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‘Our Hospitals’? Voluntary Provision, Community and Civic Consciousness in Nottingham Before the NHS

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One of the strengths, contemporaries argued, of Britain’s pre-NHS voluntary hospital system was that, unlike the monolith that replaced it, its provision was organically guided by, and responsive to, the direct needs of the community it served. The hospital was not simply a place of medicine but an active and symbiotic cultural site, where local people came together to further joint needs; a place of overarching pride and attachment. Yet the relationship between the community and hospital was set to change as working-class payments increased as a proportion of hospital income, so that financial costs were now more broadly shared across the classes. Did then local people truly come to view the hospital service as belonging to them — as ‘ours’ — gifted through their various fundraising and locally organized insurance contributions? Or was this more rhetoric, provided by those appealing for funds and resisting state intervention?

KEYWORDS civic, community, hospital, inter-war, Nottingham, voluntary

With the war over, as a newly elected Labour government pondered on the future shape of health provision, the executive of Nottingham’s wealthiest and most prestigious voluntary hospital reminded its local community of past collective achievements. Afraid these would become obscured, he observed:

The term ‘Our Hospital’ is not new but one that the public is inclined to overlook. The Hospital belongs to the Public […] From the earliest days to recent times there have been public-spirited benefactors from all classes who have always been anxious and willing to provide the capital […] [whatever] the outcome of the proposed National Health Service, the Public of Nottingham and District have good reason to be proud of the voluntary General Hospital and its work.¹

¹ University of Nottingham Library, Manuscripts Department (hereafter NUMD), Uhg R16, AGM, 18 Oct. 1945, General Hospital, 1945. All hospital records are located at the Nottingham University Manuscripts Department.
Perhaps they ought not to have worried. Forty-five years later, local journalist David Lowe remembered interviewing one former hospital administrator who had remarked that he had always been ‘absolutely knocked backwards by the strength of feeling about the General Hospital. It was really quite overwhelming’. Lowe was apparently less surprised: ‘As a Nottinghamian’, he recounted, ‘I am well aware of the depth of feeling for what has always been regarded as the People’s Hospital’.2

Yet such views have been largely airbrushed from our national history, camouflaged by the British affection for the National Health Service. From its inception, its popularity seemed assured. Polled in 1948, 35 per cent thought its establishment the best achievement of the post-war Attlee government.3 Anchored in our national imagination within a ‘tale of evolutionary progress’, the creation of the NHS is offered as our ‘crowning achievement’, and a cornerstone of British national identity, as those who oppose subsequent change are quick to remind us.4 Yet contemporary campaigners for hospital reform had been equally condemnatory. Surveys from the 1930s and 1940s revealed ‘a considerable hidden need’ caused by bed shortages, ‘gloomy and depressing’ buildings, and wholly ‘inadequate’ accommodation. Others focused on the need to ‘eliminate’ the ‘cold as charity’ ethos that dominated voluntary hospital provision, and the resultant perfunctory and patronizing treatment of patients.5 The voluntary hospitals, not surprisingly, saw matters very differently. Its ‘glory’ was that it allowed the ‘more fortunate’ to ‘give help and encouragement to their less favoured fellow citizens’, necessitating the ‘co-operation of men and women of all classes and creeds to assist in the finance, the management and the carrying out of this great work’.6 Here hospitals became not only iconic medical spaces, but also salient cultural institutions, ‘serving the widest range of social welfare functions’.7 Indeed, politicians were later to regret the loss of such supposed connectivities.8

This article, therefore, tests for such forms of association, responsiveness, and communal embedment through the experiences of four hospitals in Nottingham — the General (552 beds), the Children’s (134 beds), the Women’s (107 beds), and the Eye (44 beds) — and two supporting organizations — the Cot Fund and the Hospital Saturday Fund — in the first half of the twentieth century. The hospitals themselves were generally of a good standard, the product of significant investment during the inter-war years.9 The Hospital for Women was newly constructed, there were

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several major new facilities at the General, and the Children’s Hospital had been significantly extended in the 1920s. The exception was the Eye Hospital. The city, too, was relatively prosperous, with a balanced economy. Certain industries like tobacco, clothing, and pharmaceuticals had expanded rapidly inter-war, although others like lace and coal suffered significantly.10 The city was spared, therefore, the major structural ruptures that affected certain other regions; it operated also within industrial and political spheres that were more consensual than radical.11 Under such potentially positive conditions, just how socially organic, then, was voluntary hospital provision before 1945?

National opinions

Things are not always as they seem when read through the distorting publicity generated by voluntary institutions, perpetually conscious of their financial vulnerability to the vagaries of public loyalties, and supported by a compliant local press which reproduced largely unquestioningly the positive statements passed to it.12 Yet to read hospital organicism as simply a media construct — devoid of context and lived everyday experience — would be equally misleading. Even contemporary critics acknowledged the power of the voluntary hospital to foster a deep-rooted, community-based goodwill.13 Indeed, few when questioned had a neutral view on voluntary hospitals, but 16 per cent more of the public approved rather than disapproved.14

A more detailed understanding of what ordinary people thought of pre-NHS provision is more difficult to ascertain. Reporting in 1947, Mass-Observation found that ‘there existed an emphatic consciousness of the value of the work done by all hospitals’.15 Three quarters of ex-patients, mostly treated in voluntary hospitals, were largely satisfied with their hospital experience, with only 19 per cent expressing dissatisfaction.16 The ‘greatest measure of support’ for voluntary hospitals came from ‘working-class people in general and from working-class women in particular’. Valued particularly was their ‘human touch’, the belief that ‘individual patients were likely to receive more sympathetic and specialised attention’. Typical of the many comments were: ‘They are exceptionally good. I don’t know what we would do without them places’ (Working-class man, 62); or ‘I think that when people have helped to keep the hospitals going there is likely to be more friendliness about it. I don’t know if this is going to be same from the State’ (Working-class housewife, 56).17

15 Ibid.
16 M-O File 1665, ‘Feelings About Hospitals’, Apr. 1943, i, 6, tables V and VI.
Nonetheless, people were also ‘critical of the running of voluntary hospitals’. Many objected to flag days and appeals, feeling that hospitals ought not to ‘depend on charity, but should be financed out of public funds’. This clearly raises questions about the fundamental tenets of local voluntary agency within the civic arena. Yet there was a certain ambivalence present here also. If one in three disapproved of charity, only one in twenty never gave, and about one-third gave every time they were asked. Hospitals, particularly, were ‘clearly regarded’ as one of the ‘most praiseworthy causes’. Indeed, we should not necessarily conflate popular attitudes to charity and voluntarism. Surveyed in 1947, half favoured voluntary provision, with only a third disapproving, but only ‘one in three had anything approving to say about charity or charities’. Indeed, in real terms, voluntary hospital income from philanthropic sources — that is donations, legacies, church collections, and proceeds of entertainments — continued to rise during the inter-war period, even as it fell as a proportion of total income as direct patient payment and workplace-based contributory schemes became more important. Its importance also varied, so that in London, the south-east, the east midlands, and Lancashire, and in specialist rather than general hospitals, ‘endowment and traditional forms of charity’ remained ‘significant’, even vital to hospital finances. Nor, overall, was there any popular large-scale ideological conversion away from voluntarism to state-provided medicine before 1939.

**As sites of participation**

The most successful health ‘fundraisers’ — and thus key participatory sites — for voluntarism during the inter-war period, however, were not charitable but mutualist. The popularity of these hospital Saturday and other contributory funds is well known. Covering some twenty million members and dependants by 1939, all the survey data suggests that ‘there was little but praise for the way in which these schemes work’. John Pickstone, amongst others, has read such engagement primarily as one of offering workers, for a 2d or 3d contribution per week, a useful form of medical

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20 M-O File 2507, ‘Voluntary Social Services’, 34.
insurance to secure value-for-money hospital treatment. But he notes that for many of the funds’ organizers — from whatever social station — supporting the local hospital was also a ‘moral campaign and a source of civic pride’. Such networks offered ‘uncontentious’ spaces where ‘respectable workers could take a place in town’, when medical self-help and mutualism were core components of working-class identity. Contributory schemes lay content within such a dual, interlocking identity, offering themselves both as ‘insurance organizations’ and as ‘an integral part of the Voluntary Hospital Service’, where ‘many thousands of voluntary workers [...] feel they are playing their part in the support of the hospital’. ‘There is a real sense’, voluntarists argued, ‘in which the Contributory Schemes network makes possible a living interest in the hospital and social service’, ‘creating a real democratic element in the voluntary hospital system’.

How successful they were in achieving this is open to question. We might usefully start by viewing such spaces as part of a social process and a state of mind that generated trust and mutual understanding, played out on the ‘stage’ of the locale through the common, intimate experiences and needs of communities and interest groups. Within such a construct, by the turn of the century voluntary hospitals were offered as civic sites of ‘inter-class solidarity’, ‘strongly identified with place’, connected by shared ways of thinking, feeling, and doing. If management structures remained at times remote, Pickstone argues, the hospitals themselves were increasingly seen locally as ‘people’s hospitals’, firmly embedded in the community that paid for their upkeep. Sufficiently flexible to retain and replenish pluralist links with all sectors of the local community because of their high profile, the hospitals offered the utilitarian benefits of improved healthcare to employers and workers alike.

Such spaces were also traditionally seen as places where urban elites could — and indeed were expected — to prove their credentials as local social leaders. Whether for altruistic or egotistic reasons, the giving of time or money symbiotically conferred

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status. Trainor, looking at the late nineteenth century, found that posts were ‘plentiful enough to satisfy the ambition of many local citizens, but were never so numerous as to confer no distinction on their holders’. It also allowed post-holders to win approbation and networking advantage beyond the limits of firm, church, or immediate social circle. Extending what Croll has labelled a ‘civilized gaze’ over the local community, the local paper recorded who did what, who gave and perhaps as importantly in terms of a status-conscious citizenship, who did not, as it created its various civic publics.

Yet, as Gunn reminds us, the human body is more than text. ‘Power and power relations are located in the fabric of everyday life’, in the face to face contexts of human practices, meetings, civic rituals, and interactions, and in the activity itself. Beyond 1918, however, the key question was whether traditional elites wanted to be part of this intimate urban civil project. Many, like Beveridge, identified a break-down in attachment between elites and provincial locale, reducing significantly the propensity for volunteering. Others have speculated on the diminution of traditional charitable activity — particularly with hospitals — as being central to middle-class identity. Yet recent studies have shown that such assumptions are significantly overstated. A survey, for example, of some one thousand individuals in Nottingham from 1900 to 1950 across a range of leading charities revealed no falling off of the social status of volunteers across time. If charitable benevolence by the wealthy or moderately wealthy was still ‘expected’, nevertheless ‘excessive calls on time’ remained a strong disincentive to volunteering. On many occasions, individuals in Nottingham had to be persuaded by fellow board members to stay when external commitments or even ill health intervened.

So what types of people were involved in medical charitable work and what did they do? If we examine the class profile of the executive management committees of the four Nottingham hospitals from 1900 to 1950 (Figure 1), the disproportionate

presence of an urban upper elite across the half-century is readily apparent, either as major manufacturers or commercial operators, or, in fewer cases, as higher professionals. The middle-middle classes — those less wealthy employers or higher professionals — are less evident (when some one per cent of the city’s population would be deemed upper-middle class, and some ten to fifteen per cent middle-middle class). Thus, despite the costs and adverse indicators, in Nottingham there was no falling off in belief amongst the city’s urban elite in the value of voluntarism.

As might be expected, between 1900–50 all six chairs of the monthly board of management of the General Hospital were from this upper-middle-class sector. Five were major industrialists, men like the autocratic Sir Charles Seely, who ‘gave lavishly of his great wealth’, but equally demanded the final say in how his money was spent. His successor Frederick Acton, a well-to-do city solicitor, turned his back on local politics to concentrate instead on hospital work, where he was thought ‘an outstanding figure in civic, commercial and philanthropic circles’. Acton, who bequeathed the hospital £10,000 (some 20 per cent of his estate), was followed

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40 See status criteria, see N. Hayes, “Calculating Class”: Housing, Lifestyle and Status in the Provincial English City, 1900–1950”, Urban Hist., xxxvi (2009), 113–40.
41 Ibid.
42 Nottingham Journal [hereafter NJ], 11 Apr. 1920; R. G. Hogarth, The Trent and I Go Wandering By: Stories of over Fifty Years of My Life in Nottingham (Nottingham, 1948), 9; R. Mellors, Men of Nottingham and Nottinghamshire (Nottingham, 1924), 95.
43 F. H. Jacob, A History of the General Hospital near Nottingham (Bristol, 1951), 282–3; NUMD, Uhg/M1/3, House Comm. mins, General Hospital, 22 Mar. 1933.
by William Player, who with his brother ran the Player tobacco empire, one of the largest businesses in the city. Like Acton, he offered himself as a hospital enthusiast, where such work was central to his public and private persona. Speaking at the 1928 annual meeting of the Hospital Saturday Fund he recounted that:

No work I have ever done in my life has given me so much pleasure as this for the General Hospital. I may be criticised for not having done other things — municipal work, for example — but we are able here to frame our lives according to our bent. On the job we can all work together, shoulder to shoulder, rich and poor, without any political or other differences.\(^{(44)}\)

Volunteering, then, was seen as a more consensual activity than entering into the public arena of local politics, with its public scrutiny, electioneering, or bellicose nature, and also one where the potential impact could be more immediate.\(^{(45)}\) Yet for Player it was not simply the grand gesture — for example, the £150,000 he donated for capital projects. He could also be found wandering around the hospital site checking to see if the dustbins had been emptied or the hospital chimney flues worked satisfactorily.\(^{(46)}\) When he stood down in 1932, he was replaced by Sir Louis Pearson, an engineering industrialist. He similarly spent ‘two or three afternoons a week, at least’ on hospital business.\(^{(47)}\) His nephew, Lt. Col. Noel Gervis Pearson, took over prior to nationalization and also made the hospital ‘the chief interest (one might say “hobby”) of his life’, visiting ‘every day’.\(^{(48)}\) As one medic noted: ‘the reason the Nottingham General Hospital stood so high was due primarily to the fact that it had so many powerful, generous and zealous friends’.\(^{(49)}\) He might have added that each spent a considerable amount of time at the hospital’s behest, which went well beyond any simple ‘call of duty’.\(^{(50)}\)

Similarly, William Player’s brother, John, ran the city’s Children’s Hospital through the inter-war period. It was through his ‘generosity’ that the hospital acquired new wards, outpatients and other departments, and a nurses’ home, at a total cost of some £180,000.\(^{(51)}\) Player had been a member of the board for forty-nine years and its chair for twenty-eight of these. His predecessor was John Spalding, the managing director of a large department store. Like Seeley and the Player brothers, Spalding also gave his name and time to many other city-based charities: for example, the Hospital Saturday Fund, the Children’s Hospital Cot Fund, the Red Cross, the Association for the Prevention of Consumption, the City Dispensary, Prisoners’ Aid, and the Cripples’ Guild. Those chairing the executive of the city’s Eye Hospital were likewise

\(^{(44)}\) NJ, 26 Nov. 1928.
\(^{(46)}\) NUMD, Uhg M/1/3, Mins House Comm. General Hospital, 20 Aug. and 26 Nov. 1930.
\(^{(47)}\) Ibd., Uhg R16, AGM General Hospital 1944; NJ, 10 Feb. 1942; Nottingham Evening Post, 5 Nov. 1943; NJ, 20 Sept. 1928.
\(^{(48)}\) Nottingham Evening News, 27 Nov. 1958; Hogarth, Trent and I, 51.
\(^{(51)}\) NUMD, Uhc/R/2/22, Annual Report (hereafter AR) Children’s Hospital, 1947.
upper middle-class: Job Derbyshire, who ran a large accountancy business but who also held directorships in several local companies, the lace manufacturer Harry Weinberg, the wealthy newspaper proprietor William Bradshaw, and John Parr Ford, the director of a major local brewery. Only on the board of the Hospital for Women do we find chairs drawn from the middle-middle classes: two city solicitors, William Parr and Charles Rothera. The majority, however, were upper-middle class, including, briefly, the already noted Sir Louis Pearson.

Clearly, no claim can be made here for representative balance. Indeed, although the proportion of lower-class executive members rose through time, the numbers varied significantly. By the mid-1920s, the Eye Hospital had three Saturday Fund representatives on its Board (or about one-third of the total membership), men like miner Sam Pegg, or Ernest Purser, a draper, later chair of the city’s Health Committee and a key member of the local Labour Party establishment. However, its longstanding representatives were professional or managerial: people such as William Squires, who was also organizing secretary at the General Hospital. The Hospital for Women only had one such member, Julia Day, who was a welfare supervisor at the Boots Company and sat on the Hospital Saturday Fund Executive through the 1920s to the 1940s. Day was also its representative on the executive of the General Hospital.

In fact, the majority of working- and lower-middle-class representation on local hospital boards was consequential, as might be expected, on such overlaps. Before 1914 this was limited to a single representative on the General Hospital’s management board, but by the 1920s this had risen to four, or some ten per cent of the total composition, and was set to rise still further (Figure 1). Selection was by election, but in practice the major subscribers consistently held a certain sway. Thus the local mining industry always had representation — men such as colliery checkweighman George James, who was also a delegate to the local trades council, the Notts Miners’ Council and to the Miners’ Federation of Great Britain. Boots, as a major employer, also had a continuing presence, so that Day superseded Reginald Hallam, a clerk with the company. Robert Osbourne, a factory foreman at Players, served through the 1930s and 1940s; John Husbands, a cashier in the corporation’s trams division, served from before the First World War. Other appointments were linked to sustained effort on behalf of the Fund: for example, Robert Johnson, a fishmonger and grocer, who collected contributions from the city’s market Tenants’ Association.

Lower-class membership of the Children’s executive board was more esoteric, though also tied to fundraising capacity. Because each year the city’s local authority schools collected substantial sums for the Hospital, there was from the 1920s onward always a teacher on its management board, to represent ‘the thousands of youngsters in the City who gave up their pence to this cause’ on behalf of the ‘weak and suffering little ones’. Ernest Draper, a lace draughtsman, served on the executive of the Hospital Saturday Fund, but he was also very active in the local Sick and Annual Societies’ movement, which under the auspices of its Cot Fund raised considerable sums each year through its networks of pubs, clubs, and workplace collections for the Children’s Hospital. His successor as the Cot Fund representative was John Bosworth. On his retirement in 1940 as assistant secretary, the board granted him a

52 Ibid., Uhc/R/2/5 & R/1/8, AR Children’s Hospital 1915–16 and 1930.
pension of 30s per week — in recognition of the ‘splendid work’ he had done since 1902 as ‘the mainspring of the Nottingham and Notts Sick and Annual Society, through which organisation many thousands of pounds had been collected for the institution’. 

Beyond the executive, social exclusiveness was even more apparent. As Sir Edward le Marchant, a local landowner, remarked when presiding at the AGM of the Eye Hospital, ‘it was very fitting and proper that the list of their Presidents and Vice-Presidents should be an influential one. The list carried weight with the subscribers, working guilds and institutions represented at the meeting’. Social status and connection were also important in terms of fundraising. The ‘ladies of the Town and Country’, as wives and members of the local landed and industrial elite, for example raised £4100 for the Children’s Hospital by holding a four-day bazaar in 1900. Sometimes, simply the hat was passed around. Short of funds at the end of the First World War, the executive considered several options but eventually a ‘private appeal was made by two members of the board to some friends of the hospital and this was most generously responded to’, raising some £2000. In 1943 did the General Hospital finally appoint a representative of the working classes as President — John Terry — who as superintendent of the city’s sanitary department was certainly no longer working class himself. Terry had been a member of the hospital’s board of management for thirty-two years, but perhaps more importantly he had given even greater service to the Saturday Fund whose representative he was.

Nonetheless, in the constant search for money, elites were not immune from criticism. Frederick Acton noted, as he once again appealed for funds, that ‘they had great wealth in the county, they had influential people who could do an immense lot for the hospital, and a great deal more than they did’. As Acton condemned the gentry and ‘swells’, Sir Thomas Shipstone, a wealthy local brewer, similarly attacked local employers for not donating more themselves or more readily supporting the work of Hospital Saturday Fund. The public contrasts drawn between working-class, middle- and upper-middle-class support could be starkly and publicly painted. Indeed, across the fifty years supporters of the hospitals regularly lamented that, as Harry Weinberg noted, whilst ‘local workpeople’s organisations’ were ‘so splendidly championing the cause’ of local hospitals, they ‘did not seem to have received sufficient support from those people who could well afford to come to their aid’. As one leading city doctor noted, ‘it was always the same people who gave’.

A working-class voice?

Worker representation, particularly a minority one, did not guarantee an effective lower-class voice, and without this the holistic claims made by voluntarists would...
lack weight. Indeed, not all hospitals welcomed a significant working-class membership on the boards of management, nor did increased representation reflect directly the scale of increasing worker financial contribution. Yet the degree to which working people as members of management boards were either willing or able to exert strong influences over the hospital management function also varied between hospitals and according to the topic under discussion. It was at times a fluid relationship as hospitals became increasingly reluctant to ‘antagonise the management of mass contribution schemes’, as contributor expectations and sense of entitlement increased. Yet at the same time the majority of executive or house committee meetings focused on the day-to-day necessities of running the hospitals and of raising income. In Nottingham, as elsewhere, contributor delegates played their part in this process, beyond simply offering a working-class and/or patient perspective. As Derbyshire noted, when chair of the Eye executive: ‘we all work in a spirit of accord; our three Hospital Saturday Fund representatives are wonderful hard workers and put in a good deal of time on their subcommittees and the preparation of their reports’.

Nevertheless, Saturday Fund and Sick and Annual Societies’ representatives did at times put forward a sharply critical voice; it was not always a predominantly cosy or cordial relationship. In 1902, Draper, for example, forced the founding of a Children’s Hospital House Committee to make hospital staff more accountable and less autocratic. He acted also as a filter for patient complaints. On receiving reports that the hospital’s house surgeon was refusing ad hoc to treat outpatients that he suspected could afford to pay for private treatment, the board was persuaded to change its admissions policy so that such patients were treated until directed otherwise following financial enquiry. When protests arose about ‘out-patients being kept waiting and receiving harsh and discourteous treatment’, he was able to threaten that ‘unless resolved such complaints would lead to a loss of money being contributed to the hospital by the members of the Friendly Societies’. In consequence, both the matron and the nurse concerned resigned. Others also were not slow to voice criticism. Day, after taking two Boots’ employees to the General Hospital’s outpatient department, accused its medical staff of treating these and others ‘like blocks of wood’: they were ‘not told anything or expected to ask a question’. She wrote: ‘I must lodge a protest after actually seeing such dilatory casualness in the treatment of suffering citizens, who seem to be subjected to unnecessary pain and suffering’.

60 Gorsky et al., *Mutualism*, 93–9; Cherry, ‘Accountability’, 223.
62 TNA, MH 77/22, Sir Laurence Block to Sir John Maud, Permanent Secretary, Ministry of Health, 4 Sept. 1941; Cherry, ‘Accountability’, 224, 230–1.
63 NUMD, Uhe R/24, AR Eye Hospital, 1938; Gorsky et al., *Mutualism*, 124–6.
65 Uhc/M/1/6, Mins Management Comm., Children’s Hospital, 18 Nov. 1902.
66 Ibid, Uhc/M1/7, 17 Nov. 1902.
68 Ibid., Uhg/M/1/4, Mins House Comm., General Hospital, 16 Nov. 1933.
Indeed, it might be argued that the power of the contributors — or at least their representatives — held sway. When the vice-chair of the local whist shield competition that generously supported the General Hospital complained about the poor treatment afforded one local man, an internal inquiry was opened to enquire into the circumstances. Through the inter-war period workplace branches of the Saturday Fund could be vociferous in their demands, entering into prolonged correspondence with the hospitals they supported if it was thought their members were not receiving their due entitlement. Nuffield investigators testified that making a contribution generated a strong feeling of ownership of the hospital amongst working people, but noted, too, that members could harbour resentment ‘very strongly’ if they felt ‘they contribute something and do not get full value for money’. In Nottingham, when the Hospital for Women discontinued its practice of issuing recommendation for hospital treatment to subscribers, several of the area’s largest employers complained bitterly, so that an accommodation had to be reached. Similarly, when contributors from one local colliery felt patients were being discharged sooner than they ought to be, Player was quick to meet with miners’ representatives to resolve the matter. Outpatient departments particularly attracted critical attention. When one miner raised the question of excessive waiting times, he was initially ruled out of order by the presiding President at the Eye Hospital’s AGM (this being the owner of the mine where he worked). Nonetheless, the chair of the management committee was more sensitive to the nuances of the situation and agreed he should be heard. ‘Some patients’, it was reported, ‘who had come 10 or 15 miles, arrived in the morning and did not receive attention until late afternoon’. Dismissing claims that such delays no longer occurred, he pressed his case strongly and admission procedures were modified.

In fact, Nottingham’s hospitals came actively to encourage working-class engagement, even if it was accepted that such inclusion brought with it tensions. As one miners’ representative noted: workers wanted increased representation ‘to bring them into closer touch with the institution, and the closer the touch, he thought, the greater response there would be from the workers’. ‘It gave them very great satisfaction to know that they were doing their duty to these charitable institutions’. In certain key areas, working-class organizations had a major impact on policy formation. Two years after its formation in 1902 the Cot Fund, at its own initiative, offered an additional grant of £100 if the Children’s Hospital Board consented to give all outpatients free medicine for one year. The Board was initially resistant, thinking that free medicine would further encourage larger numbers at outpatient clinics which would increase costs. Nonetheless, it was finally persuaded when the fund agreed to
offer funding for a full five-year period. It proved, as one doctor confirmed, ‘a great boon and had been deeply appreciated’. On several subsequent occasions as financial pressures bit, certain board members and honorary staff sought to end this concession, and each time this was rejected. The Cot Fund’s authority was only strengthened by the depth of its working-class support in the community, where the efforts of the sick and annual societies and the other working men’s organisations [were] […] showing the richer folk how to raise money in a good cause. They were getting the money in pence and if some of the ladies in the city who had plenty of leisure time and money would follow the example, and get money by the shilling in the same way the hospital would not have a deficit of £1,100.

Exactly how socially representative the Saturday and Cot Funds were can be seen in Figure 2. Across time at least half of the Cot Fund executive was working class; and this presence grew stronger. Most were skilled rather than semi- or unskilled men. Perhaps not surprisingly, given the societies were pub and workplace based, no women served on the executive, although there was a limited presence in other offices. The balance consisted predominantly of clerks, teachers, shopkeepers, that is lower-middle class rather than middle ranking. If we go beyond the executive to

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**FIGURE 2** Class composition of the executive boards of the Nottingham and Nottinghamshire Cot Fund and Saturday Hospital Fund 1900–39.
(Sources: NUMD, AR, minutes 1900–48; Nottinghamshire Archives Office, Nottingham City and County Rate and Valuation Books 1928–55; Nottinghamshire Trade Directories; National Probate Registers).

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77 Ibid., Uhc/R/1/2, AR Nottingham and Nottinghamshire Sick and Annual Societies Children’s Hospital Cot Fund 1905–6.
78 Ibid., 18 May 1909, 8 July 1909.
79 NG, 1 Apr. 1909.
include those who were active at branch level the same broad pattern emerges, although the skilled and this time semi-/unskilled working-class presence is more marked, standing at 61 per cent and 12 per cent respectively across time, roughly reflecting the overall class structure of the city.

Executive membership patterns for the Saturday Hospital Fund were more complex. Through the 1900s to the 1920s working-class numbers rose slightly, from around 25 per cent to just over 30 per cent. Nonetheless, the largest constituent was lower-middle class — at roughly 50 per cent across time. In the 1930s, however, the balance changed noticeably, for once the fund finally became a fully operational contributory insurance scheme in 1938, and the income from contributions rose sharply, upper-middle and middle-middle class representation similarly increased: particularly medics, accountants, and solicitors, but also several wealthy industrialists. Of new appointments as the numbers on the executive expanded, only 20 per cent combined was working or lower-middle class. The fund was thus effectively professionalized.

People’s hospitals?

The move in 1938 to change the nature of the Saturday Fund from that of a subscriber-based system of recommendations issued by individuals, employers, and workplace branches, to a contributory scheme based on vouchers, was part of a broader voluntary readjustment in medical voluntarism from the turn of the century that touched some city hospitals more than others. There was already a diversity of admissions policies across Britain. Specialist hospitals, for example, were more likely to level a direct charge than general hospitals, whereas children’s hospitals, for example in Nottingham and Birmingham, never operated a system of recommendations or charged for either in or outpatient treatments. They were also often more successful proportionately in attracting philanthropy. Nottingham General had, by contrast, always operated a ‘Recommend’ system, yet through the inter-war period it continually resisted the appointment of almoners to enquire into a patient’s financial circumstances. The Saturday Fund executive particularly thought ‘it would cause a great deal of discomfort amongst our members’. Such disquiet was commonplace. PEP found that workers were prepared to pay ‘considerable premiums for medical insurance without any form of means test. Insurance payments are popular, but means tests, however mild, are odious.’ Nonetheless, direct payment through the almoner system was collecting significant sums of money elsewhere. By the late 1930s, whilst some four million pounds was being paid over by contributory schemes to

80 Gorsky et al., Mutualism, 18–42.
81 Ibid., 32; J. Reinarz, ‘Investigating the “Deserving Poor”: Charity and the Voluntary Hospitals in Nineteenth-Century Birmingham’, in Borsay and Shapely, Medicine, 120.
83 NUMD, Uhg M/1/3, Mins House Comm., General Hospital, 13 Apr. 1932.
cover treatment, a further two million pounds (or about one-eighth of total hospital income), was being recovered by almoners to cover inpatient treatment, or in real terms double what had been raised a decade previously, although again the proportions varied across the regions.85 Finally, in 1937, the General Hospital succumbed, but stressed that Saturday Fund contributors would always be exempt from such enquiries.86

The linked functional change to the nature of the Saturday Fund was similarly controversial, within the Fund and on the General Hospital executive.87 It was largely sold on the basis of direct entitlement, but also on notions of collective equity. As the President, solicitor George Thornton Simpson, explained to some four hundred Fund delegates:

It has been said that a contributory scheme did away with the voluntary nature of the hospital [... ] this was not the case. The only difference was that at the present time a large number of people who came into the hospital were not members of the Hospital Saturday Fund. They came in and paid nothing.88

Simpson continued, from now on ‘people who could afford to pay, if they were not in the scheme, would be asked to do so’, although ‘nobody would be refused admission because of an inability to pay’.89 Equity meant also ‘extending the scope of the Hospital Saturday Organisation to include not only employees of the large firms, but employees of the smaller firms and shopkeepers’.90 Having heard the arguments, some one-third of delegates still voted against the change — a testament to the resilience of voluntarist beliefs in the city. Yet the rise in income that followed was dramatic. In the year immediately before the change the fund raised some £37,000 (the then highest figure ever). By contrast, income for the first full subsequent year of the revised scheme rose to £69,310. For individual city hospitals this meant a substantial boost to their finances. The change, as expected, also formalized the system of enquiry into the financial circumstances of non-contributory members, so that the medical staff at the city’s Children’s, Eye, and Women’s Hospitals also pressed for the appointment of almoners, although after reflection only the Hospital for Women did so.91

Robert Hogarth was a senior surgeon at the General Hospital (and a past president of the BMA). As its vice-chair in the 1930s, he had pushed strongly for the adoption of a fully contributory system, against the wishes of a majority of executive members. This caused considerable tension, as did his advocacy of greater financial support of voluntary hospitals by public health authorities. The strength of resistance forced him

86 NUMD, Nh/M2/3, Mins Executive Hospital Saturday Fund, 2 Mar. 1937.
87 Hogarth, Trent and I, 42.
88 NJ, 28 Nov. 1938.
89 NG, 28 Nov. 1938.
90 NUMD, Uhg R15, AR General Hospital, 1938.
91 Ibid., Uhw M2/8, Mins Finance Comm. (sub-comm. to discuss appointment of almoner), Women’s Hospital, 3 Dec. 1939; Uhc Mt/11, Mins Management Comm, Children’s Hospital, 1 Aug. and 8 Nov. 1939; Uhe Mt/12, Mins General Comm. Eye Hospital, 8 Mar. 1948.
to resign his presidency of the hospital. For Hogarth this advocacy was not simply a matter of maximizing income. Patient payment as a contributor begat entitlement, ‘for those who pay will expect to receive hospital treatment as a right in the case of serious illness’. Collective payment, he argued, also meant collective ownership, so that when the ‘small contributor begins to talk about “our hospital,” the vitalizing spirit of voluntarism is at work’. Yet this in itself was a product of a changing relationship between hospital and community, based on an opening out of the population base treated to beyond charitable cases, and the already noted expectation of treatment as a right. If this undercut philanthropic approaches to the sick poor, it also meant that hospitals became more generally inclusive and community based as they lost what some saw as their charitable stigma.

Hogarth had also been an early advocate for the provision of pay beds to cover what were commonly labelled the ‘new poor’ sick: those whose higher earning precluded them from membership of Saturday Funds, and who as a consequence were denied ready access to affordable medical care. He wanted the hospital to be there for ‘all who can use it, with no distinction of rich or poor’. Yet the trend for pay beds was already established in Nottingham’s smaller and less financially robust hospitals for less altruistic reasons, just as had been the case elsewhere, particular amongst specialist hospitals. The Hospital for Women had had a limited number of private beds before 1914. Both it and the Eye Hospital, unlike the General or Children’s Hospitals, also charged inpatients a maintenance fee, although this could be remitted in cases of hardship.

Yet worker representatives were sensitive to the problems that direct charging brought, just as they disliked financial enquiries into personal circumstance. As one miner argued at the Eye Hospital’s AGM in 1924: ‘in some cases the 2s per day for maintenance was a great inconvenience to getting the cases into hospital’, even though, as the finances of the hospital improved, so too the charges for inpatient treatment had similarly been reduced from 2s 6d. Indeed, shortly after they were reduced still further to 1s 6d per day. Yet he noted also that:

The only thing — and I honour them for it — is they have a little pride and they would not like to come into this institution […] and feel that they were not paying their way, being admitted as free patients […] my friends will bear me out that the working classes are prepared to pay for the keep of these patients while they are in the institution.

The Eye Hospital’s medical staff, however, were more preoccupied by purported abuses of the system. As one of its doctors opined in 1922: ‘during past decades our numbers have gone up considerably; this increase is not in proportion to the increase

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92 Hogarth, *Trent and I*, 42; NUMD, Uhg M/1/4, Mins House Comm., General Hospital, 25 Nov. 1936 and 2 Dec. 1936.
93 Hogarth, *Trent and I*, 131.
95 *NJ*, 31 Jan. 1927.
97 NG, 20 Feb. 1924; NUMD, UHe M/10, Mins General Comm., Eye Hospital, 26 May 1924.
98 NUMD, UHe R/10, AR Eye Hospital, 1923.
in the general population of “necessitous poor.” Consequentially, the Charity Organization Society on the Hospital’s behalf made regular enquiry into patients’ circumstances for those claiming free treatment, which led to complaints that patients in urgent need of treatment were being refused.99

Yet the COS also reported that it had ‘frequent enquiries from persons requiring eye examinations or treatment who were able and willing to pay a small fee to the Infirmary’, even if they could not afford a private consultation.100 When financial circumstances allowed, the Hospital’s honorary staff also strongly favoured acquiring a pay bed wing, and the fees this would bring. Arguing that the ‘requirements of the poor are being well met by present arrangements’, the Hospital thus acquired nine pay beds in a private ward for that ‘large section of the population who cannot be described as poor, but who are of such limited means as to be unable to bear the heavy cost of a surgical operation when carried out in the ordinary way’.101 The Nottingham Guardian, an active advocate, argued that as ‘the reasonableness of what is being done must be obvious to everyone, possibly some of the ordinary hospitals will follow the example of the Eye Infirmary’.102 Frederick Acton, as chair of the General Hospital’s Monthly Committee, agreed, wanting it to ‘follow in the Infirmary’s footsteps. But at present there was a lot of water on the wheel’, lest the hospital’s foundations be compromised.103

Acton’s pessimism proved to be correct. Against the trend elsewhere, it was not until finally 1938 that a separate pay bed wing in the General Hospital was opened, although its income from paying patients had already increased steadily.104 The capital cost was met through public subscription, but more particularly by a large donation of £25,000 given by John Player, supplemented by £4600 from the city and county’s freemasons. The medical staff thought it would prove a ‘great boon to those who have been compelled by force of circumstance to occupy [‘free’] beds in the Hospital’. Player had in mind those in the middle classes earning up to £550 p.a. (over twice typical clerical or manual earnings but about half the income of the average solicitor or general practitioner). Fees were set at four to six guineas per week, with a cap of twenty guineas on surgeon’s fees. Of the thirty beds proposed, five were to be set to one side for ‘well to do families’ who were ‘friends of the hospital’, with costs of ten to twelve guineas per week and no upper limit on consultant fees.105

As one former nursing sister who worked on the wing recalled: the patients were mainly ‘just ordinary folk, anyone […] it belonged to the City of Nottingham, it was their nursing home’, people felt it was ‘their hospital’.106

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99 Ibid., UHe M1/10, Mins General Comm., Eye Hospital, 30 Jan. and 13 July 1922; NJ, 20 Jan. 1937; Nottingham Evening News, 1 June 1938.
100 NUMD, UHe M1/10, Mins General Comm., Eye Hospital, 18 Dec. 1922.
101 Ibid., 31 Jan. 1924 and 3 Nov. 1924.
102 NG, 16 Dec. 1924.
103 Ibid.
105 NUMD, Uhg M1/4, Mins House Comm., General Hospital, 17 and 24 Jan. 1934; Uhg R15 AR, General Hospital 1937; G. Routh, Occupation and Pay in Great Britain 1906–60 (Cambridge, 1965), 64–9, 78–9, 88.
106 Nottingham Central Library, Oral History Archive, A51/a-b/1.
Socially inclusive and important as such developments were in offering a more broadly based and affordable health care system for all, the majority of patients were, of course, not middle class, nor did they occupy pay beds. As the Hospital for Women noted: it was ‘very largely used by a class of woman who are both able to pay something towards their maintenance and treatment, but not to incur heavy expenses, being mainly drawn from the working classes’.\textsuperscript{107} When the Children’s Hospital surveyed the income of patient’s parents attending its outpatients department immediately before the First World War, only a very few earned over 40s per week (that is, roughly the upper limit for skilled male workers).\textsuperscript{108} Some 20 per cent of those treated as inpatients in the financially punctilious Eye Hospital, which did its best to restrict such numbers, still qualified for free treatment. In the 1930s 10 per cent of inpatients at the General Hospital were too poor to make any contribution; the majority, however, some 60 per cent, were Saturday Fund members.\textsuperscript{109} The numbers of such inpatients per year rose from 2275 in 1900, to 6631 by 1930, and finally to over ten thousand by 1947. Outpatients numbers rose even more dramatically, rising from 9578 in 1900 to 81,020 on the eve of the creation of the NHS. Thus, at one level, hospitals simply became more universalist.\textsuperscript{110}

Yet the local press also presented and understood identification through other filters. Reporting in 1920, the \textit{Nottingham Guardian} commented favourably that ‘upwards of 1,500 worshipers took part in the General Hospital’s anniversary service at St Mary’s Church, [with] several hundred more unable to secure admission’.\textsuperscript{111} If attendance fell in any one year, the rebuke could be sharp and public. ‘When you consider the number of motor cars there are in the county’, Lord Manvers observed two years later, it was ‘a disgrace that the owners cannot use them to come to the House of God on such occasions as these’.\textsuperscript{112} Civic attachment found expression, too, through the architects, accountants, and solicitors who offered their services free of charge or goods at reduced rates. Chain grocer Joseph Marsden, for example, supplied the General Hospital with its food at a heavily discounted price.\textsuperscript{113} And if some wanted their good works publicized or memorialized, others — including the Player brothers — instinctively shied away from any attendant publicity. Egg and potato weeks in the 1920s also saw the collection of many tons of produce: in 1926 some 96,000 eggs were collected and 49 tons of potatoes; ten years later the number of eggs collected had risen to over 140,000 annually.\textsuperscript{114} Public visibility found form in a variety of other ways. Saturday Fund officials were particularly taken by ‘the presence of a goodly number of the ladies belonging to the British Red Cross Society, who looked exceedingly well in their attractive uniforms’ as they paraded through the city for the annual Saturday Fund church parade.\textsuperscript{115} One correspondent urged local

\textsuperscript{107} NUMD, Uhw M/2/3, Mins General Comm., Women’s Hospital, 15 May 1912.
\textsuperscript{108} Ibid., Uhc/M/1/8, Mins Management Comm., Children’s Hospital, 1909–10; Routh, \textit{Occupation}, 86–8.
\textsuperscript{109} Ibid., UHe M1/7, Mins Finance and House Comm., Eye Hospital, 12 June and 10 July 1912; Uhg M/1/4, Report of the Almoner, General Hospital, 6 Oct. 1937.
\textsuperscript{110} Ibid., Uhg M/1/3, Mins Management Comm., General Hospital, 15 May 1930.
\textsuperscript{111} NG, 12 Nov. 1920.
\textsuperscript{112} NJ, 13 Oct. 1922.
\textsuperscript{113} NUMD, Uhg M/1/3, Mins Management Comm., General Hospital, 14 May 1930.
\textsuperscript{114} Ibid., Uhg R/13-15, AR General Hospital, 1926, 1935, 1936.
\textsuperscript{115} Ibid., Nh M1/2, Mins. Hospital Saturday Fund, 14 Nov. 1914.
women to become actively involved in the Linen Guild. The ‘cash book is growing’, she observed, ‘due to the women of Nottingham — and all the wide district served by the Hospital — who organise dances, concerts, whist drives, sales of work’.116 Some events in particular carried a significant social cachet. The annual General Hospital Ball was one such, growing in popularity, and even outshining that of the South Notts Hunt so that ‘every well known family in the city and the immediate neighbourhood were [sic] represented’.117 As Hogarth wryly observed, there existed numerous voluntary agencies in the city which had been ‘cunningly devised for the diversion of small sums of money which otherwise would have been thrown away into other channels of expenditure. Some, like “Rags” and “Flag Days” may be semi-piratical, others deftly took ransom from our pleasant and harmless vices’.118

In fact, against the national trend individual subscriptions, donations, or monies raised by entertainments remained particularly buoyant, in part because of the delay moving towards a contributory scheme. For the city’s General Hospital, calculated at constant prices, the average raised during the 1930s compared to the previous decade increased by 27 per cent for subscriptions, and for both donation and from entertainments by a full 75 per cent (compared to a fall nationally of some 5 per cent for donations and a rise of 6 per cent in subscriptions).119 Entertainments, parades, school collections, hampers, foods, bazaars, charity sports events, a pub and workplace culture which had a strong hospital presence — all these worked towards building a strong association between place and space, physically, in print and in the popular imagination. ‘Where would we be’, asked Hogarth again, ‘without these subsidiary rills of benevolence?’ And if buying a flag or sitting down at a Whist Shield competition did not make a contributor a “pious benefactor”, those that did the work in organising these great moments deserved the title as richly as any, for they did it purely out of love for the hospital’.120 Such ‘everyday practices’ of daily life, recurrent and permeated with values and myths, locked into spatial patterns of practice and representation on the urban landscape, cemented the relationship between individual, community, and the hospitals, and are best understood outside of a ‘framework of coercion, authority, manipulation and so on’.121 Indeed, it might be argued that the purpose of such activities was as much to raise awareness of the hospital work in the community as to raise income.122

Deconstructing the hospital community

Reporting to the AGM of the Children’s Hospital in 1900, the Revd Henry Russell noted that ‘people were taking up the work of hospitals who perhaps would

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116 NJ, 8 Dec. 1928.
117 NJ, 22 Dec. 1928.
118 NG, 31 Oct. 1929; Waddington, ‘Grasping Gratitude’, 185–7. Rag weeks might not have been popular with all, but the crowds they attracted each year in Nottingham can be glimpsed at the Pathè News website: http://www.britishpathe.com.
119 NUMD, Uhg R12-16, AR General Hospital 1920–38.
120 NG, 31 Oct. 1929.
never have thought of doing so years ago’. He spoke warmly of ‘now having the co-
operation of a large number of very important organisations of working men’.123
Thirty years later Albert Atkey, reflecting on his year as lord mayor, remembered:

I shall never forget the first revelation of this aspect of local [voluntary] life which
occurred when I went, in all innocence, to attend a meeting of the Hospital Saturday
Fund [. . .] I knew of the existence of such a body, but I had no idea that it so belied its
description, and that I was really invited to a ‘committee’ meeting of some thousand
persons. Of these some two or three hundred actually attended, and when I realised
that these men and women were individuals representing a still further array of workers’
interest in the Nottingham General Hospital, I could not help feeling profoundly
affected.124

How we should read such statements is open to question. Both are working to
construct civic publics, just as were the newspapers when they reported on this.
But both were operating, too, within a framework of personal approbation which
was shared beyond only an intimate circle of volunteers, anchored as it was to the
everyday practices of health and community which, in terms of who was treated and
on what terms, was becoming increasingly pluralistic through time.

How these changes impacted varied. As Prochaska observed, ‘in a society in which
expectations were becoming more egalitarian, philanthropists found their position
increasingly ambiguous’.125 ‘Flag days in the past had been a useful way of raising
money’, noted the president of Nottingham’s newly established contributory fund,
but he no longer felt ‘they were compatible with the dignity of the voluntary
hospitals’.126 Indeed, most thought that, notwithstanding the popularity of medical
charities, hospitals should also receive some state support.127 Yet even here many
activists in Nottingham would have disagreed. Not only did this group continue to
volunteer — giving copious amounts of time and money during the troubled years
of the inter-war period — but they also resisted initially at least any transfer from
Saturday Fund to contributory scheme, and in the case of the General Hospital, the
introduction of pay beds.

Was this simply a resistance at the top? In terms of the move to a fully contribu-
tory scheme, that was certainly not the case. On a broader canvass of satisfaction,
the national polling data would also suggest the lack of universal clamour for change.
Asked in 1944 whether hospitals should remain as voluntary institutions, be run
by a public authority, or become partly voluntary and partly public, 42 per cent
supported a fully public system, but an equal number favoured either wholly or partly
retaining the status quo.128 Yet clearly, just as today, not everyone was content.
Complaints — although proportionally few in number — were most frequently raised
through those with a claim to representing directly the working-class patient, who

123 NUMD, Uhc M3/1, AGM Children’s Hospital, 6 May 1900.
124 NJ, 5 Nov. 1929.
126 NUMD, UHw/M2/9, AGM Women’s Hospital, 17 May 1944.
127 Beveridge and Wells, Voluntary Action, 56–8; M-O File 1921, ‘Attitudes to State Medicine’, 100.
by and large, prosecuted these vigorously. Some — the waiting times in outpatient departments particularly or the brusqueness of staff — were certainly not unique to Nottingham, nor were they to pass away with the creation of the NHS. When raised they were generally dealt with sympathetically, albeit defensively, by the institutions: wary of offending major contributors and of bad publicity generally, within a mentality that the hospital was largely right until proven otherwise.

However, the number of formal complaints offers only one snapshot of the relationship between hospital and community. The rise in importance of the Saturday Fund, and of the Cot Fund also, offered certain conduits between the classes that went beyond the advocacy of patients’ views. Within this, too, a camaraderie developed, so that when members of the Saturday Fund Executive died the local great and the good attended the funeral. John Player, for example, could be found paying for the cigars and wine for annual Saturday Fund dinners, or placing the grounds of his home at the disposal of its Executive for its annual fete and other such events. Such courtesies were appreciated. At the same time, these self-same bodies were also very capable of demanding and achieving change to, and redress from, the institutions of which they were an essential part.

Perhaps more importantly, the circle of ‘activists’ was set to broaden, not narrow, during the inter-war period, stretching out into the community in ways in which it previously had not. Raising money through entertainments and so on was of course not new in Nottingham or elsewhere. But in terms of scale and continual engagement the inter-war period witnessed new levels of enterprise, witnessed through its potato weeks, eggs collections, whist drives, rag days, and other fundraising novelties. At a time when ordinary revenue income from all sources stood at some £50,000–65,000 p.a., Nottingham University students alone raised over £18,000 to endow beds for the General Hospital across this period, whilst the Hospital’s own flag days raised a similar amount. The Hospital’s Whist Shield raised some £1000 p.a., and various carnivals in outlying districts typically a further £1500, all of which, as the Board of Management acknowledged, ‘took a vast amount of work’ and organization. The other local hospitals received proportionate funding, scaled down by size, but also ran their own Pound Days, school collections, and a plethora of other activities. Noticeable particularly were the activities of the Sick and Annual Societies’ Cot Fund, which raised on average over £1500 each year for the Children’s Hospital through its community-based network.

At a time when the city’s hospitals were treating more patients and from a broader social base, raising money, in pennies or pounds, brought the classes together through common cause, just as it offered foci within each class. As one working-class delegate remarked: ‘helping to maintain’ the hospital buildings provided ‘so generously’ by benefactors offered a ‘working’ testimony of their indebtedness. If relationships

130 NUMD, Nh M2/1, Mins Executive Hospital Saturday Fund, 4 Feb. 1913; NJ, 15 Mar. 1927; NG, 18 June 1928, 1 Dec. 1930.
132 NUMD, Uhg R.14 AR, General Hospital, 1934.
133 NG, 1 Dec. 1930.
were never equal, socially or numerically, then at least they were wrapped in a core of shared beliefs and objectives which spread beyond those individuals immediately concerned — the activists from all classes who gave generously of their time — out into the broader community. If contemporaries tell us that they valued such things, then who are we to disbelieve them?

Notes on contributor

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