of venereal disease. Meanwhile, no one who suspects infection need go unassured and no one who is infected need go untreated; and Parliament has wisely prohibited the pernicious practices of treatment of, prescription for, and advice on venereal diseases by unqualified persons.[1]

[1] Venereal Diseases Act, 1917.

CHAPTER XVII

HOSPITALS AND HOSPITAL ADMINISTRATION

THE early efforts of sanitary authorities and their staffs were directed against an evil environment; the discovery and abatement of nuisances were their main functions. But as medical and bacteriological science advanced it became more and more evident that man himself, especially the sick man, was an important factor in the dissemination of disease. The whole theory of infectious and contagious disease indicated the necessity for proper isolation and disinfection, and the growing knowledge of social conditions proved beyond dispute the impossibility of securing this in the homes of many, perhaps most, of the sufferers. To meet the want, collective effort, voluntary or public, was shown to be essential. The treatment and care of disease in institutions was found to be an integral and necessary part of the work of prevention. The utility of isolation had, in fact, been recognized as early as the eighth century, when leper-houses or "lazars" were first founded in France, and later, when "pest-houses" were established on the outskirts of many mediæval towns for the isolation of persons suffering from plague, and, perhaps, other diseases recognized as infectious.[1] In two directions institutional treatment was provided in the early years of the nineteenth century; the foundation and maintenance of hospitals for the sick and infirm was a favourite form of philanthropic effort in the seventeenth and eighteenth centuries,[2] two important London hospitals, the Small-pox Hospital and the Lock Hospital for venereal diseases, being established

[1] H. F. Parsons, *Isolation Hospitals*, pp. 1 and 2.
[2] B. Kirkman Gray, *The History of Philanthropy*.

in 1745 and the following year;[1] and these persisted alongside the institutions in which the Poor Law authorities were compelled of necessity to make some sort of provision for infectious paupers, although accommodation, apart from the mixed workhouse, was rare. Later, when general hospitals were still largely used for infectious diseases, serious epidemics occurred, chiefly in the crowded urban areas, and these hospitals were unable to cope with the great pressure upon their accommodation, the Poor Law authorities were doing little or nothing, and thus the onus of providing isolation was thrown directly upon public health authorities, who responded by renting buildings or constructing temporary institutions. When the voluntary hospitals ceased to provide for infectious disease the sanitary authorities were compelled by circumstances to extend their efforts for the isolation, treatment, and cure of those diseases which their purely preventive work had not warded off. The objects and advantages of this extension of the functions of sanitary authorities are well summed up by Dr. W. H. Power, a late medical officer of the Local Government Board, in the statement:[2]

"The provision of hospital accommodation for cases of infectious diseases is to be regarded primarily as a measure of sanitary defence, for the protection of the public against the spread of these diseases. It is true that such accommodation incidentally serves other useful purposes. Thus, it is frequently of value for the relief of individual sufferers from infectious disease, whose sufferings may be alleviated and recovery promoted by affording them better accommodation and attendance than they are able to obtain at their own homes. Or it may be the means of avoiding serious inconvenience and pecuniary loss, as when infectious disease breaks out in a school, lodging-house, or place of business."

Local authorities are empowered, singly or in combination, to provide hospitals or temporary places for the reception of the sick inhabitants of their district, and may either themselves build or contract or agree with public authorities

[1] *Isolation Hospitals*, p. 2.
[2] Local Government Board Circular, May, 1902.

or private persons having charge of such places, and may recover the cost of maintenance of patients.[1] The Isolation Hospitals Act of 1893 went a step further by giving the lately constituted county councils power to provide or cause to be provided hospitals for the reception of patients suffering from infectious disease in any district of the county. The county council may be moved by an application from a rural or urban district council or any twenty-five ratepayers of a contributory place, or they may themselves direct the county medical officer of health to report upon the necessity for an isolation hospital in any district. The consent of the local authorities affected is required, unless it is shown that they are themselves unable or unwilling to provide the necessary accommodation. The local authorities, for the purposes of this Act, may transfer to the county council any infectious hospital provided by them under the Public Health Act, 1875, or any local Act. If satisfied, the county council must constitute a hospital district and form a committee consisting wholly or partly of members of, or persons elected by, the council, or wholly or partly of representatives of the local area or areas affected, which cannot include any county borough, or, unless the local authority consent, any borough having more than 10,000 inhabitants. The expenses incurred by the county council in providing and maintaining the hospital are chargeable upon the rates of the area served, but the county council may, in certain cases, contribute a capital or annual sum to both or either the structural and establishment expenses of such hospital; this provision has been extended to include the extension or enlargement of any hospital provided under the Public Health Act, 1875.[2]

The Public Health (Prevention and Treatment of Diseases) Act, 1913,[3] empowered the Ministry of Health to declare a county council to be an authority to execute and enforce regulations made by the Ministry under Section 130 of the Public Health Act, 1875, with a view to the treatment of

[1] Public Health Act, 1875, ss. 131 *et seq.*
[2] Isolation Hospitals Acts, 1893 and 1901.
[3] Section 2.

persons suffering from cholera or any other epidemic-endemic or infectious disease. It has now been made clear that this power may be extended to the provision of hospitals for the treatment of such patients, the costs being assessed on parishes on a basis of user instead of being charged generally.[1]

The use of these powers throws a heavy responsibility and much onerous work upon the medical officer of health, who must not only advise his authority upon the need for such accommodation and sketch out how it is to be provided before the architect drafts the completed design, but has to support his recommendation before the inspector of the Ministry of Health, who inquires into the need for the application for a loan, and, finally, to supervise the general hospital administration, and even in many cases to treat the patients himself. In some places patients are required or permitted to provide their own medical attendant, skilled nursing being provided by the authority.

The powers to provide for the treatment of sickness are, on the whole, adequate, but unfortunately they are very far from being taken full advantage of.[2] Mr. and Mrs. Sidney Webb, after the exhaustive inquiries made by the Poor Law Commission, were able to write that "a majority of the rural district authorities and not a few urban district authorities have no hospital accommodation, even for the most infectious diseases,"[3] and it is certain that where there has been an attempt made it is often very unsuitable and wholly inadequate. Of hospitals, as of nearly every other branch of public health work, no general statement can be made, unless it be that the variety is amazing. Where provided they range from a two- or three-roomed cottage or shed awaiting a possible case of small-pox up to the great institutions with all their specialized departments, latest scientific apparatus, and large highly-trained and skilled staffs, provided by such towns as Liverpool, Leeds and

[1] Public Health Act, 1925, s. 61. This power is extended to the provision of dwelling-houses for employees at the hospital by Public Health Act, 1925, s. 65.

[2] *Minority Report of the Poor Law Commission* (Fabian Society, 1909), p. 283.

[3] *The State and the Doctor*, p. 208.

Sheffield. The same variation is found in the diseases treated.

Under the Isolation Hospitals Acts the provision of hospital accommodation is restricted to that for infectious diseases—a retrograde step, since the powers given by the Public Health Act, 1875, enable a local authority to provide for the reception and treatment of the sick. The latter power has been held to include a great variety of non-notifiable diseases, as at Liverpool, and urgent surgical cases and accidents, as at Barry and Widnes,[1] and, anticipating the National Insurance and Finance Acts of 1911, phthisis at Brighton, Manchester, and Liverpool. In some few cases, out-patients' departments for the treatment of ringworm, impetigo, and similar complaints have been added; in others domiciliary treatment by municipal home nurses is provided for cases of puerperal fever or erysipelas, or, where no other provision is made for treatment, of the sick poor.

Local authorities have from time to time been authorized [2] to give donations and subscriptions (generally of small amounts) to voluntary hospitals, but this authority is no longer necessary since they are now empowered [3] to give such subscriptions or donations to the extent of the produce of a penny rate. The following statement gives some idea of the kind and amount of hospital accommodation provided or aided by various local authorities:

HOSPITALS PROVIDED BY LOCAL AUTHORITIES

	Number.	Beds.
1. For Tuberculosis	158	10,963
2. For acute infectious diseases	1,040*	37,700*
3. Maternity Hospitals (not including maternity wards in General Hospitals or Poor Law Institutions)	68	908
4. Babies' Hospitals	12	260

* Round figures. At fifty-two of these hospitals there are 2,230 beds for the treatment of tuberculosis.

[1] *Minority Report of the Poor Law Commission* (Fabian Society, 1909), p. 267. H. F. Parsons, *Isolation Hospitals*, p. 15.

[2] Under Local Authorities (Expenses) Act, 1887.

[3] Public Health Act, 1925, s. 64.

VOLUNTARY HOSPITALS AIDED BY LOCAL AUTHORITIES

	Number.	Beds.
1. General Hospitals:		
(*a*) Used in connection with Tuberculosis Schemes	153	†
(*b*) Used in connection with Venereal Diseases Schemes	139	†
(*c*) Maternity Sections used in connection with Maternity and Child Welfare Schemes	12	175
2. Tuberculosis Hospitals	127	8,563
3. Maternity Hospitals (not including Maternity Sections in General Hospitals)	52	917
4. Babies' Hospitals	12	334

The figures under the above headings are exclusive of accommodation in homes for unmarried mothers and their babies, observation wards in connection with maternity and child welfare schemes, and convalescent homes.

INSTITUTIONS PROVIDED BY POOR LAW AUTHORITIES

	Number.	Beds.
1. Institutions wholly for the sick, exclusive of institutions for mental cases	64	35,250
2. Mixed institutions (with a total accommodation of some 180,000)	590	79,000‡

† Available beds used as and when required.
‡ Beds for the sick.

During the year 1925, the Ministry of Health held ten public inquiries connected with the provision of isolation and small-pox hospitals, and its officers made ninety-eight inspections of hospitals and hospital sites.[1]

In other places advantage is taken of the powers given by the Public Health Act, 1875,[2] to provide a temporary supply of medicine for the poorer inhabitants; this, in fact, was one of the earliest efforts to prevent the spread of infectious diseases, having been employed at the time of the cholera epidemic of the early 'thirties and still persisting in the distribution of diarrhœa mixture at Manchester, and to hop-pickers in certain districts frequented by them. Two hundred and forty-eight local authorities have, with

[1] Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, pp. 186–7.
[2] Section 133.

the sanction of the Ministry of Health, made arrangements for home nursing of young children suffering from infectious disease. Of these 156 contracted with District Nursing Associations, others employ health visitors and, in a few populous districts, special nurses. Vaccination, although essentially a preventive measure, is provided by the Poor Law authorities, but antitoxin is in many places supplied to medical practitioners free of charge for use in cases of diphtheria.

There is, therefore, lack neither of powers nor precedents for the provision of adequate treatment for cases of preventable disease, a term which science has so extended that it is now estimated to include about two-thirds of the total. But, despite this fact, such provision is neither general in distribution nor similar in kind and amount, and, whilst in many places every effort is made to provide accommodation and to encourage all requiring treatment to enter and benefit free of charge, it is to be regretted that in some cases where hospital accommodation is provided it is so hedged with restrictions that the institutions remain empty and patients must rely upon the Poor Law and charity. The defect is due to the fact that there is no general obligation upon local authorities to provide treatment or accommodation for any particular sick person, however needy he may be, or however dangerous it is to the public for him to remain at home without proper care, treatment, or isolation.[1] Local authorities may charge for any accommodation or treatment provided, but in most cases this is freely given, the expenditure being rightly judged to be well-incurred, and justified by the improved health and greater safety of the community. The Ministry of Health favours the latter practice; but where a charge is made it can only be charged to the patients, as not even the father of a child treated in hospital can be successfully sued for the expenses incurred.[2] This has led to the practice in

[1] See, however, the powers of the county council under the Isolation Hospitals Acts, 1893 and 1901, referred to earlier in chapter.
[2] *Hull Corporation* v. *Maclaren* (1898), *Local Government Chronicle*, p. 585.

some places of requiring guarantees for the costs before admitting patients, and, as previously indicated, tends to defeat the objects for which hospitals should be provided.

As an essential part of the work of the sanitary authorities as regards infectious disease, powers are given to provide disinfecting apparatus and to disinfect infected articles free of charge, a feature of their work which is frequently carried on in conjunction with the hospital,[1] vans being used to convey bedding and other things to and from the disinfecting station. For the conveyance of sick persons to or from the hospital, an ambulance may be provided,[2] and, where Section 50 of the Public Health Acts Amendment Act, 1907, has been adopted, this power extends to similar provision for cases of accident.[3] Where the isolation hospital is provided under the provisions of the Isolation Hospitals Act, 1893, it must possess an ambulance or ambulances for the purpose of conveying patients to the hospital, which must be, as far as practicable, in connection with the system of telegraphs.[4] This is an excellent and necessary requirement, except that the telephone is nowadays more useful.

The powers given by the Cleansing of Persons Act, 1897, to the councils of county boroughs and urban and rural districts, as well as, by an act of legislative folly, to boards of guardians, to provide the necessary apparatus and to permit verminous persons to cleanse themselves and clothing, are such as may be economically exercised in conjunction with a disinfecting station. These powers have now been replaced and strengthened where Part IV of the Public Health Act, 1925, has been adopted.[5]

It is becoming increasingly common, and, in the light of advancing knowledge, more and more necessary, for a bacteriological laboratory to be established in connection

[1] Public Health Act, 1875, s. 122.
[2] *Ibid.*, s. 123.
[3] A charge may be made for conveying patients on discharge from an isolation hospital or for removal of non-infectious patients.—Public Health Act, 1925, s. 63.
[4] Section 13.
[5] Sections 45 to 50.

with the larger hospitals[1] and the time may not be long distant before every county and county borough will establish, maintain, and control a chemical and bacteriological laboratory wherein all scientific work connected with infectious disease, water, sewage, gas and foodstuffs can be rapidly and efficiently carried out.

This expectation seemed justified by the words of the Chancellor of the Exchequer, who, in introducing his Budget for 1914, stated that:

> "There is another deficiency in our health service which has been exposed by the operations of the Insurance Act. There is no provision for the scientific diagnosis of disease. In Germany, in almost every town, and I think also in France, there are pathological laboratories, which are of enormous assistance to doctors in ascertaining the real character of the disease when they are in any doubt upon the subject. There are a few boroughs in the United Kingdom where something has been done in this direction—even in London: but we propose to make a grant for the purpose of aiding the local authorities to set up laboratories throughout the United Kingdom."[2]

But the War intervened and progress remains very slow.

In such a system of hospitals, incomplete in extent and with units of such varying character, it is impossible to indicate any method of administration which can be said to be generally adopted. It is perhaps the best plan to describe the characteristics of the administrative organization of a fair-sized hospital at which the essential conditions for success are practically realized. The object of a hospital is to cure disease and, by isolation, to prevent its spread amongst the members of the community; large or small, its administration must be directed to this end, but at the same time its organization should be such as to permit of expansion with the minimum of friction and disturbance. For any hospital it is essential that the staff be adequate in number and efficient in skill and knowledge, the responsi-

[1] See Report of the Medical Officer of the Ministry of Health for 1925 for a summary of the pathological and bacteriological work done by or in connection with this department, p. 199.
[2] Speech by the Right Hon. D. Lloyd George, May 4, 1914.

bility of each official must be definite in amount and direction, and in the absence of any one of them another should step in automatically to undertake the same duties and carry the same responsibility. In an institution where lives are at stake discipline is a very important consideration, but it is equally necessary that in its enforcement no sense of injustice or arbitrariness should be felt by the staff. To this end it has been found advisable that in every case an appeal should be left to a higher authority, terminating, in the more serious cases, with the committee controlling the hospital.

The official control of a hospital is vested in the medical superintendent, who may be the medical officer of health, in which case, as such superintendence is not one of the duties prescribed, in the Order of the Ministry of Health an additional salary is paid. In the case of the large hospitals the office is a separate one held by a medical practitioner possessing wide clinical experience together with a high degree of administrative ability. Sometimes the officer is definitely subordinate to the medical officer of health, but the most approved plan appears to be for the medical superintendent to be directly responsible to the hospital committee for its administration, whilst the medical officer of health determines which patients are admitted, except in cases of emergency. Under such conditions the medical superintendent usually has a very free hand, although the medical officer of health may take an indirect interest in the administration of the institution. Under the medical superintendent a hierarchy of officials and servants is to be found, varying in number and kinds in the different classes of hospitals; they include medical officers, matrons, sisters, nurses, probationers, steward, clerks, ward maids, domestic servants, gardeners, porters, ambulance men, disinfectors, and others.[1]

The sanitary authority invariably delegates the powers of control of hospital administration to the public health committee or a special hospital committee, a sub-committee

[1] See H. F. Parsons, *Isolation Hospitals*, Chapter XIV.

usually being formed for the purpose in the former case. To this committee all questions relating to hospital administration are referred, and all reports from the responsible chief are presented; the latter including the fortnightly or monthly reports showing cases of each disease admitted, deceased and discharged, staff cases, and existing number of patients and vacant beds, together with a requisition for the various goods and appliances ordered or required. Where an annual report is presented it summarizes the year's work, and may be accompanied by observations of any special circumstances relating to administration or treatment during the year dealt with, or by suggestions for improved methods for the future.

The medical superintendent is directly responsible for the care and treatment of the patients entering the hospital, for the discipline, training and good order of his staff, and for the general economical and efficient administration of the institution. If he is a good administrator he will exercise his control through a descending series of responsible officers, matters of sufficient importance to be dealt with by him personally reaching him at daily conferences with the departmental chiefs—the senior medical officer, the matron and the steward—official communications between whom should only pass through the medical superintendent.

The medical officers are responsible for the clinical and nursing work of the wards, of which they have charge, each ward sister being subordinate and responsible to them for these purposes. The matron, a highly-qualified and experienced nurse, controls the work of the ward sisters, except as above indicated, the general behaviour of the nurses when off duty, and the female domestic staff; in the institutions where an assistant matron or home sister is appointed she controls the female domestic staff and is herself responsible to the matron. The ward sisters—nurses who should have received a general as well as a fever training, of whom there is usually one for each division—are responsible for the general efficiency and cleanliness of the wards,

controlling the staff nurses, who are often only fever trained, and probationers, who are undergoing training, in all their work, and the ward maids for rough cleaning. The steward or headman deals with the accounts, clerical work, and stores, other than drugs, and controls the work of the lay male staff.

Local authorities are experiencing difficulties in securing a sufficient number of properly-trained and qualified nurses or of probationers of the right class. Probationers, who should be carefully selected, are received for two years, at the end of which time they are certificated if successful at an examination. These examinations were formerly set by the hospital officials, and varied so much in standard that certificates were of little value as a criterion of knowledge and ability unless the methods of the institution were known. The leading fever hospitals then took up a scheme instituted by the Fever Nurses' Association, by which a hospital of sufficient size and efficiency was recognized by the association, in which case nurses had to be trained in accordance with a scheme drafted by the association, which also approved the appointment by the Hospital Committee of an independent examiner to examine them in their practical work. The examination paper was set by the Education Committee of the association, the nurses who passed being certificated and registered. The arrangements for examination and registration were regarded by the Fever Nurses' Association as purely temporary, and every effort was made to secure examination and registration by the State, a proposal which had the support of the British Medical Association and practically all organized bodies of nurses in the United Kingdon. The need for a good system of nursing was recognized by a former Chancellor of the Exchequer when he testified to the good work being done by some voluntary associations and local authorities, and declared it to be the Government's intention "to provide a substantial annual sum to help to provide for the training of an adequate supply of nurses."[1] As State regula-

[1] Right Hon. D. Lloyd George, May 4, 1914.

tion and control is the logical outcome of State aid, the efforts of the Fever Nurses' Association were crowned with success in 1919, when the Nurses Registration Act was passed. This provided for the establishment of a General Nursing Council, amongst the duties of which were the formation and keeping of a register of nurses of various classes (including fever nurses), the making of rules regulating the formation, maintenance and publication of and admission to the Register, and the conduct of examinations. On the 31st March, 1927, there were 57,313 nurses on the Register, including 5,118 qualified by examination since June, 1925.[1]

The problem of training is not the only one confronting hospital authorities. It is necessary to secure a sufficient number of applicants of the right class for training, and these will only be obtained by improving the remuneration and conditions of service. At present the hours are generally long, liberty is small, the work is arduous and the pay insufficient to attract the best class.

The first two drawbacks can only be removed by increased staffs, and as an increased supply of nurses can only be obtained by offering adequate salaries, the Fever Nurses' Association, which is particularly active, has formulated a minimum wage schedule as follows :

1. *Probationers and Junior Assistant Nurses :*
   First year, £40. Second year, £45.
2. *Staff Nurses :*
   Those who are on *either* the General or Fever Registers : £60 rising to £70 by £5 annually.
   Those who are on both Registers : £75 rising to £85 by £5 annually.
3. *Sisters :*
   Those who are on the General and Fever Registers : £90 rising to £120 by £10 annually.
4. *Night Superintendents and Home Sisters :*
   Those who are on General and Fever Registers : £100 rising to £150 by £10 annually.

[1] Eighth Annual Report of the Ministry of Health, p. 6.

5. *Sister Tutors:*
   Without Diploma: £120 rising to £150 by £10 annually.
   With Diploma: £150 rising to £190 by £10 annually.
6. *Assistant Matrons:*
   Up to 100 beds: £120 to £130.
   100 to 200 ,, £130 to £150.
   200 to 300 ,, £150 to £175.
   300 to 400 ,, £170 to £200.
   over 400 ,, £200 rising.
7. *Matrons:*
   Up to 50 beds: £120.
   50 to 100 ,, £150 to £180.
   100 to 200 ,, £200 to £250.
   200 to 300 ,, £250 to £300.
   300 to 400 ,, £300 to £350.
   over 400 ,, £350 rising.

These demands, which have already been accepted by many of the more progressive authorities, are not excessive, and it is probable that economic forces will compel the most unwilling local authorities to adopt the scale in order to competently staff their institutions, especially since health visiting, school nursing, and sanatoria are rapidly increasing the demands for nurses.

CHAPTER XVIII

THE CONTROL OF TUBERCULOSIS

BEFORE the year 1911 sanitary authorities and their public health departments were not, as a general rule, specially concerned with the treatment or prevention of tuberculosis, despite the fact that the toll of deaths levied by this disease was only exceeded by those from bronchitis and pneumonia, diseases which it frequently follows. The reduction of the tuberculosis death-rate from 3·5 per 1,000 in 1851 to 1·6 in 1907 was a result of the general improved sanitary conditions, and not of any definite steps taken to combat this particular disease.[1] There were exceptions, however; several authorities, such as the Liverpool, Brighton and Blackburn Corporations, adopted systems of voluntary notification of phthisis, whilst Sheffield and Blackburn Councils early in this century obtained powers under private Acts which made notification compulsory. Administrative control, treatment and preventive effort followed as a matter of course; and by December, 1911, nearly 1,400 beds had been provided by sanitary authorities in addition to 9,000 beds in Poor Law institutions occupied by consumptives, and 400 beds rented by local authorities at some of the eighty-four sanatoria (4,200 beds) provided by private persons or voluntary associations. Besides these efforts fourteen sanitary authorities had provided tuberculosis dispensaries, and in fifty other districts tuberculosis dispensaries under voluntary management were available.[2] The experience thus gained, together with the growing

[1] See Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 81.
[2] Forty-second Report of the Local Government Board (Medical Officer's Report), p. xxxix.