HOSPITALS IN THE COLONIES

The Changing Face of Medicine in the Sixties

[By O. W. POWELL, M.D., M.R.C.P.E.]

(Read at a meeting of the Society on 22 August 1968)

It is my aim in this paper to give some description of colonial hospitals as they were just after the middle of the last century, in the early 1860's, and at the same time to compare them, so far as it is possible, with similar institutions in the Mother Country.

There are several reasons for choosing this particular period. In the first place, it marks the end of an era. The decade from 1858 to 1867 saw a series of discoveries which changed the face of medicine more profoundly than in any similar period before or since. It was the decade of Louis Pasteur and Joseph Lister. Until this time very little more was known about the cause of disease than had been known for centuries. As a result of the work of these men came the science of bacteriology and immunology, the development of modern surgery, and the modern hospital. In the 'sixties we are at the dawn of a new age, and it is especially interesting, therefore, to look at hospitals at this time.

EXTENSIVE SURVEYS

Another reason is that we know a good deal about English hospitals of the period because it happens that there were, at that time, two very extensive surveys of such institutions in that country.[1] As a result we have a well-documented basis for comparing colonial hospitals with those in what was then the most socially advanced Western community. Finally, and most important of all, we have a considerable amount of information on the hospitals in many of the colonies at this time because of a Report which was circulated by the Colonial Office in 1864.[2] Much of this paper is based upon that Report.

---

1. A detailed survey of hospitals in Great Britain carried out by T. Holmes and J. S. Bristowe at the request of John Simon, appeared as an Appendix to the *Sixth Report of The Medical Officer of the Privy Council* (London, 1864); a survey of metropolitan workhouse infirmaries appeared in *The Lancet* throughout 1865.

2. *Colonial Hospitals and Lunatic Asylums*—enclosure with Circular Despatch, 6 April 1864, F 445, C.O. 854/7.

In the 'sixties the Colonial Empire of Great Britain was as yet less extensive than it was to become. Much of Africa, for example, had still to be explored and exploited, and many of the central African colonies were little more than beach-heads from which traders, missionaries, and explorers were later to advance inland. Nevertheless, it was extensive enough, for the great settlement colonies of Canada, New Zealand, and Australia had still to loosen the ties which bound them to the Mother Country. Some of these ties were — naturally and properly — of sentimental origin; that sentiment which made a colonist speak of "Home", though he may never have seen it. Others were legal and constitutional. The responsible colonies had their origin in Imperial legislation and although their own governments were, by definition, responsible to their legislatures, they were still by no means independent of the Imperial authority; and, of course, there were many non-responsible colonies where that authority was absolute.

RESPONSIBLE GOVERNMENT A NEW IDEA

But yet another sort of tie existed, and this seems to have stemmed from a slowness on the part of the Colonial Office to adjust to the implications, as well as to the facts, of colonial responsible government. This was rather more than the reluctance of a parent to admit that a child has become an adult, although this is superficially an attractive analogy. It went, however, somewhat deeper than this. The idea of responsible government was still new in mid-century, not only to the colonists, but scarcely less so to the Colonial Office itself which at this time was still rooted, particularly in terms of its senior staff, in an earlier period. One has but to contrast the situation later, at the end of the century. Responsible colonies were not then, constitutionally, vastly different from what they had been forty years earlier; but by that time attitudes had so changed that in practice they had become independent to a degree which would never have been countenanced in the 'sixties. There was, in fact, a curious ambivalence in the attitude of the central authority at that earlier period. On the one hand there was a reluctance to accept, at an emotional level, a situation which on the other hand was not only clearly understood intellectually, but was indeed approved and encouraged.

"WISE OLD MEN IN DOWNING STREET"

And so we find the Colonial Office sending out, even to Governors of responsible colonies, a steady stream of ad-

vice, admonition, and instructions which, to be truthful, those officials must often have found embarrassingly difficult to persuade their colonists to accept; and which it was at most only doubtfully in the power of the Home government to enforce. Nevertheless there were some redeeming features attached to this practice. There were some wise old men in Downing Street, and they had the advantage both of experience and a global view. They saw the problems of all the colonies, and not of just one. When the Colonial Office acted, as it sometimes did, as a clearing house for information from all the colonies, the advice which it gave benefited from this wide view, and could be very good indeed. The Report which has been mentioned falls into such a category.

ECHO OF JAMAICAN INIQUITIES

It is not my intention to say very much about the circumstances which led to this Report, as I hope to describe them elsewhere, but a brief comment may be of interest. It is really a study in colonial administrative history on a small scale. Or — more romantically, it is the story of how the iniquities of Assistant-Surgeon Keech, of the Hospital and Lunatic Asylum in Kingston in Jamaica, and the brutalities of the Matron, finally found an echo in places as far away as Brisbane.

It had all started in 1858 when a Scottish physician in Jamaica named Bowerbank commenced to agitate against the inefficiencies and brutalities which he saw in those institutions. He was at first frustrated. He was obstructed by the officers of the institutions, and by the Governor himself. Finally he travelled to England, where he enlisted the aid of the Earl of Shaftesbury, that great Tory philanthropist, who was one of the Commissioners in Lunacy and who, by putting pressure on the Colonial Office, succeeded in having the matter investigated.[3] After some delay a Commission was set up in Jamaica, and its report was delivered in 1861.[4]

Jamaica at this time was a sorry condition. The once prosperous old colony was but a shadow of its former self. Abolition of slavery — necessary enough on moral grounds — had disrupted the labour structure of the Island, and competition on the Home market was adding to the economic

---

3. Shaftesbury to Lytton, 14 May 1859, C.O. 137/347. Forster to Newcastle, 25 June 1859, C.O. 137/347 (Forster was Secretary to the Commissioners in Lunacy).

4. *Report on the Management of the Public Hospital* (Kingston, 1861)—enclosed with Darling to Newcastle, 7 February 1862, Despatch No. 37, F 225, C.O. 137/364.

chaos. The colony, with a predominantly coloured population, was financially bankrupt, and its essential services had suffered correspondingly. The lunatic asylum had been condemned years before as out of date and inadequate, but although a new one had been commenced, money had run out and the project had lapsed. But the colony was not only financially, but morally bankrupt. Corruption was widespread, even in official life. The legislature was an object of derision, by reason of its venality and its irresponsibility. Anthony Trollope, who was there in 1859, remarks that Parliament was spoken of contemptuously, even by its own members.[5] Corruption, poverty, and the brutalising effects of corruption and poverty, were a part of Jamaican life.

"CORRUPTION AND BRUTALITY"

It is unnecessary to deal with the details of the Commission's report. It exposed gross inefficiency, flagrant corruption, and appalling brutality. Such incidents were brought to light as the curious custom of what was called "tanking" in which the Matron had unfortunate female lunatics held under water in a stone bath in the yard until they became exhausted; and from which some of them died. Keech, the Assistant-Surgeon, was shown to have refused admission to a young woman because he feared that her child, which was reputedly his, would be thrown upon him for maintenance. There were many similar examples — and worse. It must have been an incredibly bad institution.

BOWERBANK'S MOTIVES GENUINE

The Colonial Office had been rather slow to appreciate that Bowerbank's motives were genuine. They cannot altogether be blamed for this, since their own Governor had repeatedly told them that he was merely a mischief-maker.*

In fairness to them, however, once the facts emerged they were genuinely shocked, and as a result, and probably at the suggestion of Henry Taylor, who was Senior Clerk in charge of the West Indian Department, it was decided to hold an enquiry into the conduct of such institutions

5. Anthony Trollope, *The West Indies and the Spanish Main*, 4th ed. (London, 1860), pp. 116-117.

* Sir Charles Henry Darling (1809-1870) was the nephew of Sir Ralph Darling, of New South Wales fame. He had, indeed, commenced his colonial service with his uncle in 1827. After leaving Jamaica he was posted to Victoria, where his conduct of a constitutional crisis led to his recall by Edward Cardwell, then Secretary of State for the Colonies.

throughout the colonies. To this end a questionnaire was prepared for circulation to all colonies.[6] This had been drawn up with the assistance of the Royal College of Physicians of London and the Commissioners in Lunacy, and was designed to produce the sort of information on which the quality of these institutions could be judged. There was a variety of questions relating to such matters as the types of patients admitted; the administrative structure of the hospital; finance; staffing; diets, drainage, and so on. They were good questions and, competently anwered, they provided a comprehensive picture of the situation in any particular colony. Predictably, they were not all competently answered.

The returns were collated, analysed, and condensed into a "digest" by a young barrister — a man called Robert Wright, who later became one of Her Majesty's Judges. A lawyer seems a curious choice for this purpose, and this lawyer was only 26 years of age; but he must have been a most capable young man, and he certainly seems to have had the confidence of the Colonial Office, since he was used by them on other similar enquiries. As well as being asked to comment upon a Leprosy survey, for instance, he had the conduct of an extensive survey of prison establishments, and at a later date was entrusted with the drafting of a model penal code for the colonies.[7]

A COMPETENT REPORT

Whatever his qualifications, he eventually produced a most competent report. In this he acknowledged help from the College of Physicians and the Commissioners in Lunacy. No doubt he also received advice from medical acquaintances of whom we know nothing, and in particular he was assisted by Florence Nightingale's book, "Notes on Hospitals," which was re-published that year (1863) in its third and expanded edition. Indeed, he may have had a personal contact with Miss Nightingale, since his tutor at Oxford — and lifelong friend — was Benjamin Jowett, who was an intimate friend of that lady.

Wright's report was circulated to all colonies in 1864. Not all were represented in it. Some, such as New South Wales and South Australia, sent their answers too late for inclusion. Others— Queensland, perhaps characteristically,

---

6. Circular Despatch, 1 January 1863, C.O. 854/7.

7. Sir Henry Taylor, *Autobiography of Sir Henry Taylor 1800-1875* (2 vols., London, 1885), vol. *ii*, pp. 281-282; Rogers to Wright, 30 July 1864, F 347, C.O. 323/-276.

was one — never ever completed the questionnaires. But all told, answers were received in time to be included from 33 colonies, representing 39 hospitals and 28 lunatic asylums, and covering all areas of the colonial empire.

"A HETEROGENEOUS EMPIRE"

It was, one must agree, a most heterogeneous empire. There were responsible colonies, Crown colonies, and all shades between. There were wealthy colonies, and there were colonies which were almost destitute. One of the most succinct descriptions of the empire as it then was appears in an issue of the *Economist* in 1862, which divides them into those which were merely garrisons, naval stations, convict depots, or "philanthropic crotchets" — such as Gibraltar, Malta, Bermuda, and Sierra Leone; the Sugar Islands of the West Indies and Carribean; those which were really dependencies, such as India (although this was not under the Colonial Office nor included in Wright's survey); and finally, the colonies proper, in the classical sense of the term —Australia, New Zealand and Canada.[8] And, just as the colonies were many and diverse, so were the hospitals which served them.

It is essential to be very clear about what a hospital was in those days — but more especially, perhaps, what it was not. It was not, in almost any respect, what a hospital is to-day. Nowadays a hospital is a place to which we go, be we rich or poor, for skilled attention, for complex surgery, for scientific investigation, or for any of a variety of services which only it can provide. A century ago there was not a great deal of surgery — mostly following accidents, or a small repertoire of relatively simple elective procedures; there were no investigations; and there was certainly no highly specialised treatment — how could there be when nobody understood anything of the cause of most diseases?

HOSPITALS A "CHARITY FOR THE POOR"

A hospital then was a place to which one was taken if one could not be cared for in one's home, because of poverty, or because home may only have been a tenement room or, in the colonies, a slab hut or a tent. The emphasis was on custodial, rather than on medical care. Essentially it was a charity for the poor. Private hospitals as we now know them simply did not exist, since the well-to-do could be as well looked after, indeed could be more safely looked after,

---

8. "Our Colonial Relations," *The Economist, vol. xx* (1862), pp. 590-591.

in their own homes. It must not be forgotten that hospitals could be dangerous places. To illustrate just how dangerous even good hospitals were in those days it is worth remembering that if one suffered an accident in London severe enough to have needed a leg amputated (which would have been the case for an ordinary moderately severe compound fracture), and had been taken to one of the London teaching hospitals, there would have been a precisely 50 per cent chance of dying as a result of the operation.[9] By contemporary standards these were good results — in one German series the mortality for amputations was almost 80 per cent.[10] A great part of this mortality was due to infection sustained in the hospital. In non-operative cases a similar situation existed — anywhere in England there was a very real risk of contracting typhus in hospital, whatever the reason for admission.

THREE TYPES OF HOSPITALS

Hospitals in England were of three types. Firstly, there were the great London teaching hospitals, some of which were descended from the monastic hospitals of medieval times (e.g., St. Bartholomew's), and others of which had developed as voluntary hospitals in the latter part of the 18th century. Secondly, there were the large county hospitals which were run on similar lines to the London voluntary hospitals — obtaining their funds from subscribers, and limiting admission to those patients who could obtain a recommendation from a subscriber. With all their faults, all these hospitals were then advanced, and were certainly far superior to any which we shall see in the colonies, except for the largest institutions.

THE WORKHOUSE INFIRMARY

But it is not fair to use these as the only basis of comparison because, throughout the length and breadth of England, there was to be found a third class of hospital hidden under the name of Workhouse Infirmary. These were for the destitute poor who could not obtain tickets to the other hospitals, and who could not be looked after in the dreadful hovels in which they lived. Until the *"Poor Law Amendment Act of 1834"* the destitute sick had no accommodation outside their own homes, but from that date

---

9. Quoted by Simon in *Sixth Report.*

10. I. H. Upmalis, "The Introduction of Lister's Treatment in Germany," *Bull. Hist. Med.*, vol. *xlii* (1968), pp. 221-240.

it became increasingly the practice to accumulate them in the workhouses, and after the re-constitution of the Poor Law Board in 1847 the infirmary component became a significant part of the workhouse population.[11]

It is against these infirmaries, as well as the recognised hospitals, that colonial hospitals should be measured, since, by and large, the latter combined the functions of the ordinary hospital and the workhouse infirmary. Even in those few towns — speaking particularly of Australia, but it was probably the same elsewhere — in which there was a Benevolent Asylum separate from the hospital, the pauper sick remained the responsibility of the hospital. In most places, including Brisbane at this time, the Benevolent Asylum was virtually part of the hospital.

With these facts in mind we can look at Wright's Report to see what such institutions were like throughout the world. For this purpose I have chosen, more or less at random, a few examples from three of the four geographical divisions of colonial administration, to see what Wright said of them. When we come to deal with the fourth region — our own — I propose to use, as well as the Report, the questionnaires from which Wright worked, and a few other sources, in the hope that a picture can be developed of our own colonial hospitals as they once were.

"ALMOST INCREDIBLE IGNORANCE"

It is clear from Wright's preliminary remarks that he was not very impressed with what he could discover:

> "There seems to prevail in the large majority of cases an almost incredible ignorance of the necessary conditions of efficiency, and it frequently happens that arrangements are described with complacency which are at variance with the most elementary principles. . .

and elsewhere he goes on:

> . . . "even the largest establishments in the richest colonies, with a few exceptions, show something of a makeshift character, and of utility narrowed by mistaken economy."

By far his worst strictures were reserved for the West Indian colonies, and it is obvious that Jamaica had been only marginally worse than the others. As anyone knows who has read anything of Florence Nightingale, questions of sanitation, ventilation, and space were at this time topics of predominant interest in hospital planning. The sanitary state of the West Indian hospitals must have been appalling:

---

11. Ruth G. Hodgkinson, *The Origins of the National Health Service* (London, 1967), chapter 14.

Drainage left to nature, often where nature would have to work uphill, sewerage passing through open gutters into cesspools, the very cleansing of which in a tropical climate only diffuses miasma. . .

In the asylum at Dominica single cells provided but 300 cubic feet of space per patient, and this in the Tropics. It was in fact an old military prision. The Georgetown hospital was quite large, admitting over 3,000 patients per year, and presumably, therefore, holding over 200 patients at any one time. Yet for these it provided but two night nurses. These were typical of the rest. No doubt it stemmed from a combination of ignorance, the poverty of the colonies, and sheer lack of interest on the part of the authorities.

NORTH AMERICAN COLONIES

The North American colonies were clearly much better off, although there were some glaring deficiencies. For example, New Brunswick and Nova Scotia, with a combined population of about half a million, had no public hospitals whatsoever. Such hospitals as there were, however, were quite good. Alone of all the colonies, in the two Canadas (that is modern Ontario and Quebec) there were a number of non-government hospitals which were presumably run by religious orders. Wright was particularly impressed with the Canadian lunatic asylums. These seem to have been the best of any in the colonies, perhaps due to the fact that in Canada they were subject to strict legislative control. This was, maybe, just as well since he remarks upon the high incidence of lunacy. This was most noticeable in Newfoundland, a fact which he attributes to the monotonous life in winter and to the common habit of consanguineous marriage. Before leaving the North American area we should mention the Bermudas, which were administratively included with it. Bermuda was a convict station and, incredibly, had no hospital whatsoever. It possessed, however, a lunatic asylum, about which Wright's words will suffice — "It would be very little to say of this institution that it had better never existed."

TREMENDOUS DIVERSITY

The Mediterranean and African department cared for an area which extended from Heligoland to the Cape of Good Hope. Inevitably there was tremendous diversity. At the Cape and at Durban, as might be anticipated, the hospitals seem to have been quite reasonable, although he notes one at Port Elizabeth which had neither drains nor baths

for its 36 patients. Curiously enough, the more primitive central African colonies appear to have had fairly good hospitals. Perhaps he was unconsciously applying West Indian standards — that at Gambia, for instance, was downwind of a malarious swamp, it had no sewerage, and its one latrine was emptied when necessary into the sea; but "in other respects it seems to be good." One oddity was at the Gold Coast, where it is noted that the hospital had been closed in 1861 because the inhabitants had refused to pay the poll tax! African lunatic asylums, however, were much less good than the hospitals. At Robben Island at the Cape, he comments upon the use of mechanical restraint for patients who were said to be "foolish in manner and action." In fact, there was remarkably little evidence of excessive restraint, at any rate as an official policy, in the colonial asylums, although there were also some bad examples in the West Indies. His main complaint against all asylums, however, was the almost total lack of any recreational or occupational facilities.

THE AUSTRALIAN SCENE

What I should now like to do is to survey the Australasian scene, as it is revealed in the questionnaires, and see if one can get any idea what it was like to have been a patient in those times. For brevity I shall omit any consideration of lunatic asylums. Questionnaires are available from all the colonies except Queensland, which did not complete them, and New South Wales. These latter were completed, but at some later stage have been detached from their enclosing despatch and are not bound, as are the others, with the governor's despatches. There were two hospitals in Western Australia — a very small colonial hospital in Perth, and a convict hospital at Fremantle. South Australia had one only, as had Tasmania. There were four in Victoria — at Melbourne, Geelong, Ballarat, and Castlemaine. In New Zealand there were also four — at Wellington, Dunedin, Auckland, and New Plymouth. The missing New South Wales file described, according to its covering despatch, 16 country hospitals as well as that which was the oldest institution in the country, the Sydney Infirmary.

DIFFERING ADMINISTRATION

The administration of the hospitals differed in the various colonies. In Victoria, and as we know, in New South Wales and Queensland, the old English county hospital system was followed, with Boards of Management elected by and

responsible to the subscribers, and with only a loose government control. These were, of course, those colonies which had been formed from the original one, and this pattern had been laid down by Governor Gipps when the convict hospitals had first been handed over to civilian use.[12] Elsewhere the Boards were appointed by the government, and were perhaps more directly under government control. No. hospital, however, could maintain itself from its own resources, and it seems that all required some form of government subsidy.

Whenever possible patients had to pay, and the usual charge seems to have been about 2/- per day. Money comparisons are virtually meaningless at such a distance in time, but as some indication of what this charge meant it can be mentioned that in Brisbane at this time a cottage could be rented at about £1 per week; meat was 3d to 4d per lb.; a small cabbage cost 8d; a 2lb. loaf was 7d; and eggs were 2/6 to 3/- per dozen.[13] If a patient was without funds, he was admitted as a pauper patient, and in Brisbane these were about three times as common as paying patients. When a pauper patient died the hospital often had to pay for his burial, and it was customary to take possession of any valuables found on him to defray expenses. Medicines seem not to have been charged for.

STRICT CRITERIA FOR ADMISSION

Criteria for admission were very strict, and most hospitals had some provision to ensure that cases could be excluded whe were thought unlikely to benefit from treatment. In Perth, it was necessary to apply to the Colonial Secretary for admission, and we know that the same philosophy prevailed in Brisbane, where the Board of Management had to approve all non-urgent admissions. Thus, a man with advanced cancer, living in extremely poor conditions at Cooper's Plains, was refused admission because it was thought that nothing could be done for him.[14] Indeed, on one occasion the hospital charged Dr. Bell, one of its Visiting Surgeons, for the funeral expenses of a patient whom he had admitted *in extremis,* and who died shortly afterwards.[15] *Clearly, hospitals were not intended to be available merely*

---

12. O. W. Powell, "The Early Development of the Royal Brisbane Hospital: 1848-1867," *Med. J. Aust.,* vol. *i* (1967), pp. 685-693.

13. Anon., *The Queen of the Colonies,* 2nd ed. (London, 1876), p. 17.

14. Brisbane Hospital Committee Minutes, 28 September 1865.

15. *Ibid.,* 15 December 1859.

because one was dying. This was not, of course, as unreasonable as it sounds. Horror of death in the home is a recent social phenomenon. One hundred years ago such an event, like birth in the home, was normal, natural and expected.

RESIDENT MEDICAL STAFF

Most hospitals had resident medical staff, usually without any right of private practice, and some had honorary staff in addition. Perth was an exception in this, being small, but Melbourne Hospital, with over 300 patients, had four resident doctors and 16 honorary staff. As an indication of how times have changed, nowadays it has, with about double that number of patients, almost 100 full-time staff, and an honorary staff of about 300.

Nursing was very meagre. None had, as yet, any trained nurses — Sydney was to be the first in the field in 1868 — and nursing duties were carried out by untrained women (not always of good character), wardsmen, and ambulant patients. The number of nursing attendants of all types averaged about one to every ten patients, including night duty. Again for comparison, in my own hospital at the present time we have about one nurse for every 1.2 patients; but there must have been little real nursing done in those days, as we now understand the term.

STRICT DISCIPLINE

Patients were subject to strict discipline. To quote from the Rules for the Hospital at Hobart Town:

> The Patients shall not smoke tobacco, or play at cards, dice, or any other game, or be guilty of rude or improper behaviour, or of using indecent language, on pain of being dismissed.
>
> All such Patients as are judged by the Physicians or Surgeons to be able to assist in the service or work of the Hospital shall be occasionally employed in the same.
>
> The Rules for the Patients shall be hung up in every room and Ward, and read when necessary, in order that none may plead ignorance of them.

It is perhaps no wonder that one of the common entries in the Case Book of the Brisbane Hospital — since no doubt similar rules were in force there — is "left of own accord." On the other hand, Rule 10 of the New Plymouth Hospital was somewhat novel — "It is expected that all will live in brotherly love, and show kindness one to another."

DIETARY SCALE

Breakfast — 1 pint of tea; 5 oz. of bread.
Dinner — 1 pint of soup; 12 oz. of meat; 2 oz. of bread; 12 oz. of potatoes; green vegetables as ordered.
Supper — 1 pint of tea; 5 oz. of bread; ½ oz. of butter.
Daily — 1/6 pint of milk; 1½ oz. of sugar; ¾ oz. of barley; ½ oz. of salt.
Weekly — 2 oz. of flour.
Wine, Porter, Ale and Spirits at the discretion of the medical staff.

These last items, incidentally, constitute a considerable charge in hospital accounts. They were obviously freely prescribed, and perhaps helped to make the discipline bearable.

COMMON ILLNESSES

Common illnesses, and these were remarkably uniform throughout the colonies, seem to have been Rheumatic conditions, chest complaints. Ophthalmia, Fever, and Syphilis. The rheumatic conditions were probably a mixture of musculo-skeletal disorders, including arthritis and fibrositis. Possibly the high incidence was related to the exposed conditions of working. Syphilis and other forms of venereal disease were rampant. Fever, of course, could have been anything. Some of it was certainly typhoid — and was recognised as such — and from time to time typhus was imported in an immigrant ship. Many hospitals had a rule that all deaths were to be submitted to post-mortem examination. Whether this was so in Brisbane I am not certain, but the high proportion of such examinations in the Hospital Case Book is impressive, and suggests a high standard of work.

HOSPITAL CONSTRUCTION

The overall quality of hospital construction and facilities was variable. In the larger cities — especially Melbourne and Hobart — the hospitals seem to have been very good. That at Brisbane, as we know, was at the end of its useful life, and a new one was being planned. The smaller country hospitals were inevitably at a disadvantage, but some of them, at any rate, were quite good. Sanitary facilities generally were poor, except in the very largest institutions, and water was a problem in some. It was so in Brisbane, for example, although this was not confined to the hospital.

Had Queensland completed the questionnaires, what

would have been mentioned of its hospitals? Unfortunately, through lack of records, we know virtually nothing of any of them except Brisbane. There were six mentioned in the Statistical Return for 1863, and the bed states gives some indication of their sizes. These were the figures for patients in hospital on 31 December 1862:

Brisbane (the oldest)	67
Ipswich	33
Rockhampton	15
Toowoomba	9
Gayndah	5
Maryborough	4

SMALL HOSPITALS

In 1863 they admitted, between them, 858 patients.[16] This figure was to increase rapidly in the next few years as the population mushroomed in the 'sixties. It is clear, however, that at this time they were all, except the first two, quite tiny. Governor Bowen was rather prone to a flowery grandiloquence, but perhaps he was not exaggerating too much when, describing his new settlements as "mere collections of wooden huts and sheds, springing up in clearings of the primeval forest," he went on:

> "One of the best of these huts or sheds was generally a rude hospital, like the field ambulance of an army, for those who had been struck down by illness, maimed by falling trees, speared by the blacks, gored by savage cattle,[17]. . ."

and he lists a few more misadventures. Be that as it may, and they were almost certainly not as crude as he describes, they were there, and no doubt they served their communities as best they could.

And this brings us to a question about all these hospitals in the various colonies — what value were they to their communities and to their patients?

NO SPECIFIC TREATMENT

To answer this we must look at them in the context of their time, accepting the fact that for virtually all diseases there was no specific treatment and that symptomatic medication was in most cases all that could be offered; and that the outcome of any illness depended to a large extent upon the ability of a patient to remain alive until the disease had run its course. In so far as nourishment and shelter were given

17. Bowen to Cardwell, Despatch No. 40, 12 August 1864, F 287, C.O. 234/10.
16. V. & P., Legislative Assembly of Qld., 1864.

to those who would not have had them otherwise, and may have died for want of them, they must have done a great deal of good. And it is worth remembering that even the smaller hospitals could have done as much as the larger in most illnesses, which is distinctly not the case to-day.

On the other hand, whether they fulfilled Miss Nightingale's dictum — that the first requirement of a hospital is that it should do its patients no harm[18]— is less certain. No doubt some harm was done — much treatment was heroic by our standards and may well have hindered recovery. But this is not fair comment since we are not comparing them with 20th century hospitals. What one would like to know is how their results compared — like for like — with those of the London hospitals of the time. We do not have sufficient information for this, but one feels, taking the Brisbane Hospital records as an example, that there was a good deal less cross-infection than was the case in England. Hospital gangrene and Pyaemia, for instance, do not figure as prominently in the records as they must have done in the older hospitals.

SUPERIOR TO LONDON HOSPITALS

In one respect there is no doubt of their superiority. Earlier it was commented that we should really use the Workhouse Infirmaries as our yardstick. In the mid-'sixties *The Lancet* had caused to be conducted an extensive survey of these institutions, and had published a series of reports on them. Here is part of its summing up:

> "Foreigners coming over here are not slow to realise that the Public Hospitals of London, of which we boast so much, accommodate but a small proportion of the sick. The State hospitals are in workhouse wards. They are closed against observation; they pay no heed to public opinion; they pay no toll to science. They contravene all the rules of hygiene; they are under the management of men profoundly ignorant of hospital rules. The doctor and the patient are alike the objects of a pinching parsimony.[19]"

As an indication of just how bad they must have been, one may quote what Sir James Paget and Dr. William Jenner laid down as minimum standards to be aimed at — with the clear implication that existing conditions were much worse:

3 nurses for 50 patients (including night nursing)

18. Florence Nightingale, *Notes on Hospitals*, 3rd ed. (London, 1863), p. iii.
19. *The Lancet*, vol. *i* (1866), pp. 404-405.

1 resident medical officer for 250 patients
1,000 c. ft. of space per patient.[20]

Compare also the diet scale for Geelong with this one, laid down in 1862 by the Strand Union Guardians (the body administering the Strand Workhouse) and approved by the Poor Law Board:

4 oz. beef or mutton daily
12 oz. bread daily
8 oz. potatoes daily
1½ pints of tea daily
On two days per week soup and rice to be substituted for meat and potatoes.[21]

The West Indies may have been bad, perhaps even as bad as this, but surely nowhere else in the colonies, and it is one of the curious and characteristic features of the times that the home authorities could have been so concerned with conditions in the colonies which they ignored or tolerated upon their own doorsteps. But that is another story.

The essential conclusion seems to be that, by and large, colonial hospitals were efficient according to the standards of the times. They were probably not markedly inferior to the recognised English hospitals, and were certainly far superior to the Workhouse Infirmaries whose function they provided in their own countries.

I have tried in this paper to give some idea of what hospitals and the practice of hospital medicine were like in the colonies a century ago. It has been, inevitable, a sketchy account of a very wide subject. If nothing else, it may serve as a reminder that there was a time when "colonialism" was not the unpleasant word it has become, and when a colonial authority, however ineffectively, could be genuinely concerned for the betterment of social welfare in its colonies.

ACKNOWLEDGEMENTS

Permission to quote from material in the Queensland State Archives is gratefully acknowledged. Transcripts of Crown-copyright records in the Public Record Office appear by permission of the Controller of H.M. Stationery Office.

REFERENCES

Note: C.O. refers to Colonial Office material held in the Public Record Office, London.

---

20. *Ibid.*, p. 382.

21. Ruth G. Hodgkinson, *op. cit.*, p. 547.

Completed questionnaires from the various Australasian colonies accompanied the following despatches:

Western Australia—No. 63, 20 June 1863, C.O. 18/128.
Tasmania—No. 67, 21 July 1863, C.O. 280/359.
Victoria—No. 70, 25 August 1863, C.O. 309/64.
South Australia—No. 37, 18 July 1864, C.O. 13/114.
New Zealand—No. 142, 5 October 1864, C.O. 209/183.