saw the publication of the *Interim Report of the Consultative Council on Medical and Allied Services*, or the Dawson Report as it became known. Its author wrote in the *British Medical Journal* during the Second World War, declaring that the report's recommendations for regionalisation 'might well form the basis of reconstruction to-day'.[2] Indeed, the Dawson Report has often been cited as a founding document in the movement for co-ordination and regionalisation in the medical sector.[3] The Gloucestershire scheme and the Dawson Report had similar ideas as they both adhered to a prescription of a network of local health centres as a means to bring about a co-ordinated regional health service. The two can be seen as central and grassroots expressions of the same line of thought.

A clear path could be drawn from such local integrated schemes for the delivery of healthcare in a mixed economy to the establishment of the National Health Service nearly three decades later. However, the political and intellectual lineage of the movement for a more co-ordinated mixed economy of healthcare was not so clear-cut. At the same time as the Gloucestershire scheme was being established, there was a proposal for a simultaneous and rather different development in Bristol. This was for the wholesale amalgamation of the voluntary hospitals of the city. Unlike the Gloucestershire scheme, the amalgamation proposal never became a reality, and as such the city's voluntary and early municipal hospitals continued to develop a mixed economy of healthcare as was the case nationwide. Although it never came to fruition, the proposal does tell us a great deal about the agenda for and opposition to reform in the early twentieth century hospital sector. Concerns that the central philanthropic mission of individual institutions would be lost were a driving force in opposition. Fundamentally, it was feared that the city's hospitals would be reduced to departments in a University Hospital, where teaching would be prioritised over patient care. Although voluntary sector rivalries played their part, it is here argued that it was essentially the traditionalist sentiments of the medical faculties that prevented the amalgamation of Bristol's medical charities in 1920. This study reveals its potential when placed in a multidimen-

sional historiographical context.

The history of the voluntary sector had, until recent decades, been somewhat eclipsed by the historiographical focus on the increasingly central role of the state in the nineteenth and twentieth centuries. This traditionally whiggish view of welfare envisaged charity as a second-rate alternative to state provision.[4] Even those rare volumes that considered philanthropic welfare as a subject for study in its own right ascribed to a similar 'teleological' view, seeing the voluntary sector as being reduced to a 'junior partner in the welfare firm'.[5] This only really began to change with a broader loss of faith in both the desirability and credibility of the welfare state during the 1970s and 1980s.[6]

At the heart of the response to this is a growing body of work considering the historical nature of charity itself. These histories have often sought to define voluntary effort by means of its role within the mixed economy,[7] or by either mediating or perpetuating the relationship between rich and poor.[8] The involvement of women has also been a recurring theme, given that charity was one of the few spheres in which female participation was acceptable.[9] Another particular focus in relation to medical charities has been the power of philanthropists and doctors over patients and recipients, whether in terms of 'policing the body' or of 'reciprocity'.[10] The approach adopted here is to consider the nature of the voluntary sector as perceived by those working within it, by evaluating what the policy considerations and decisions reveal about the ideological conceptions of medicine and healthcare adhered to, whether knowingly or otherwise, by those involved in delivering services in the voluntary hospital movement.[11] It is here suggested that this approach is a valuable counterpart to those contributions that seek to understand such charitable endeavours by their social consequences or in terms of naked self-interest. A specific case of proposals for change, and the arguments for and against that change, offer a rich source for analysis in this field.

Of course this study should also be seen in the context of the history of Bristol, a wealthy provincial city, regarded by many as the unofficial capital of the South West.[12] Its wealth had been the basis for the founding of the city's extensive network of private and charitable hospitals, which ranged from a great many small 'cottage' hospitals to major voluntary hospitals. Within this network the two general hospitals dominated, accounting for 75 per cent of the hospital beds in the city's voluntary sector.[13] The 1920 proposal for amalgamation concerned the larger institutions, all but one of which were founded in close proximity to both the working docks that were at the heart of the local economy and residential areas such as Clifton where the city's trading elite had

made their home, in a similar pattern to that found in London.[14] The very fact that, as Table I shows below, Bristol was home to the second provincial voluntary hospital and then the second provincial specialist ophthalmic hospital in England and that voluntary hospitals continued to be founded into the twentieth century, despite mounting financial troubles in the sector, is a reflection of the long-term economic prosperity of the region. The resilience of medical philanthropy over the centuries is one of many realities which call into question the commonly held view of Bristol as a city whose economic fortunes had been in decline since the eighteenth century.[15] As a result of this prosperity, which allowed for the continuing strength of philanthropy, there was a strong voluntary sector. This may well account for the fact that the proposal was an exclusively voluntary solution to the problems experienced across all sectors of healthcare in the period.

This study also falls within the history of healthcare in the early twentieth century, a subject which has received something of a revival in recent years. In this expanding field works have often focused on the two key areas of finances and co-ordination. The period saw a movement away from charitable funds as the sole pillar of voluntary hospital income, which Steven Cherry has interpreted this as a transition to a 'quasi-insurance' system.[16] Whereas Gorsky, Mohan and Powell have perceived this more as a wholesale 'diversification' of income sources in which contributory schemes, direct patient payments and public funds each played a significant role alongside continuing philanthropic funding. 'Planning' has also been a key theme in the history of healthcare.[17] Fundamental in the planning of the National Health Service was what Daniel Fox termed 'hierarchical regionalism', according to which services are organised around a central hospital or group of hospitals which would be a regional centre for research, medical education and specialist services.[18] Planning and co-ordination have generally been seen as built around the evolving municipal hospital sector, not least in London.[19] However there were organisations advocating reform within the voluntary sector which gathered pace in the 1930s, notably the King's Fund and the Nuffield Provincial Hospitals Trust. It was within this trend that a 'coherent system' emerged amongst Bristol's hospitals in the same decade, although Martin Gorsky has noted that this was achieved only after a series of 'false starts'.[20] One of which was the proposal to amalgamate the city's medical charities.

The example of this scheme, even though it never came to fruition, demonstrates not only that regionalisation organised around medical education was an approach adopted at a local level as early as 1920. It further shows that this was the case for those who sought solutions

Table I. The Nine Medical Charities Included in the 1920 Proposal

Institution	*Foundation*	
Bristol Royal Infirmary (Bristol Infirmary until 1850)	1737	Second provincial voluntary hospital in England – motto 'charity universal' from 1749
Bristol Dispensary	1775	Carried out cowpox inoculations before the 1798 publication of Jenner's book
Institution for the cure of Diseases of the Eye among the Poor (later Bristol Eye Hospital)	1810	Third specialist ophthalmic hospital in England, and the city's first specialist hospital, only five years after the first at Moorfields in London
Bristol Eye Dispensary	1812	Located near the Eye Hospital
Bristol General Hospital	1832	Founded to meet the demand the Infirmary alone could not
Bristol Royal Hospital for Sick Children and Women (later Bristol Children's Hospital)	1866	Had been a dispensary since 1857, became one of many such specialist hospitals to open in this period
Orthopaedic Hospital and Home for Crippled Children	1876	Poor Law Board often acted as patron to patients
Queen Victoria Jubilee Convalescent Home	1899	Located on the Downs, away from the other hospitals near the central city docks
Cossham Memorial Hospital	1907	Founded from the legacy of Liberal Bristol East MP, Handel Cossham, to serve colliery workers of Kingswood

Source: C. Bruce Perry, *The Voluntary Medical Institutions of Bristol* (Bristol, 1984).

within the voluntary hospital sector, a more conservative approach than the integrated service put together by the Gloucestershire scheme.[21] This goes beyond Fox's 'hierarchical regionalism' thesis in that it suggests there was a mood for regionalised co-ordination closer to the grassroots of the voluntary hospital movement from the outset of the period Fox considered.[22] Indeed, while Fox looked to the Dawson Report and key figures of central administration such as Sir Robert Morant, evidence of similar lines of thought can be found in the board rooms of voluntary hospitals in 1920. However, the division caused by the proposal is more in line with Webster's critique of the idea of a consensus around hierarchical regionalism.[23] Furthermore, by considering the proposals and the debate, the question of why this scheme should be a 'false start' will be addressed. It will here be argued that the political realities and difficulties of the situation, such as personal and institutional rivalries, played an important role. However, a number of key concerns on the part of those who opposed the scheme speak to the conceptions of healthcare to which they adhered. This ideological dimension to the debate is here argued to be crux of the matter, and failure to address this on the part of those advocating amalgamation was the fundamental reason for its failure.

II

'The distinction between the voluntary and public sectors was never absolute', as Mohan and Gorsky have recognised.[24] This was never more true than when a collective wartime hospital system was implemented, by which 'Voluntarism itself became-almost-collectivised'.[25] During the First World War, Southern General No.2 was the organisation that incorporated Bristol's public and voluntary hospitals alike under the control of the War Office, and to which the Bristol Royal Infirmary's King Edward VII Memorial Wing served as headquarters.[26] The financial legacy of this wartime role was a troubled one for the voluntary hospitals nationwide, and it was to examine this issue that the Cave Committee was established.[27] The King's Fund famously calculated that government reimbursement for the contribution to the war effort was £530,000 short for the hospitals of London alone.[28] The Bristol Royal Infirmary, for example, received only £3,000 in 1920 and a further £12,000 in September 1921.[29] This came against the backdrop of a 'palpable crisis' which Gorsky, Mohan and Powell judge constituted the only 'genuine threat to the system'.[30] It was one which saw the overdraft of the Infirmary, financially the strongest of Bristol major voluntary hospitals, grow within two years from £17,985 to over £42,125 by the end of 1920.[31]

This troubled legacy of wartime collectivisation to a large extent set the tone for relations between the public and voluntary hospital sectors during the interwar period. During the 1920s, the position of the voluntary hospitals in this mixed economy was largely defined by their provision of services contracted to them by the various levels of government. For example, the Infirmary worked with national government in arrangements over a War Pensioners outpatient department and local government in the establishment of a venereal disease outpatient clinic.

The former was an expansion of an emergency orthopaedic clinic funded by the Ministry of Pensions, 'hearty support' for which lasted only a month before there was contention over funding.[32] The level of funding was considered so inadequate that the Infirmary went as far, on 9 November 1920, as to limit the number of beds provided to 238 until the full maintenance cost was paid to the Infirmary, and further threatened to halt the treatment of pensioners with tropical and ophthalmic diseases from 1 January 1921 unless the Ministry grant was increased.[33] Similar views that the Infirmary was underpaid for services contracted from public bodies plagued the outpatient venereal disease clinic.[34] Another major concern expressed, especially by the faculty, was that the services under agreement with public bodies could threaten the provision of free beds for the 'suffering poor', which in turn threatened the philanthropic ideology of the Infirmary.[35]

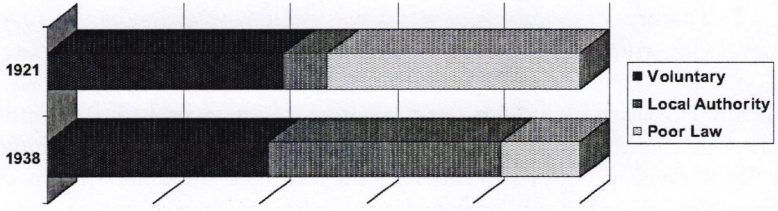
The nature of this mixed economy was altered somewhat by the 1929 Local Government Act, which allowed local authorities to 'appropriate' Poor Law infirmaries as hospitals for the community as a whole.[36] Not all local areas saw these powers put into effect, but in Bristol the appropriation of Southmead Hospital (previously a Poor Law Infirmary) became a local 'flagship policy'. In order to alleviate 'the undesirable taint of pauperism', Southmead developed a specialism in maternity care and a relationship with the University of Bristol, which began nominating faculty members as consultants. This challenged the monopoly of the voluntary hospitals in medical education, as Southmead's opening of an outpatient clinic was a further threat to the territory of the voluntary sector.[37] In 1935:

> The Faculty discussed the repercussions of this proposal and considered that it was highly undesirable, unnecessary, and expensive: and wished to know whether better provision for cases of chronic sickness cannot be made.[38]

Southmead also presented a challenge to philanthropic funding, as many could now perceive they were already financing a general hospital service through the rates. Meanwhile Southmead's stated priority to the poor sick, whilst offering access to everyone dependent on paying some or all of their cost when able to do so, raised the question of how different voluntary and public hospitals really were.[39]

The appropriation of Southmead in the image of the voluntary hospitals was a source political tension, before which relations between voluntary hospitals and government at various levels had been strained. However, as Figure I shows, the place of the voluntary hospitals was not diminished. The division of hospital beds between the voluntary sector and the public sector (within which appropriation moved many beds from the Poor Law to the local authority after 1929) remained remarkably consistent throughout the interwar period. In Bristol the proportion of the city's hospital beds provided by the voluntary sector fell only by 2 per cent (from 44 per cent to 42 per cent) between 1921 and 1938. Meanwhile, nationally the voluntary sector's share actually grew from 25 to 33 per cent.[40]

Figure I Hospital Bed Distribution in the Voluntary and Public Sectors in Bristol, 1921 and 1938



Source: V.Cope, W. Gill, A. Griffiths and G. Kelly, *Hospital Survey: The Hospital Services of the South-Western Area* (London, 1945), pp. 30-34, 178. See also M. Gorsky, '"For the Treatment of Sick Persons of All Classes": The Transformation of Bristol's Hospital Service, 1918-1939' in P. Wardley (ed.), *Bristol Historical Resource* (CD-ROM, 2001), ch. 2:1.

As such, the voluntary sector in the interwar period, despite its political problems, did survive. In fact, amalgamation proposals continued through the period as well; with the unsuccessful attempt to merge the Infirmary and the Children's Hospital in 1927 and the successful merger of the Infirmary and the General in 1939, although there was not such a major amalgamation as was proposed in 1920 until

the foundation of the National Health Service.[41] However, from the perspective of 1920, it was a genuine fear that the voluntary hospitals could be swept away by expanding municipal provision.[42] This and the financial struggles of the sector in the wake of the First World War provided motives for reform, but there was also a structural concern that reform was needed to bring about a co-ordinated voluntary sector. Pre-NHS hospital services have often been characterised by a lack of co-ordination and criticised for a wasteful 'duplication of services'.[43] The contrast with and influence of the 'rationalization' of business and industry under the principles of 'scientific management' over this period only served to heighten this perception.[44] Criticism of this kind came from all quarters. The Royal Commission on the Poor Law was famously so divided on fundamental matters of principle that in 1909 it produced two reports, a Majority Report and a Minority Report. However, on this matter the two echoed each other. The majority sought 'to organize schemes of co-operation between public assistance institutions and voluntary hospitals' while the minority wanted to forge a 'unified' medical service.[45]

Similar reform was also taking place in the field of medical education. A decade before the Bristol proposal, Abraham Flexner arrived in London having already succeeded in remoulding medical education in the United States of America, with Johns Hopkins University the classic example of the importing of the German scientific approach. Flexner's ally in reforming British medical education along such lines was the popular Regius Professor of Medicine at Oxford, Sir William Osler. In 1912, Osler told a Royal Commission under the chairmanship of Lord Haldane: 'We need an invasion of the hospitals by the universities'.[46] In this context, it is no surprise that the Medical School at the University of Bristol was keen to pursue a stronger working relationship with the hospitals of the city. These tended to focus on the possibility of setting up some form of 'Unit System'.[47] Such a system would involve University chairs of departments, typically Medicine, Surgery and Obstetrics (or Gynaecology), leading a team within a large ward especially designated for the purposes of their specialist practice, research and teaching.[48] Around this time, Flexner was advocating the wider adoption of the German-style 'clinical units' being introduced in London at University College Hospital, St. Bartholomew's, St. Thomas's and the London Hospital in 1919 and 1920.[49]

In 1919, the University of Bristol had secured the support of the gynaecologists of the Infirmary and General Hospital, and drawn up a proposed 'Scheme for Organisation of a Medical Unit'.[50] This proposal envisaged nearly 200 hospital beds at the Infirmary and General being

designated to four 'Services' to be staffed by a chief, one assistant and one house physician with clinical clerks and possibly clinical assistants. It was a proposal in which research and teaching featured far more prominently than clinical work. This was furthermore 'a deliberately provisional scheme', expected to be a stepping stone to a 'Central University Hospital' for the city in a matter of years. However, in the first months of 1920, the University was informed by the new University Grants Committee that they would not support the medical unit scheme as it was considered to be 'not sufficiently scientific'. The UGC argued that the University would not have adequate control over the appointment of medical professors and that those University chairs would not be powerful enough in directing research.[51] As a result the possibility of amalgamation was the only option open to the University if it wanted better co-ordinated medical education in the city.

Encouragement had been given when, on March 12th 1919, Sir George Newman addressed a 'conference of representatives of Bristol Medical Charities' at the University.[52] At the time Newman was representing both the Board of Education and the Local Government Board, but in a matter of months his sphere of influence would come to encompass the Ministry of Health and the University Grants Committee.[53] Newman explained at length that the state of the nation's health was a cause for concern, citing the falling birth-rate and sickness amongst women alongside other issues. He explained what he saw to be the remedy:

> I submit to you that there are two ways out of these difficulties –
> 1. An adequate and co-operated scheme of medical and surgical treatment for the great masses of the people: early, prompt, and effective.
> 2. New standards for the teaching of Medicine, particularly from the preventive Medicine point of view.
>
> We must have an adequate, co-ordinated and effective scheme for medical treatment for every town and village in the country, and we must have a great medical school.

Regarding the situation in Bristol he claimed the many medical charities of the city to be 'giving inadequate returns through lack of co-ordination'. He told the conference: 'You have everything here, but organisation'.

> The thing wants organisation and thinking out for a long period of years, and I submit that the time has come for the co-ordination of

> medical charities on your part, firstly to form a great medical school and secondly for the organisation of an attack on disease in this City. There is a lot of overlapping going on; there are two hospitals for the medical school instead of one, a duplication of staffs and wasting of time. You want to unify.
> [...]
> That gentlemen, is my case: with organisation in Bristol you could obtain an economical, efficient, and great University School and you would ensure proper, early, prompt and effective treatment of the sick, which is a national problem, I may say an imperial problem.

His advice was clear: "Co-operate! Co-ordinate! Unify!"[54]

III

Following the Newman conference, a group was formed of those present with Major Stanley H. Badock, treasurer of the University, as its chair. This 'Medical Charities Committee' produced a proposal for a scheme of amalgamation.[55] It had been an assumption amongst many that some form of amalgamation would take place. Repeatedly hospital and University committees specifically put off decisions on certain issues, from fundraising appeals to the introduction of patient payments, until the hospitals had been amalgamated.[56] The proposal put forward by the Committee was essentially one to create a new 'Central Authority' to take charge of those hospitals that signed up, to be known as the 'Bristol Joint Hospitals'.[57] It further demanded that 'all the buildings, properties, investments, legacies, donations, subscriptions and assets, and all the liabilities of the amalgamating Institutions shall be transferred' to the new Authority.[58] Criticism of this was expressed by Mr Clare Smith of the General, who argued it was

> premature to part with their property before they satisfied themselves that the future management of the institution would be a great improvement upon that of the past.

This was echoed at the same meeting by Dr. J. Odery Symes who agreed co-ordination was needed, but considered this proposal to mean 'handing over the institution lock, stock, and barrel'.[59] This was bound to make individual institutions defensive and emphasise rivalries, not least with regards to the city's two general hospitals.[60]

The committee's proposal was for a genuinely city-wide amalgamation. However, the crux of the scheme was the merger of the

Infirmary and the General, the two big beasts of the city's voluntary sector. The extent of this even stretched to the committee's proposal explicitly stating that

> In the event of the Bristol Royal Infirmary and Bristol General Hospital agreeing to amalgamate, the amalgamation of these two Institutions shall take place in any case, even though any or all of the other Institutions should refuse to agree to amalgamate.[61]

These two institutions had a history fuelled by their rivalry. The General's establishment had been 'nominally in response to the under-capacity of the Infirmary; however the schism in local politics at the time [of the 1832 Reform Act] was also instrumental'.[62] As well as political factors, religious sectarianism had also played its part in building rivalry between the Tory-Anglican Infirmary and the Whig-Nonconformist General. 'Hence it was said that patients going to the Infirmary would receive a sovereign remedy, but those at the Hospital a radical cure'.[63] Further, rivalry between the staffs of the two institutions has also been commented on.[64] Although there was no suggestion of friction when the two institutions collaborated over the introduction of patient payments in 1921, the hope was that amalgamation would avoid what Major Badock called 'co-ordination without co-operation'.[65]

The details of exactly how this co-operation would be achieved were strikingly absent from the proposal, and indeed the discussion. At a meeting of General governors, Mr. Herbert Baker said that, as he saw it, the proposal

> asked the institutions to take a leap in the dark. The scheme embraced only the machinery for amalgamation but the promoters strenuously resisted any discussion or attempt to get information as to their intentions should amalgamation take place, and insisted that the only answer was to be "yes" or "no".[66]

This created a void that was inevitably filled by speculation about the changes that would be made once an amalgamation had been achieved. Baker claimed the scheme would grant a 'blank cheque' to the new Authority

> to carry out very great changes, such as the status, election, and government of the medical staff, and the transfer of clinics from one institution to another; in fact, to change the institution from a general hospital to a department of the general scheme.[67]

Similar concerns were expressed at the Infirmary during a General Committee meeting on 14 April 1920 by Mr. W.E. Budgett, who was well-placed to do so having attended the Newman conference and been on the Medical Charities Committee. Budgett was addressing the Infirmary's President, Mr. H.H. Wills, in particular when he made a speech covering the key areas of concern for those who opposed amalgamation: the fear that the fundamental nature of the voluntary system's philanthropic mission was under threat and of the loss of community attachment to their local voluntary hospital. As the minutes of the meeting state:

> [Budgett] produced documentary evidence to prove [altered to read 'evidence, which in his opinion proved'] that the result of the scheme, if not the avowed object, would be to make the amalgamating Hospitals a University Hospital, in which teaching would have precedence over the treatment of the sick poor.
>
> He said that the old tradition of the various Institutions would be swept away and that there could never be the same personal interests and individuality in carrying on their work, as had been the case heretofore.
>
> Letters from the Vice-Chancellor of the University in his opinion clearly proved that a scheme for working the "Unit System" was in existence, by which patients would have to be transferred from Hospital to Hospital according to the treatment they required.

He went on to express concerns that this major and 'irretrievable step' was being rushed through without proper debate or financial and organisational guarantees. However, Budgett's influence in the Committee proved to be limited:

> The President said that the [improvement] of Teaching was one of the main objects of the scheme. He was sure there would be a saving of expense and asked the Committee to take the scheme as a whole and to settle the details afterwards.
>
> The following resolution was then proposed by the Chairman, seconded by the President, and carried, Mr. Budgett alone dissenting:-
>
> That this Committee agrees to the proposed scheme for amalgamation drafted by the Sub-Committee appointed for the purpose, and recommends its adoption to the Governors of the Bristol Royal Infirmary.[68]

The importance of Mr. Budgett's isolation cannot be exaggerated, for as Honorary Secretary of the Infirmary he played a central role in the affairs of the Infirmary. However, at the next meeting

> Mr. W.E. Budgett asked the Committee to accept his resignation of the post of Honorary Secretary.
>
> He felt that after having devoted practically the whole of his life to the Bristol Royal Infirmary for nearly 25 years, the time has now come when a younger man should take his place.
>
> He promised to help a new Secretary to the best of his power.
>
> The President said that the present was a very inconvenient time.[69]

At a series of meetings of the General Committee of the Bristol Royal Hospital for Sick Children and Women to discuss the issue similar arguments were made. Those who opposed the proposal raised the spectre of the 'unit system', while Badock attending one meeting spoke in favour of a 'team system'.[70] He argued amalgamation would increase the likelihood of donations from 'the moneyed people of the city' and that the scheme contradictorily offered both 'possible Government subsidy' and a means to 'postpone state aid'.[71] Meanwhile his opponents saw the scheme as a threat to its links with the local community and the identity of the institution if it were 'converted to any other use than a Children's Hospital'. Rev. Dr. Thomas voiced a concern that its central mission could be compromised by the exclusion of women. Mrs. Found noted that if governorship in the new Authority was dependent on paying seven guineas, this would exclude many working class people.[72] It was resolved

> That the Bristol Royal Hospital for Sick Children and Women are willing to assent to join the proposed amalgamation of Bristol Medical Institutions, provided –
>
> 1. That the Bristol Royal Hospital for Sick Children and Women shall, in the future, continue to be carried out for the purpose for which it was formed, i.e. as a Children's Hospital.
> 2. That sick children, whether in or outpatients, shall, at all times, continue to be admitted, as at present, without admission note, or letter of recommendation.[73]

This was supported by a special meeting of the governors, at which Mr. H.H. Wills, who was both President of the Infirmary and a Governor at the Children's Hospital, proposed an amendment:

> That this meeting of the Governors of the Bristol Royal Hospital for Sick Children and Women, having considered the scheme of amalgamation, hereby resolves to support the same and gives power to the Committee to take whatever steps may be necessary to bring it into effect, provided that the Committee is satisfied with the number and standing of the other Hospitals and Medical Charities, that agree to amalgamate with the Bristol Royal Hospital for Sick Children.

He argued for this amendment on the unusual grounds that

> During the war, the Allies were co-operated and co-ordinated without bringing anything grand about. Lloyd George amalgamated the Allies, and because of that he smashed the Germans.

However, this argument failed to convince and the amendment found no second. Regardless, the more conditional resolution in favour of amalgamation stood.[74]

At the Infirmary and the Children's Hospital support may have been secured for the proposed amalgamation, but the President of the General, Mr. G.A. Wills, was less successful. On May 18th 1920, the Hospital Committee passed a resolution declaring

> That the Committee of the Bristol General Hospital after careful consideration and full discussion, with the members of the Honorary Staff, records their opinion that, in view of the uncertainty of the provisions of the Bill which it is understood is now being prepared by the Ministry of Health, they cannot see their way to accept the suggested Scheme of Amalgamation of the Bristol Hospitals, particularly having regard to its proposal for the immediate transfer of all the Buildings, Investments and other Assets to a new Authority.
>
> The Committee will, however, gladly consider any proposals for co-operation and co-ordination which are calculated to benefit the sick poor [amended to read: the Sick and Improve Medical Education].[75]

A special meeting of the governors of the General was called on June 14th to consider the resolution. The President had been a staunch advocate of the proposal, arguing that

> if amalgamation took place he thought that probably they would be able to do more good for Bristol's sick poor than could be done by

individual institutions as such.[76]

However, when the 'long and animated' special meeting convened, suspiciously Wills was not present. Instead, the chair was filled by Mr. Herbert Baker, an ardent critic of amalgamation, who announced 'the meeting was arranged for a date when they had not contemplated their president would be away in Scotland'. After which he opened the meeting with a long and impassioned speech against the scheme, which he alleged to be an attack on the principle of 'lay control', for replacing the governors of each hospital with the new Authority. He further described the scheme as 'only the thin end of the wedge to University control'. Badock countered that only three of the new Authority's 36 members would be elected by the University and argued amalgamation would allow 'for viewing the needs of the city as a whole'. He argued co-ordination 'was of very little power without amalgamation', whereas others were in favour of co-ordination, but feared 'absorption'.[77]

Dr. Carey F. Coombs attempted to mediate by suggesting the proposal be accepted on the following conditions:

> That the committee receive a guarantee that the buildings and investments of the Hospital would be used for the purposes for which they were given, viz., (1) as a general hospital for South Bristol; (2) as a maternity hospital; and (3) as a dental hospital; and, further, that the Lord Mayor be invited to preside over the proposed Joint Hospital Council.

However, Baker dominated the meeting. He voiced fears that each institution's links with the local community would be damaged, which could endanger subscriptions, and that beds would be 'allocated for teaching purposes' rather than in the interest of the patient. He went on to express his judgement that 'every facility for education could be given without violating the principle of lay control under the governors'. These opinions appear to have struck a chord and the resolution rejecting amalgamation was upheld.[78]

This meant that, as long as the General was not prepared to join, the amalgamation could not go ahead. In an attempt to turn this around, Mr. H.H. Wills created an immediate financial incentive for the General to amalgamate. He promised a donation of £105,070 worth of securities to the new Authority if the General agreed to the amalgamation by December 31st 1920, or else the donation would go solely to the Infirmary. He had pointed to a financial incentive before, at the meeting

at the General on June 14th, when he claimed a gentleman had told him 'he would be glad to give a house in Clifton, bringing in £150 a year' to the new Authority.[79] However, in neither case was this enough to affect a reversal in the position adopted by the General. It was the largest gift ever received by the Infirmary.[80]

IV

There are three potential explanations for the failure of the amalgamation proposal: economic, political and ideological. However, given their invocation both for and against the scheme during the debate, economic arguments are not here considered to be a decisive factor in the 'non-decision' on amalgamation.[81]

The politics of institutional rivalry have to be considered, especially given the aforementioned deep-rooted history of rivalry between the Infirmary and the General, dating back to their establishment by different religious and political communities. Meanwhile, the reaction to the changing role of Southmead Hospital after the 1929 Local Government Act supports the view that institutional rivalry was still a significant factor in the character of the interwar mixed economy. The 1920 proposal was bound to raise these issues given the assumption that individual institutions would hand over their assets to a central body. Furthermore, the lack of concrete details in the proposal allowed the unspoken prospect of University control to loom large over the debate. The fact that there was a rather open debate within and between the relevant institutions suggests a pluralist view of 'non-decision making'; although it should be noted that a genuinely pluralistic process would have involved the patient population and perhaps the local community. To that extent, this process was more elitist than it might at first appear.[82]

However, institutional rivalries cannot be considered the key factor, given the degree of co-operation and co-ordination displayed by the hospital over the interwar period. Examples of this with regard to the Infirmary and the General are plentiful, from the joint introduction of pension arrangements and patient payments to a more long-term focus of inpatient provision at the Infirmary and outpatient provision at the General.[83] In fact, a second political struggle was taking place between personalities. This struggle for control was evident in a number of key committee meetings. The consequences of the confrontation between H.H. Wills and Budgett showed Wills to be in a far superior position. Meanwhile, Baker had seized the chair from G.A. Wills in what is hard not to regard something of a coup, given the ferociousness of his

argument. This and the failure of H.H. Wills' financial offer to the General show even such powerful positions to be limited.

Certainly these political factors played a role, but ideology should not be dismissed. The very fact that advocates of amalgamation were unwilling to entertain any discussion of changes that could be brought about by the new Authority suggests an awareness that any likely or desired changes would be controversial. The alternative explanation, that there were no planned or expected changes, simply does not ring true given the degree to which they had been sought after and promoted by the University Medical School. It is argued here that the evidence points to a division between two incompatible ideological conceptions of healthcare. One approach was that of those who supported amalgamation. This viewed both the hospital and the medical school as institutions primarily for training and research. As Sir George Newman argued, this would allow medicine to provide better for the community and the patient of tomorrow.[84] This trickle-down view of healthcare can be seen in stark contrast to the philanthropic traditionalism adhered to by many amongst the honorary staffs. This placed the charitable care of the individual patient above all else, and as such could not be reconciled with the more scientific approach of those in favour of amalgamation. Political rivalries undoubtedly served as a driving force for the opposition to amalgamation, but it was an ideological division that set the two camps on a collision course.

Regardless of its ultimate failure, the very existence of the proposal is revealing on a number of accounts. Perhaps most tellingly, it was a scheme entirely exclusive to the voluntary sector. In this respect, it supports the notion that there was no emerging consensus around a unified (voluntary and municipal) health service. Rather, there were many false starts and alternative policy approaches, which came from national policy right through to the local and institutional level.[85]

Furthermore, the nature of the scheme demonstrates that amongst those within the voluntary sector in favour of reform, the concept of 'hierarchical regionalism' was, as Fox has argued, central to their understanding.[86] Indeed, it bears a striking resemblance to the thinking of the 1945 Ministry of Health survey of the region.[87] This report espoused a view of Bristol as the 'clinical capital' of the South West, where the 'regional hospital centre' should be the 'seat of medical training' and be the home of 'senior specialist staff in every branch of medical science'.[88] The key differences between the two are the lack of attention paid to the 'division of specialists' in the 1920 scheme,[89] which is hardly surprising given the considerable concentration of the city's voluntary hospital beds in the two general hospitals;[90] and a city-wide rather than a regional

coverage. This approach of 'hierarchical localism' only serves to highlight the fact that a shared basic approach can be put into practice by a variety of different schemes within different contexts.

In the proposal and, even more so, in the debate it inspired, the role of the University Medical School was a key issue. The virtual absence of the 'unit system' from the history of pre-NHS hospitals is illustrative of the fact that the interface between hospitals and medical education has been somewhat overlooked in the historiography. The influence of German and American experiences on British reforms, the balance between scientific and clinical approaches to medicine, the cultural role of the hospital and the remit of the educational establishment are all issues which could be discussed in this context, but have not been to date.[91] This is therefore an obvious direction for further studies in this field.

The 1920 proposal was ultimately unsuccessful. However, despite this it has here been demonstrated that such 'non-decisions' can still provide a useful source of analysis and insight into the culture and politics within which they emerge.[92] Not least, they offer insight into the local picture, something which historians are increasingly turning to as a means of understanding the context and colour of central government policy and the national narrative.

Above all, this study has sought to demonstrate that there was no simple progression or clear direction for reform in the decades before the introduction of the National Health Service. Reforms and proposals for reform came from different parts of the hospital sector, taking a wide range of forms and being influenced by different strands of progressive thinking. Further, those who opposed reforms were not necessarily conservative stalwarts or merely concerned with the pre-eminence of their profession, but often took genuine ideological objection to the direction of the proposed reforms. The 1920 proposal, the debate it inspired and its ultimate failure serve as testimony to the fact that reform in the health services has always been the result of political negotiations to resolve ideological conflict. Indeed, there was no consensual road to the National Health Service of 1948.

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3 See C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History* 1 (1990), 121-24.

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5 M. Daunton, 'Introduction' in M. Daunton (ed.), *Charity, Self-interest and Welfare in the English Past* (London, 1996), p. 1. For example D. Owen, *English Philanthropy 1660-1960* (Cambridge, 1964), pp. 525-72.

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7 See G. Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History* 1 (1990), 183-206; J. Lewis, 'The Voluntary Sector and the State in Twentieth Century Britain' in H. Fawcett and R. Lowe (eds), *Welfare Policy in Britain: The Road From 1945* (Basingstoke, 1999), pp. 52-68.

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9 For example A. Summers, 'A Home from Home: Women's Philanthropic Work in the Nineteenth Century' in S. Burman (ed.), *Fit Work for Women* (London, 1979), pp. 33-63; F.K. Prochaska, *Women and Philanthropy in Nineteenth-Century England* (Oxford, 1980).

10 Fissell, *Patients, Power, and the Poor*, pp. 11, 196-97; Jones, 'Some Recent Trends', p. 55; A. Kidd, 'Philanthropy and the 'Social History Paradigm'', *Social History* 2 (1996), 184, 186-187; Porter, 'The Gift Relation', p. 150; R. Titmuss, *The Gift Relationship* (London, 1970).

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12 Such characteristics of Bristol have been highlighted in a recent comparison with Hospitals services in Middlesbrough. See B. Doyle, 'Competition and Cooperation in Hospital Provision in Middlesbrough, 1918-1948', *Medical History* 51 (2007), 344.

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23 C. Webster, 'Conflict and Consensus', 120-25.

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25 Finlayson, *Citizen, State*, p. 198. See also Owen, *English Philanthropy*, pp. 525-53.

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32 BRO 35893/8.d, BRI Faculty Meeting Minutes Book vol. IV, 1911-1925, 18/3/1918, 6/11/1920; BRO 35893/2.r, BRI General Committee, 1918-26, 9/12/1919, 23/7/1918, 13/5/1919, 17/6/1919, 23/12/1919.

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45 Abel-Smith, *The Hospitals*, pp. 217-33.

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51 Ibid., 27/02/1920, 30/04/1920.

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54 Although this is not found in the minutes of the speech, it has been directly

quoted and referenced to this event by the chairman of the conference on more than one occasion: BRO, Bristol General Hospital [hereafter BGH] House Committee Minutes, p. 542, letter from Stanley H. Badock, Chairman of Medical Charities Committee, March 18th 1920; BRO 37424/1(b), Children's Hospital, General Committee Minute Book, 19/04/1920.

55 BRO 40530/A/1(a)15, BGH House Committee Minutes, p. 542, 'Proposed Amalgamation of Bristol Hospitals and other Medical Charities: Suggested scheme'.

56 BRO 35893/2.1 BRI General Committee Minutes, 1918-26, 23/12/1919, 13/01/1920, University Medical Board, 02/05/1919.

57 BRO, BGH, 'Proposed Amalgamation'.

58 Ibid.

59 BRO, BGH Board Minute Book, p. 21, newspaper cutting 15/06/1920.

60 BRO, BGH Board Minute Book, p. 21.

61 BRO 40530/A/1(a)15, BGH House Committee Minutes 1915-21, p. 542.

62 Gorsky, 'For the treatment', ch.2:2; Gorsky, *Patterns of Philanthropy*, p. 152.

63 Perry, *The Voluntary Medical*, p. 6.

64 C. Clarke, *Bristol Royal Infirmary: a personal study written to commemorate the first 250 years, 1735-1985* (Bristol, 1985), p. 27.

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66 Ibid.

67 Ibid.

68 BRO, 35893/2.1 BRI General Committee Minutes, 1918-26, 14/4/1920.

69 Ibid., 27/4/1920.

70 BRO, 37424/1(b), Children's Hospital, General Committee Minute Book, 5/05/1920, 19/04/1920.

71 Ibid., 19/04/1920.

72 Ibid., 5/05/1920.

73 Ibid., 5/05/1920, 21/05/1920.

74 Ibid., 21/05/1920.

75 BRO, BGH Board Minutes, p. 21 and 18/05/1920.

76 Ibid., p. 21.

77 Ibid.

78 Ibid.

79 Ibid.

80 B. Perry, *The Voluntary Medical*, p. 6; Gorsky, 'For the treatment', ch.5:1; BRL, BL8BZ Bristol Royal Infirmary Annual Report for 1921 (Bristol, 1921), p. 9.

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82 See Kamuzora, 'Non-Decision Making', pp. 65-66.
83 BRO, 35893/8.d Bristol Royal Infirmary Faculty Minute Book IV, 1911-1925, 6/3/1919; BRO 35893/2.r General Committee Minutes, 1918-26, 13/1/1920, 26/10/1920, 14/6/1921; *Bristol Times and Mirror*, 2 July 1921, p. 7.; Gorsky, 'For the treatment', ch.3:2.
84 This ideological perspective is evident in Newman's Bristol conference speech. See University of Bristol Special Collections, DM 1149: Medical Board File.
85 The best discussion of these issues remains Webster, 'Conflict and Consensus'.
86 See Fox, *Health Policies*, ch.2, pp. 21-36.
87 For an overview of the surveys in general, see M. Powell, 'Hospital Provision before the National Health Service: A Geographical Study of the 1945 Hospital Surveys', *Social History of Medicine* 5 (1992), 483-504.
88 Cope *et al.*, *Hospital Survey*, pp. 127-28.
89 BRO, BGH Board Minutes, p. 21.
90 Gorsky, 'For the treatment', ch.3:1.
91 The closest that exists to date is the excellent but far broader study of medical education in Britain, Germany, France and the USA: Bonner, *Becoming a Physician*.
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