

THE EVOLUTION OF THE COTTAGE HOSPITAL*

by

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IN THIS essay I have endeavoured to outline the trends in medical practice which led to the formation of the cottage hospital. The cottage hospital was something special, quite different from the other types of hospital. To understand these differences it has been necessary to mention the way other kinds of hospitals developed. The influence of these new hospitals on general practice in the nineteenth century may be compared with the influence of group practice and health centres on medical practice today. It was a movement which injected a new spirit into the minds of family doctors.

It is difficult to define what a cottage hospital really is. Individual inspiration, local needs and what could be provided in the neighbourhood conditioned the kind of establishment which was formed. Essentially, it was a small building, usually one already standing, which was used as a hospital without any major alterations being made to it. All the doctors in the area were allowed to admit patients to it, and in-patients were expected to pay a small weekly sum for their keep. But the variations on the theme were many, and for this reason alone the story is necessarily discursive.

'Hospitals are for people', so says the 'Hospital Plan of 1960.' Today this statement is a platitude, but until fifty years ago hospitals were for the poor only. During the lifetime of many of us there has been a revolution in the use of hospitals.

In Anglo-Saxon times, the religious houses had their *infirmaria* for the treatment chiefly of their own sick who were looked after by monk physicians. There were also some hospitals—that is places where the sick could be received and looked after—quite unconnected with the monasteries. Bede, speaking of the death of Caedmon in about the year A.D. 680, wrote, 'In his neighbourhood there was the house to which those who were sick and like shortly to die were carried. He described the person that attended him . . . to make ready a place there for him to take his rest'.¹ Abbot Warin (died 1193) of St. Albans who had studied at Salerno made regulations concerning the care of the sick and the building of hospitals and other matters of medical interest. The hospitals of his time were sometimes hospices or places of rest and sometimes hospitals for the care of the leprous. They were distributed widely over the country. In Devon, for instance, there were leper hospitals in Exeter, Honiton, Totnes, Barnstaple and Torrington. The study of old wills tells us that they were well supported and that it was not unusual for a testator to leave legacies to more than one. As the influence of the church diminished and the incidence of leprosy waned, some of these hospitals were diverted to other uses and some, as at Nottingham, became the responsibility of the town corporation. After the Reformation many of them declined but some continued long after, usually as alms houses. In Stuart times, except for the two Royal foundations of St. Bartholomew and St. Thomas, England was almost

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without any hospitals. And this was at a time when plague was always present and every few years spread in waves through the land. However, when it reached epidemic force in any town, plague hospitals or pest houses were rapidly built or commandeered. Most of these were temporary structures which could easily be pulled down: others remained, as that at Tavistock, to become a burden to the people and an eyesore. In war-time again, similar temporary hospitals were set up, or buildings were taken over, for the reception of the wounded and the sick or the sick were quartered on the people. This happened when William of Orange landed in Brixham. His sick and wounded were left to the care of the citizens of Exeter.* In earlier times old soldiers had often been admitted to alms houses. The Earl Leicester's Alms House at Warwick was founded for twelve old soldiers. The Royal Hospital at Chelsea was opened in 1692.

During the eighteenth century a spate of hospital building started but was confined to the larger towns. The Westminster Hospital was opened in 1719, Guy's Hospital in 1724, St. George's Hospital in 1733, the Royal Hampshire County Hospital in 1736, the Middlesex Hospital, the Royal Liverpool Hospital and Shrewsbury Hospital in 1745 and the Leeds General in 1767.³ All these hospitals were founded by the voluntary efforts of philanthropists such as Alured Clarke,³ Dean of Exeter, whose initiative was responsible for the Winchester Hospital and the Devon and Exeter (1743).⁴ In the inception of these the physicians and surgeons of the localities took an active part. Those who had subscribed had the privilege of being able to issue hospital tickets for admission to those whom they thought were deserving of their charity; for example, each guinea subscribed might entitle its donor to one ticket. In this way patients from places quite distant from the county town could gain admission, but the small boroughs and market towns still remained without hospitals, a serious matter when roads were little better than tracks and when the squire, the doctor and the parson were still content to ride on horseback about their daily business.

Whilst the new voluntary hospitals provided beds for in-patients, no provision was made for out-patients or those who required visiting. The old Poor Law did nothing for those not actually declared pauper. In 1698 in an effort to curtail the growing powers of the apothecaries, the College of Physicians⁵ had opened several dispensaries for the provision of medicines at cost price and the giving of free advice for the genuine poor, but it was not until 1770 when Lettsom opened the first free dispensary in London that any real effort was made to provide for their care.⁶ The dispensary system was further encouraged by the foundation, also by Lettsom, of the Royal Humane Society 'to resuscitate persons apparently drowned'.⁷ Besides providing apothecaries and surgeons to attend and visit the sick, the dispensaries often employed nurses to tend the patients in their homes and to dispense food and drink for the needy. These dispensaries served a useful purpose, and, in the course of time, bed accommodation was added.

* 'A petition from the Mayor and Council to the King that upon application to them made by His Majesties physicians or chirurgeons at your happy arrival then did take care and provide all necessaries for an hospitals for such of the soldiers as were diseased at their arrival or fell sick there afterwards. That on Nov. 19 last [i.e. 1686] 156 diseased men were putt into the said hospitall, and afterwards such others as neede the same, at a total cost of £345 7s. 3½d.' (*Report on the Records of the City of Exeter*, Historical Manuscripts Commission, London, 1916. p. 221.)

The early histories of the Royal Infirmary, Sunderland⁸ and the West Cornwall Hospital⁹ at Penzance and the Teignmouth Hospital^{9a} are examples of this kind of evolution. In 1794, the Sunderland dispensary developed out of the Sunderland Humane Society. Subscribers of one guinea received three tickets each valid for up to six months' gratuitous treatment. The rules of the dispensary stated, however, that 'no apprentice whose master could pay, nor any person who could pay should be a dispensary patient'. If the patient was unable to attend the dispensary the apothecary visited him in his own home at least once a week for consultation. Urgent cases were to be attended immediately. Patients had to return all 'empties' and living leeches, and were liable to be dismissed if they did not attend for two weeks. After two such dismissals they were refused treatment. Similar dispensaries were established in most of the large towns in the country.

The Penzance Public Dispensary and Humane Society was founded in 1809. In 1874 it became an eight-bed hospital but it was not until 1907 that all the practitioners of the town were allowed to treat their own patients in it. So it was with most of these hospitals; only in time, if ever, did they become general-practitioner hospitals. Many, like the Sunderland Royal Infirmary, became flourishing general hospitals. Right up to the time of the inception of the National Health Service in 1948 many dispensaries continued to operate alongside the general hospitals.

Teignmouth Dispensary was established in September 1848 and one year later (September 1849) two wards with three beds each were fitted up, and placed in the charge of Mr. Ackland and Mr. Leman. In March of the following year four further beds were added, and in February 1851 an eleventh bed was added, to be a casualty bed 'upon the understanding that any case occupying the casualty bed shall be transferred to the first vacancy in the ten ordinary beds', and the board at the door of the institution was ordered to be repainted—The Teignmouth and Dawlish Dispensary and Marine Infirmary. There was another dispensary in Teignmouth—the West Teignmouth Dispensary—the date of foundation of which is unknown but which existed at the same time as the Teignmouth and Dawlish Dispensary and was supported by another set of surgeons. The rivalry between the two factions is reputed to have caused bad feeling until in 1859, after the resignation of one of the surgeons at the Teignmouth Dispensary, it was agreed to amalgamate the two institutions. In 1860 the name was changed to the Teignmouth, Dawlish and Newton Infirmary and Dispensary, and in 1896 to the Teignmouth Hospital. This hospital, now classed as a cottage hospital, differed from the cottage hospitals which were founded a little later in that it was not at first open to all the doctors in the district.

Following on the rise of the general hospitals and the dispensaries, came the special hospitals. Many of these were started in the first half of the nineteenth century and between 1860 and 1880 thirty special hospitals were established in England, mostly by private medical enterprise.¹⁰ A doctor who thought he was specially experienced in a small branch of his profession or, indeed, who wished to increase his experience, would start a special hospital usually under the patronage of wealthy and influential friends.

The establishment of hospitals brought to the practice of medicine a stimulus hitherto lacking. In the late eighteenth century and the first half of the nineteenth,

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the roots of scientific medicine, the seeds of which had been sown by such men as Harvey, Glisson, Willis and Hales, began to sprout. The Hunters and the Heberdens, Fothergill and Lettsom, Baker and Brodie, Hodgkin, Addison and Bright, all enhanced the standing and dignity of the profession. The doctors in the smaller towns, whose education was often equal to that of their colleagues in the cities, missed the convenience they had become accustomed to as hospital apprentices and dressers. In 1858 the first Medical Act gave doctors a legal recognition and status which they had long lacked. A greater pride in their profession was engendered, and the new kind of medical practitioner so well pictured by George Eliot in *Middlemarch* was alive to the new opportunities of practice. The introduction of ether in 1846 and chloroform in 1847 made surgical operations easier and a hospital in which to perform them more desirable.

The middle of the nineteenth century was a time of rapid industrial expansion, and movement between towns was increasing with the building of that vast network of railways which was once our pride. But still the poor in the villages could only be cared for at home, and rural cottages with only one or two rooms were not the places to nurse compound fractures or scrofulous abscesses. The need for small hospitals in country places was becoming obvious and it was Albert Napper¹¹ a general practitioner in Cranleigh in Surrey who stepped in and showed that 'all the good effects of a hospital might be obtained with a zealous, earnest surgeon and a good nurse in a simple cottage like that of a poor man.'^{*}

Albert Napper (1815–1894) was a typical example of the newer sort of practitioner. Born at Lockwood in Sussex, he was articled for two years to his maternal uncle at Godalming and then walked the wards at St. Thomas's before qualifying M.R.C.S., L.S.A. He spent a year at Edinburgh and also studied at Bonn before starting practice at Guildford in 1840. In 1854 he moved to Cranleigh. Burdett, in an obituary notice,¹² wrote of him as a singularly modest and retiring man with all the characteristics of a country gentleman. 'His courtesy, readiness to give information and wholeheartedly do his best for his patients won for him a reputation and popularity which the most ambitious might envy'. In 1881, when he retired, a public testimonial was raised for him by the South-east branch of the British Medical Association.

Napper departed from the old system of 'charity universal' which held that the poor should be treated free in the county hospital or by the guardians. It was known that the system of giving free tickets to subscribers was taken advantage of by many well able to pay both for advice and medicine. It was stated that 'many openly became subscribers that their servants and others employed by them may obtain cheap doctoring at the hospital'.¹³ The poor in Cranleigh and elsewhere were found to be not only grateful for the help offered by the cottage hospital but able and willing to pay a weekly instalment towards their maintenance. Horace Swete,¹⁴ relates that Napper confided his ideas of a village hospital in Cranleigh to the vicar, a Mr. Sapte, who was enthralled at the scheme. Sapte, whilst riding one day round the parish to

* A note in *Medical History*, 1962, 7, 268, describes under the heading 'An Early Cottage Hospital', the beginnings of the West Hertfordshire Hospital in 1825. But this was not a cottage hospital in the accepted definition of the term. The patients were not charged fees, the medical staff was limited and, in 1827, a resident house surgeon and dispenser were employed. The only reason for calling it a cottage hospital lies in the fact that it was first housed in a row of old cottages.

solicit interest amongst his parishioners, heard that an accident had just occurred and the victim had been taken to a nearby cottage. There he found Napper amputating a poor man's leg with the help of his dispenser, the policeman and an old woman 'the druggist had volunteered his aid but had fainted and was useless'. Cranleigh village hospital was opened in 1859 with six beds. The rules¹⁵ of this hospital for 1866 are interesting. The establishment consisted of a regular nurse and another woman 'for the necessary work of the house'; a lady had also promised 'the benefit of her assistance in all special cases'. 'The nurse shall at such times as her services are not required at the hospital, attend all women at their homes during their confinements or other illnesses, on payment of the usual fees'. The medical report¹⁶ of 1866 on the patients treated in the hospital is most detailed. Many were accidents—there was a stricture due to an accident; one who was severely gored by a large buck; a road accident—a severe contusion of the thigh, 'having whilst intoxicated fallen under the wheel of a waggon loaded with bricks'. (Whether or not he was in charge of the vehicle is not recorded.) Amongst other cases were rheumatic fever; yellow jaundice; a hopeless case of atrophy who died; a strangulated hernia 'but with no urgent symptoms' who was to have been operated on in the afternoon but having 'imprudently got out of bed about midday the bowel ruptured and he died immediately'; a hydrocoele—tapped and injected with iodine. Chloroform was twice administered. In all, twenty-seven cases were treated with ten deaths at an annual cost of £108. When, in 1864, Napper came to write *On the advantages of cottage hospitals to the public and to the profession*,¹⁷ he analysed the first hundred patients treated in Cranleigh. Of these, 61 were parish paupers, seven were incapable of remunerating the surgeon, sixteen were in humble circumstances and ten were paid by the Poor Law guardians for operations, fractures and the like to the sum of £36.

Although the patients were charged for their stay in the hospital the doctors made no charge for their treatment. This aroused the indignation of the editor of the *British Medical Journal*^{17a} who, in a leader on 'Village hospitals' asked why medical men should not charge the patients in 'these very desirable institutions'. This stirred Napper into replying that with such men as Clyne, Thomas, Brodie and Fergusson giving their services free it would be suicidal to charge in the village hospital, and Horace Swete wrote that of the patients treated in Wrington Village Hospital, seventeen were in clubs or on the parish and two were domestic servants 'who would not have been attended by any family doctor if the village hospital had not been established'. Three were sent in and attended by a neighbouring medical man who had already been paid by them what they could afford and who felt he could no longer send in a medical bill to them.

Within seven years of the establishment of Cranleigh there were sixteen similar hospitals. By 1877 there were 200¹⁸ and in 1896 there were 300 scattered all over the country.¹⁹ (See table 1.). The table reproduced from Burdett gives details of some of the early cottage hospitals founded in the West Country.

In the same year as Cranleigh hospital was founded, a hospital was opened at Middlesbrough with 28 beds, but this, the North Ormsby Cottage Hospital, was not considered to deserve the title of Cottage. However, Horace Swete writing in 1866²⁰ stated that in 1859 two new hospital plans arose, that of cottage hospitals of a small

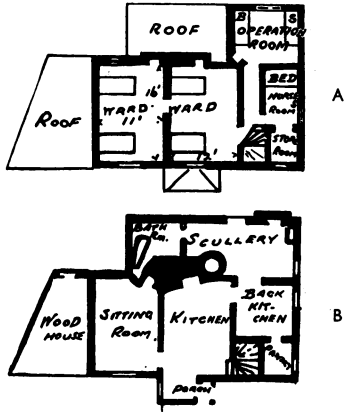


Figure 1.
Plan of Cranleigh Village Hospital.
A: First floor; B: Ground floor.

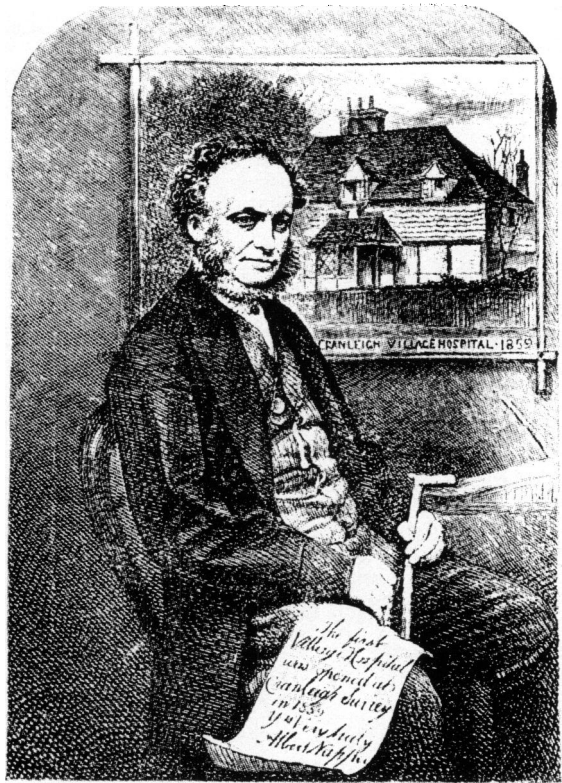


Figure 2.
Albert Napper (1815–1894),
Founder of the First Cottage Hospital.



Figure 3.
Cranleigh Village Hospital, original building.

(From *Cranleigh Village Hospital, the First Cottage Hospital, A Short History of its Origin and Growth*, Cranleigh, 1937, p. 13, front., p. 5.)



Figure 4a.
Wrington Village Hospital; Exterior.

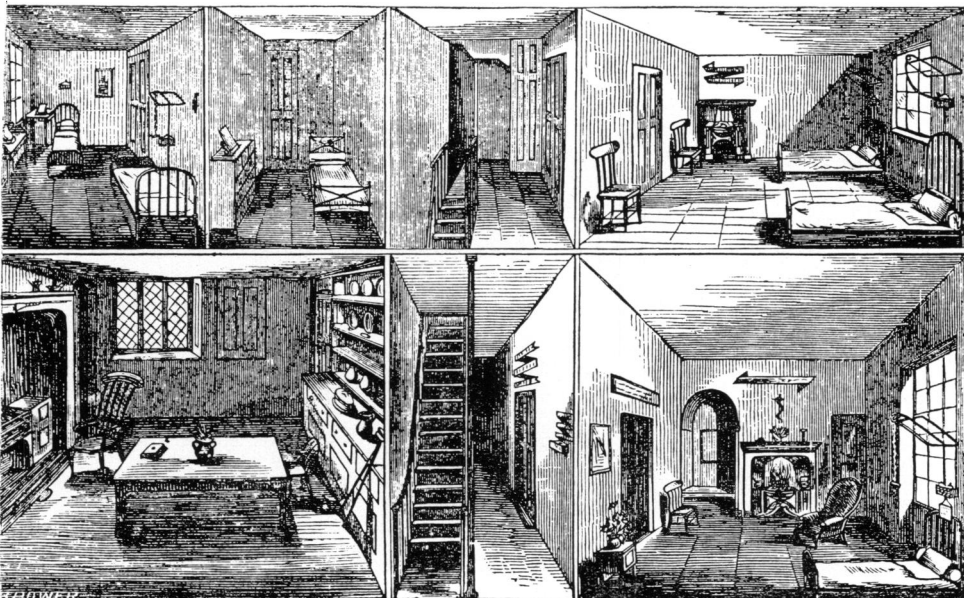


Figure 4b.
Wrington Village Hospital; Interior.

(From: HORACE SWETE, *Handybook of Cottage Hospitals*, London, Hamilton, Adams & Co., 1870, facing p. 133.)

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number of beds, from twelve to twenty; and cottage hospitals of a simpler character still. He calls the Middlesbrough Hospital the first cottage hospital and Cranleigh the first village hospital. Cranleigh is still called Cranleigh Village Hospital. Next year at Fowey in Cornwall, Dr. A. Davis opened a hospital which was said to have been run 'at a wonderfully low cost'. The cost of foundation was £22 10s. 6d. and the annual expenditure seldom in those early days exceeded £20. This hospital was fortunate in that many of the patients were seamen whose hospital costs were paid by the owners of the ships. The house was rent free and a great deal of food was given by the neighbouring gentry. There were three permanent and two temporary patients. Dr. Davies claimed that he had had a room at a cottage to treat patients before 1859 but this hardly makes him the founder of the cottage hospital movement. He was, nevertheless, a great character, who was still remembered in 1934 when I started practising in the neighbouring St. Blazey, in the house owned and previously used by his son. It was said that before Dr. Davis' son came to St. Blazey the medical care of the village was in the hands of an unregistered pharmacist; and when Dr. Davis' trap was seen in the village it was a sign that someone was about to die. In 1862, a hospital was opened at Par Consuls near Fowey which acted as a receiving hospital for Fowey. The cost of Fowey hospital was wonderful even for those times. In 1877, Burdett²¹ estimated that the average annual cost per bed in the six and eight-bedded hospitals was £42 10s. 0d., or £57 per occupied bed.

Mildenhall Cottage Hospital was opened in 1868. In the first annual report of 1869 the advantages of the cottage hospital were reiterated.

Cottage hospitals occupy different ground to the large county establishments, in the simplicity of the domestic arrangements, the comfort of being within easy and therefore inexpensive reach of relatives and friends, the quiet of a private room and the homely feeling which prevails throughout, combined with a certain amount of liberty . . . It has been thought by some to detract from the value of the charity that a small weekly sum be paid . . . The small payment procures immediate admission and besides has its moral value . . . Experience confirms the opinion that its adoption tends to its popularity and success and not only aids the funds but secures the institution against the reception of many trivial and improper cases.²²

Receipts from the 38 patients admitted during the first year was £38 18s. 0d. and a donation of ten shillings from a grateful patient was mentioned. Increasing expenses and the improvement in road transport made it necessary to close this hospital in 1932.

Dr. Horace Swete wrote his *Handy Book of Cottage Hospitals*²³ in 1870. Horace Swete—his full name was Edward Horatio Walker Swete—was the son of a clergyman in Wrington and he practised there for many years before qualifying M.D., after which he moved to Weston-super-Mare and set up as a consulting physician. An obituary notice in a local paper says 'the local medical faculty of that day however—assuming to regard the newcomer as still a village surgeon—failed to accord him that assistance which might reasonably have been expected, if only as a result of a spirit of professional etiquette, and his practice did not thrive.' He was thereafter unsuccessful in running a 'home for special treatment', and later an institution for 'medical-electro' treatment. He was one of the original promoters of the Royal West of England Sanatorium. A man of genial outlook and unfailing good nature, he was hindered in the full development of a good bedside manner by what the writer of his obituary

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calls his natural outspokenness. His book is based largely on his experience in the hospital he opened in Wrington in Somerset. He summarized the essential needs of a cottage hospital thus:

A good kitchen which was used by patients who were well enough to sit up and enjoy conversation etc.; a more comfortable room to be used as a common room by any patient able to leave the bedroom but not sufficiently strong to sit up in bed; this room will be found of great advantage, but is not absolutely necessary.

(Modern views of early ambulation are perhaps only a revival of old methods.) There should be three bedrooms, two fitted for three beds and the other with a single bed for severe cases.

This room will require a good window and a fireplace as it will be used as the operating room of the institution. The nurses' bedroom should be situated as near the patients bedroom as possible so that she may easily be called at night. If there is another small room on the bedroom floor it should be fitted as a bathroom. The offices should consist of a back kitchen, wash-house, house for coal etc., shed for ambulance or wheel chair, and what is most important, a room lighted by a skylight to be used as a mortuary chamber where if required by a jury in case of a coroner's inquest a postmortem examination may be made.

It must have been along these lines that the Wrington Cottage Hospital started. It had a very prosperous career for about five years and was then closed. The reason given for this was that it adjoined the grounds of the secretary who was a dissenter. The secretary wished the patients to attend chapel. The surgeon wanted them to go to church. The secretary bought the hospital; the surgeon ceased to attend and it was closed.²⁴

It is remarkable that so few of these early cottage hospitals were closed. Burdett writing in 1896 mentions only six; of these East Grinstead rose again to achieve great distinction.²⁵

Swete was the inventor of a new form of ambulance for country and village hospitals which he described in the *British Medical Journal* in 1866. It was constructed of varnished wood and iron, the curtains and bed being made of vulcanized india rubber, so that the whole could be washed without injury.²⁶

Like the hospital at Cranleigh, the early cottage hospitals were staffed by one nurse who was often a woman from the village with some experience of nursing. Occasionally she had been recruited from elsewhere and had experience of nursing in a larger hospital. Often she was called upon to act as a district nurse and visit patients in their own homes as well as care for those in the hospital. According to the rules of Dartmouth Hospital this was the rule when the hospital was opened in 1887.²⁷

There was much controversy in the early days of the cottage hospitals as to whether a nurse trained in the district hospital or in London was better than a woman taken from the village itself and instructed in the nursing which she was to do. Discussing 'the woman of the village with some experience of nursing' Burdett²⁸ drew this rather alarming picture:

A common sort of monthly nurse (all monthly nurses are common) who have spent their lives in learning, by the art of 'simples' what is 'good for' every disease under the sun. A person who has in her mind's eye a number of bottles filled with herbs each distinctly labelled not in the

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hieroglyphic style of the poor doctors with their dog latin but in good old English characters—'this is good for the wind'—'this is good for the water'. 'This is good for a burn' and so on *ad inf.*; while at the same time they did not stop even at phthisis and epilepsy having probably a diet good for the former, or a certain charm for the latter, such a person as a rule, has not the least idea of method or regularity and as to the regular administration of medicines, she probably pooh-poohs the very idea of the doctor doing the patient any good and the moment his back is turned has resource to her infallible herbs.

Sudbury Cottage Hospital, which was founded in 1867 and unlike most was built new and contained fourteen beds, was staffed by a matron, an under-nurse and a cook. Holden writing in 1889²⁹ points out that the necessary qualifications of a matron of a cottage hospital are numerous:

She must be a good nurse, strict and kind to the patients, and able to act promptly and wisely in emergencies; she must be an experienced dresser, attending the doctors on their visits, anticipating their wants, and taking charge of the patients in their absence; she will prepare beforehand what is requisite for operations, and will assist at them; she will learn to dispense the medicines presented by the doctor, to take care of the surgical instruments and appliances and to know their names and uses. She must be a good housekeeper and careful in superintendence of the dietary, stores and furniture. The cleanliness, neat appearance and sanitary condition of the hospital depend on her; she has to keep the monthly accounts of expenditure, and of the payments made by patients. Besides all this she will be ready to interview visitors of all ranks who are interested in patients and will be able to furnish them if necessary with a little history and prognosis of any case.

After this catalogue of virtues which would make the mouth of any hospital administrator of today water, Holden concluded that it is a 'mistake to choose an elaborately trained and experienced nurse as she is unlikely to possess that elastic adaptability so necessary to a cottage hospital'.

As a typical example of an early cottage hospital we may take Ashburton and Buckfastleigh³⁰ which is at present scheduled for closure. It had when it was founded in 1876 four beds and a cot in a rented house valued at £251; the furniture and fittings cost £177 14s. 0d. The patients were expected to pay 2s. 6d. a week and the union contributed to the cost of paupers. It was open to all the medical profession of the district. This was a general rule in all these cottage hospitals and it was quite usual for the doctors to serve *in rota*. A weekly rota was working in the Dartmouth Hospital in 1887 and has continued the same to the present day. Ashburton hospital was in 'commodious premises near the station and with a large garden attached. The house was 'for the most part newly built', the rooms large, well-lighted and airy; the entrance hall capacious, and the staircase easy and convenient. The male ward on the ground floor was 'a bright and cheerful room with a low window at the end and a pleasant outlook on green hills across the valley'. It had, what was unusual at that time, a water closet adjoining—most hospitals were content with an earth closet. There were two beds in the ward with room for a third if necessary. The washbasins were enclosed and stained and varnished. The walls coloured a warm French grey and adorned with gifts of pictures. Convalescents were expected to take their meals and sit in the kitchen. The meals provided may be imagined from the diet table. These were, as in nearly all hospitals before the second World War, of two kinds, the ordinary and the light.

Ashburton was early in the penny-a-week movement. Rule 22 of the hospital stated that 'any person paying a penny per week shall be eligible for admission into the hospital without being compelled to obtain a recommendation and while in hospital shall be exempt from weekly payments'. This was doubtless a natural development from the old friendly societies and burial clubs, but strangely enough Burdett viewed the innovation with great suspicion, regarding it as most unlikely to succeed.

Clevedon Cottage Hospital, Somerset, was opened in 1875 with six beds.³¹ The method of admission was by subscription tickets, each subscriber being entitled to introduce one patient for three weeks for each guinea subscribed. Non-subscribers could also introduce patients on payment of 10s. 6d. per week. The matron had been trained at Guy's.

At a time when infectious diseases were rife it was an almost universal rule that patients suffering from these should not be admitted. This was a wise and necessary precaution. Walsall Cottage Hospital committee in their third annual report³² in 1866 remarked on the absence of erysipelas, pyaemia and other contagious diseases stating that it was a matter of congratulation. We must remember that at this period hospital fever was one of the greatest scourges and it had even been mooted by such authorities as Sir James Young Simpson³³ that stone built hospitals should be abandoned and iron cottages be built with one or two patients in each room. These could be taken down periodically and re-erected on a new site. Infectious diseases became the responsibility of the medical officers of health of the local authorities under the provisions of the Public Health Act 1875, section 131 which was a permissive Act only. It was not until the Isolation Hospital Acts of 1893 and 1901 that the control of fever hospitals was centralized in the county councils.³⁴ It was these acts which gave rise to those small tin tabernacles situated, usually on lonely hillsides, miles from the towns they served and opened up only in emergencies. The derelict tin shed of Dartmouth's isolation hospital still stands. I believe it was used only once.

In many ports and river estuaries before the last war large wooden hulks might be seen which had sailed the seas before the age of steam. These were the quarantine hospitals used indiscriminately for quarantine and the treatment of fever cases landed in the ports from overseas. They were under the control of the Port Health Authorities. By and large until the twentieth century little effort was made to isolate fever cases. Crimmond Cottage Hospital was an exception.³⁵ Opened in 1865, it claimed to be the 'first fever hospital on a small scale to admit persons labouring under infectious diseases.' The first annual report in 1866 stated that the poisons of these diseases were harmless when diluted to a certain point. The first eleven cases admitted to the hospital were children, removed from homes where diphtheria was prevalent, and all of them kept well. Of the remaining 33 cases admitted during the year, fourteen were infectious and three died. The years disbursements were £76 14s. 5d., including £5 14s. 4d. 'for cutting, winning and wheeling out peats—two seasons.'

Dr. S. O. Habershon³⁶ a senior physician to Guy's Hospital in a paper on Cottage Hospitals read to the Metropolitan Counties branch of the British Medical Association stressed the great advantages of a small hospital in the prevention of the spread of

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disease. He described conditions in his own hospital:

In the new wards of Guy's there are 50 beds; in others 40, four rows of beds are placed in the ward and the central rows are back to back, with partial separation of walls and arches. Cases of all kinds are placed in these adjoining beds and the effects are sometimes most disastrous. The ventilation is imperfect over the central rows of beds. Some years ago, a case of typhus fever was inadvertently admitted into my ward at Guy's; and unfortunately it spread from bed to bed until, in a few weeks, or rather days, the central rows of beds were all attacked and nearly all the patients thus affected died. Heart diseases, diabetes, patients affected with all kinds of maladies were thus cut down—the effects of a large ill-ventilated ward.

They would have been better in the small ward of a cottage hospital. And he saw another advantage, that of the relative quiet of a small ward.

The loud voice, midnight moan, or wild shriek resounds from bed to bed; and the night is passed without sleep. The delirious fever patient, or one affected with acute brain disease is most trying to other patients; and a small ward is more suitable for such cases.

In 1867 it was claimed that the death rate in 818 surgical cases treated in cottage hospitals was identical with that in the metropolitan hospitals.³⁷

As early as 1867 Edward John Waring³⁸ claimed that one of the advantages of cottage hospitals was the establishment of good feeling and friendly professional intercourse between the medical men of the districts. It is difficult to quarrel with those whom you meet every day on common ground and whose help you may need at any time to administer an anaesthetic or to set a fracture. And yet in the days when competition in medicine was keen—and it used to be very keen—harmony might not be achieved even in the hospital. Although open to all, in many towns there would be doctors who refused to use the hospital and who would speak badly of it to their patients. Some who used it were so uncharitable as to carry inside its walls the feuds with their colleagues. The hospital committee was a wonderful forum for a doctor to insult a colleague with whom he was not on speaking terms, the remarks being directed with scrupulous correctness to the chair. Francis Brett Young had experience of this kind of warfare; he was in general practice in the midlands and in south Devon. The descriptions in his novel *My Brother Jonathon* are no exaggeration.³⁹

The early years of the twentieth century were for the most part ones of consolidation. New hospitals were constructed chiefly as war memorials for the 'war to end wars'; new buildings were added to those already standing. Crowborough Memorial Hospital⁴⁰ had an unusual beginning. In 1897 a flourishing District Nursing Association was formed and the nurses were housed in a cottage home. A few years later the home began to admit patients; in fact, it developed into a private nursing home, the fees being six shillings a week for Crowborough patients, and fifteen shillings per week for patients from the district and for domestic servants in regular employment. In 1911, this nursing home became the Crowborough Hospital and Nursing Association. But in 1914, on the outbreak of the First World War, the hospital and association were earning more by outside nursing than by taking patients into the home. In 1919 a War Memorial Fund was raised in Crowborough and the money devoted to enlarging the cottage hospital.

The benefits which cottage hospitals have conferred on the community have been well recognized by the people whom they serve. Financial embarrassments have met with ready help and threats of closure have been sturdily resisted. The doctors themselves have jealously guarded the privilege of being able to treat and nurse in them their own patients, and practices in places where there is a cottage hospital have always been more sought after than others and often they commanded a higher purchase price.

In writing this paper I have relied largely on the records of cottage hospitals in the West of England and in this respect my account may appear to be biased. But when the movement spread from Cranleigh it moved faster towards the south-west than it did to other parts of the country.

TABLE 1
SOME COTTAGE HOSPITALS IN THE WEST COUNTRY
Particulars of foundations and state in 1877

<i>Hospital</i>	<i>Date of Foundation</i>	<i>Cost of Erection</i>	<i>How Maintained</i>	<i>Payments by Patients</i>	<i>No. of Beds</i>
Ashburton and Buckfastleigh	1876	House rented		2s. 6d.	5 (14)
Bovey Tracey	1871	Two cottages	Furnishings defrayed by landlord	1s. to 3s. 6d.	6 (18)
Dawlish	1871	Cottage altered	Subscriptions	2s. 6d. to 7s. Servants 7s.	7-8 (18)
Fowey	1860		Subscriptions	Committee decides	8 (14)
Ilfacombe	1864	£1,000 built	Given	Free to neighbourhood	(32)
Lynton	1874	£682 and furniture	Subscriptions, Land, cartage etc., and most material given by farmers	1s. 6d. & 2s. servants 3s. labourers 1s. paid by Union	4 (10)
Newton Abbot	1874	House £767 Furniture £104	Subscriptions	Various. No paupers.	10 (64)
Ottery St. Mary	1870	£2,300		3s. 6d. average Union 2s. 6d. to 4s.	7 (23)
Redruth	1863	£2,000	Gift of Lord Roberts		30 (151)
Stratton	1876			2s. 6d. to 5s.	6 (19)
Wrighton	1864	Cottage altered	Subscriptions	2s. 6d. to 10s.	5

Number of beds today is given in brackets. Summarized from Burdett. *The Cottage Hospital, 1877*

The Evolution of the Cottage Hospital

ASHBURTON COTTAGE HOSPITAL

DIET TABLE

<i>ORDINARY TABLE</i>			
<i>Per day</i>		<i>Per week</i>	
Meat (cooked)	½ lb.	Butter	½ lb.
Potatoes	1 lb.	Tea	2 oz.
Bread	1 lb.	Sugar	½ lb.
Rice or Arrowroot	2 oz.		
Vegetables	2 oz.		
<i>LOW DIET</i>			
Beef-tea, broth, gruel, arrowroot, sago, and mild ale as ordered.			

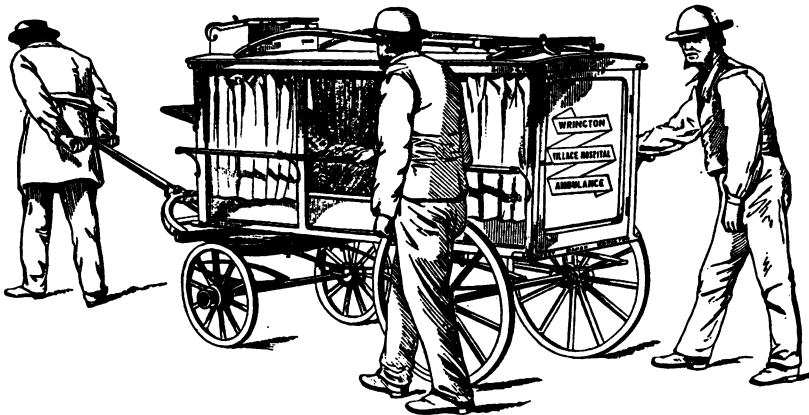
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