The treatment of tuberculosis in Ireland from the 1890s to the 1970s
a case study of medical care in Leinster

by

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Abbreviations

AGM	Annual general meeting
BMJ	*The British Medical Journal*
CSMA	Congregation of Sisters of Mercy archives
DCCA	Dublin City Council archives
DLRCC	Dun Laoghaire Rathdown County Council
FCCA	Fingal County Council archives
HSE	Health Service Executive
HTC	Hospital's Tuberculosis Committee
IHS	*Irish Historical Studies*
JRSI	*Journal of the Royal Sanitary Institute*
JSI	*Journal of the Sanitary Institute*
KCCA	Kildare County Council archives
LCCA	Louth County Council archives
LDCCA	Longford County Council archives
LGB	Local Government Board
LMA	London Metropolitan Archives
LSCCA	Laois County Council archives
MCCA	Meath County Council archives
MP	Member of Parliament
NAI	National Archives of Ireland
NAPT	National Association for the Prevention of Tuberculosis
NHA	Newcastle Hospital archive
NHCI	National Hospital for Consumption for Ireland

Abbreviations *continued*

NLI	National Library of Ireland
OCCA	Offaly County Council archives
RCPI	Royal College of Physicians of Ireland
RCSI	Royal College of Surgeons in Ireland
RDC	Rural District Council
RNHCI	Royal National Hospital for Consumption for Ireland
RSCA	Religious Sisters of Charity archive
TB	Tuberculosis
TD	Teachta Dála member of Irish Parliament
UDC	Urban District Council
WCCA	Wexford County Council archives
WMCCA	Westmeath County Council archives
WNHA	Women's National Health Association for Ireland
WWCCA	Wicklow County Council archives

Technical notes

In accordance with *Irish Historical Studies* rules for contributors, where the full title of an office or organisation is employed, capitals are used as in Minister for Health or Wexford County Council, otherwise the lower case is used where they are referred to as the minister and the county council. First references are formatted in the usual *IHS* style, that is they include the repository reference. Second and subsequent references generally do not keep the archival reference, however it is being kept in this thesis in the case of certain minutes of meetings to avoid confusion. Many of the minutes of organisations and statutory bodies have been published and are italicised in references. Minutes in manuscript form are formatted in the usual *IHS* style.

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Introduction

In the late nineteenth century tuberculosis was endemic in Ireland being responsible for more deaths than any other single cause. There was no medical cure for the disease, although various treatment regimes were tried, some with modest success. In the decade to 1891, 103,314 deaths were attributed to the disease, a ratio of one in every 8.5 deaths.[1] By the late 1960s the contribution of tuberculosis to mortality statistics was insignificant. In 1970, 221 persons died from tuberculosis in the Republic of Ireland, a ratio of one in every 152.4 deaths.[2] In terms of medical disease statistics, this fall in mortality was spectacular.

This thesis sets out to explore what was behind this dramatic change. It will do so by examining in detail the key international and national developments pertaining to the treatment of tuberculosis. How did the international understanding of tuberculosis evolve and how did this in turn influence the development of facilities to manage the disease? What models of treatment were followed in Ireland and did they contribute to effecting the change? In what way did the political system retard or accelerate the process of change?

This exploration will provide new insights into how the development of continental and British tuberculosis treatment facilities impacted upon the architectural design, governance, financing and treatment regimes of Irish facilities and also determined the overall structure of the Irish tuberculosis service. It will highlight the central role played by female members of the British aristocracy and female religious orders in providing and managing facilities and services, especially those for the treatment of tubercular children, a cohort of patients effectively ignored by government. It will elaborate how central government micro-management and political interventions retarded the delivery of facilities and led to the waste of scarce financial resources. It will show how religion influenced the design of facilities and impacted on the daily routine within institutions. It

[1] Compiled from the *Forty-fifth detailed annual report of the registrar general for Ireland containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1908*, 1 [Cd 4769], H.C. 1909, xi, 689. National tuberculosis statistics quoted in this thesis with reference to Ireland relate to the thirty-two county country up to December 1922 when the Irish Free state was established and thereafter to the twenty-six counties now comprising the Republic of Ireland.
[2] *Department of Health, report on vital statistics 1970*, Prl 3222.

will demonstrate how new diagnostic facilities and treatment methods, introduced after the Second World War, brought about the demise of the sanatoria.

Leinster is one of the four provinces into which Ireland is divided. Covering an area of *c.* 7703 sq. miles (19,950 sq. kilometers) it occupies the south east quadrant of the country. It is divided into 12 counties Carlow, Dublin, Kildare, Kilkenny, Laois (formerly Queen's County), Longford, Louth, Meath, Offaly (formerly King's County), Westmeath, Wexford and Wicklow. In 1891 the province had a population of 1,187,760, which had been continually declining since the famine of the mid 1840s having measured 1,982,169 in 1841.[3] Only County Dublin the location of the capital city Dublin had a continual population growth over that half-century increasing from 372,773 persons in 1841 to 419,216 in 1891. 245,001 of these persons comprising some 51,851 families lived in the city. 14,536 of these families lived in third class accommodation while 10,312 families lived in fourth class accommodation.[4] In 1891, 16,006 of the city residents were engaged in professional occupations, 20,686 were classed as domestic workers, 16,063 were commercial workers, 1,383 were agricultural workers, 68,414 were engaged in various forms of industry while 122,449 were non-productive.[5]

Outside of Dublin city the province was largely rural in character. Only five towns had populations in excess of 10,000[6], seven towns had populations between 5000 and 10,000[7] and eighteen towns had populations between 2,000 and 5,000 persons.[8] 942,759 persons

[3] *Census of Ireland,1891. Part I. Area, houses, and population: also the ages, civil or conjugal condition, occupations, birthplaces, religion, and education of the people. Vol. I. Province of Leinster,* 1 [C 6515], H.C. 1890-91, xcv, 1. (Henceforth *Census of Ireland,1891. Part I. Vol. I.).*

[4] Houses were divided into four classes. Fourth class houses were built of mud or perishable materials having only one room and window. Third class varied from one to four rooms and windows. Second class had from five to nine rooms and windows. All houses with ten or more rooms were first class. Third class accommodation was third class houses occupied by only one family, second class houses occupied by two or three families and first class houses occupied by four or five families. Fourth class accommodation also included 3rd class houses with more than one family, 2nd class houses with four or more families and 1st class houses occupied by six or more families. *Census of Ireland,1891. Part I. Vol. I.*

[5] *Census of Ireland,1891. Part I. Vol. I.*

[6] Drogheda, County Louth (11,873), Dundalk, County Louth (12,449), Kilkenny (11,048), Kingston (subsequently named Dun Laoghaire Borough), County Dublin (17,352) and Wexford (11,545). *Census of Ireland,1891. Part II. General report, with illustrative maps and diagrams, tables, and appendix,*1 [C 6780],H.C. 1892, xc,1. (Henceforth *Census of Ireland, 1891. Part II.).*

[7] Athlone, County Westmeath (6,742), Blackrock, County Dublin (8,461), Bray, County Wicklow (6,888), Carlow (6,619), Enniscorthy, County Wexford (5,648), Mullingar, County Westmeath (5,323) and New Ross, County Wexford (5,847). *Census of Ireland,1891. Part II.*

[8] The new Dublin city suburbs of New Kilmainham, Clontarf, Drumcondra , Clonliffe and Glasnevin were all located outside the city boundary in County Dublin they had a combined population of 19,244. The towns whose population exceeded 2,000 were Ardee (2,067), County Louth, Arklow (4,172) and Wicklow

resided in Leinster outside of the city of Dublin comprising 190,334 families. 67,754 of these families lived in third class accommodation, while 17,652 lived in fourth class accommodation. 55,469 of these people were engaged in professional occupations, 71,811 were classed as domestic workers, 15,930 were commercial workers, 189,832 were agricultural workers, 105,198 were engaged in various forms of industry while 504,519 were non-productive [9]

In 1891, 23,559 deaths occurred in Leinster, a rate of 19.8 deaths per 1,000 population. 3,833 of these deaths were attributable to various forms of tuberculosis a rate of 3.23 deaths per 1,000 of the population. County Dublin had accounted for 10,332 of these deaths (24.6 deaths per 1,000 population) with in excess of 1,735 (4.14 deaths per 1,000 population) attributed to tuberculosis.[10]

By 1971 the population of Leinster was 1,498,140 of whom 567,866 resided in Dublin city where the civic boundaries had been considerably expanded since 1891, while a further 111,882 lived in the suburbs immediately outside the city. An additional 98,379 lived in Dun Laoghaire Borough and its suburbs in county Dublin.[11] The total population of County Dublin was 852,219. 594,260 of these persons were aged over fourteen years, of whom 39,288 were engaged in professional occupations, 32,408 were employed in services, 93,747 were in commercial and clerical employment, 6,137 were agricultural workers, 119,492 were engaged in various forms of industry and transport, 39,315 were classed as labourers or in undefined occupations, while 263,873 were not gainfully

(3,273), County Wicklow, Athy (4,886), Naas (3,735) and Newbridge (3,207), County Kildare, Balbriggan (2,273), Dalkey (3,197) and Killiney (2,649), County Dublin, Gorey (2,213), County Wexford, Kells (2,427) and Navan (3,963), County Meath, Maryborough (2,809, subsequently renamed Portlaoise), Mountmellick (2,623) and Portarlington (2,021), Queen's County, Parsonstown (4,313, subsequently renamed Birr) and Tullamore (4,522), King's County and Longford (3,827). *Census of Ireland,1891. Part II.*

[9] *Census of Ireland,1891. Part I. Vol. I.*

[10] *Twenty-eight detailed annual report of the registrar general for Ireland containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1891*, 1 [C 6787], H.C. 1892, xxiv, 313. It is not possible to provide an accurate figure for tuberculosis deaths at county level. Figures were provided for deaths from tabes mesenterica (tuberculosis of the mesenteric lymph nodes), tubercular meningitis and phthisis. However deaths from all other forms of tuberculosis were included in a general category of deaths from other constitutional diseases. The corresponding tuberculosis death rates for the other provinces were Ulster 2.92 per 1,000 population, Munster 2.48 per 1,000 population and Connaught 1.84 per 1,000 population. Of the major centres of population only Belfast the most populous and industrialised city in the country had a higher tuberculosis death rate than Dublin at 5.48 per 1,000 population.

[11] The Dun Laoghaire Borough had been expanded to include Dalkey and Killiney. *Census of population of Ireland 1971, volume 1,* Prl. 2564.

occupied.[12] Between 1891 and 1969 in the twenty-six counties comprising the Republic of Ireland 515,000 houses were either built or reconstructed.[13] Resulting from this new and improved housing stock by 1971 the accommodation of the Dublin population had improved considerably with 811,158 persons comprising 205,861 households occupying 192,118 housing units. 12,186 of these units were single-room units, which included many of the bed-sit flats in Dublin city and 15,377 were two-room units. However 7,655 of the single-room units were occupied by only one person and 4,954 of them by two persons. Of the two-room units 2,800 of them were occupied by a single person and 4,714 of them by two people. In addition 4,029 persons comprising 1,189 households occupied 1,189 caravans and temporary dwellings.[14]

Although the balance of Leinster, wherein 645,921 persons resided, remained largely rural since 1891 it had become increasingly more urbanised. The population of Dundalk had increased to 21,672. Three other towns had populations in excess of 10,000[15], nine towns had a population of between 5,000 and 10,000[16], seventeen towns had populations of between 2,000 and 5,000 while eighteen towns had populations of between 1,000 and 2,000.[17] Of those persons over fourteen years of age 18,528 were engaged in professional occupations, 14,845 were employed in services, 37,024 were in commercial and clerical employment, 73,724 were agricultural workers, 66,062 were engaged in various forms of industry and transport, 28,350 were classed as labourers or in undefined occupations, while 209,623 were not gainfully occupied.[18] As in the city the standard of

[12] *Census of population of Ireland 1971, volume iv,* Prl. 4172.
[13] *Housing a review of past operations and immediate requirements,* 1948, P. 8573; *Housing progress and prospects,* 1964, Pr. 7961: *Housing in the seventies,* 1969, Prl. 658.
[14] *Census of population of Ireland 1971, volume vi,* Prl. 5263.
[15] Drogheda (19,762), Wexford (14,849) and Bray (14,467) *Census of population of Ireland 1971 , volume 1,* Prl. 2564.
[16] Kilkenny (9,838 with an additional 3,468 persons residing in the immediate environs of Kilkenny where the population had expanded significantly in the late 1960s), Athlone (9,825), Carlow (9,588), Arklow (6,948), Tullamore (6,809), Mullingar (6,790), Enniscorthy (5,704), Naas (5,078) and Newbridge (5,053). *Census of population of Ireland 1971, volume 1.*
[17] The towns whose population exceeded 2,000 were Muinebeag (2,321), County Carlow, Athy (4,270), Kildare (3,137) and Leixlip (2,402), County Kildare, Portlaoighse (3,902), Portarlington (3,117) and Mountmellick (2,595), County Laoise, Longford (3,876), Ardee (3,096), County Louth, Navan (4,605) and Kells (2,391), County Meath, Birr (3,319), Edenderry (2,805) and Clara (2,156), County Offaly, New Ross (4,775) and Gorey (2,946), County Wexford, Greystones (4,517) and Wicklow (3,786) County Wicklow. The towns whose population exceeded 1,000 were Tullow, County Carlow, Monasterevin, Celbridge and Maynooth, County Kildare, Graignamanagh, Callan, Thomastown and Castlecomer, County Kilkenny, Mountrath and Abbeyleix, County Laoise, Granard, County Longford, Laytown and Trim, County Meath, Kilcormac, Ferbane and Banagher, County Offaly, Moate, County Westmeath and Rathdrum County Wicklow. *Census of population of Ireland 1971, volume 1.*
[18] *Census of population of Ireland 1971, volume iv,* Prl. 4172.

accommodation had improved with 622,896 persons comprising 153,538 households occupying 150,564 housing units. 1,288 of these units were single-room units and 6,762 were two-room units. However 749 of the single-room units were occupied by only one person and 236 of them by two persons. Of the two-room units 236 of them were occupied by a single person and 1,911 of them by two people. An additional 4,307 persons comprising 1,298 households occupied 1,298 caravans and temporary dwellings.[19]

With general improvements in the standard of living and with better medical care available by 1971 the death rate in Leinster had dropped to 9.46 deaths per 1,000 of the population (14,173 deaths in total). The number of deaths attributed to tuberculosis was 84 a rate of .056 deaths per 1,000 of the population. In Dublin city 5,410 deaths were recorded, 37 being tuberculosis deaths a rate of .065 deaths per 1,000 of the population. Of 1,892 deaths in County Dublin tuberculosis accounted for 12 a rate of .057 deaths per 1,000 of the population.[20]

This study begins in the 1890s when the first dedicated facilities to treat the disease were being planned. It concludes in the 1970s when single-purpose tuberculosis treatment facilities were rendered obsolete following the introduction of new diagnostic and treatment practices. The province of Leinster has been chosen as it mirrored the other provinces. It contained one large major centre of population, the balance being a largely rural area wherein some medium sized towns and smaller villages were located. In addition it incorporated examples of all the primary tuberculosis treatment facilities and thus acted as a window on to the larger national picture. Leinster includes the capital city Dublin, the locus of key medical facilities as well as the place where the greatest numbers and highest concentration of tuberculosis sufferers in the Republic of Ireland was to be found.

Definition

Tuberculosis (TB) is a chronic wasting disease caused by infection with the bacteria bacillus mycobacterium tuberculosis.[21] This bacillus is a micro-organism with a slender

[19] *Census of population of Ireland 1971, volume vi,* Prl. 5263.
[20] *Department of Health, report on vital statistics 1971,* Prl 3972.
[21] Miquel Porta ed., *A dictionary of epidemiology* (5th ed., New York, 2008), p. 247.

curved rod-shaped body that measures 0.3 to 0.6µm wide by 1 to 4µm long.[22] Although this organism can infect any part of the body, its most common occurrence is found in the respiratory system, in a form known as pulmonary tuberculosis, which accounts for approximately 70% of TB cases in Ireland today.[23] The most common other sites of infection are the skin (lupus), the blood stream (miliary tuberculosis), the lymph nodes in the neck (scrofula), and the bones, joints and spine.[24] The ancient Greeks coined the term 'phthisis' for the disease, a term in common usage until the early twentieth century, as was the ancient Roman term 'consumption' derived from the Latin *consumptio* meaning wasting or destroying. The Old English name for the disease was 'hectic fever', no doubt deriving from the bright flush found on the cheeks of sufferers. The paradox was that this flush, an outward sign of health and, in the female, beauty, was in fact a symptom of the deadly disease raging within.

Recent research has shown that tuberculosis was prevalent in bovids in North America over 17,000 years ago.[25] Examination of human skeletal evidence has shown the existence of tuberculosis in Egypt and Peru, dating from *c*. 1000BC and Chile dating from *c*. 2000BC. Wall painting and papyrus figures from this era in Egypt, depicting the typical malformation of the spine caused by the disease, appear to confirm its frequent occurrence among that population. Similar conclusions can be drawn from figures in Central and South American prehistoric art.[26]

Historiography

The first major modern history of tuberculosis was written by Jean Dubos and Rene Dubos.[27] Their book highlighted the difficulties of any historical study of the disease. The authors found it impossible to obtain accurate data concerning the prevalence of

[22] *Textbook of respiratory medicine*, eds Robert J. Mason, John F. Murray, V. Courtney Broaddus and Jay A. Nodel (4th ed., Philadelphia, 2005), p. 984. A µm is one millionth part of a metre. In imperial measurement the bacillus measures .0000118 to .0000236 inches wide by .0000394 to .0001575 inches long.
[23] National Immunisation Advisory Committee, 'Immunisation guidelines for Ireland 2013' (www.hse.ie) (26 Jan. 2015).
[24] Thomas M. Daniel, *Captain of death: the story of tuberculosis* (New York, 1997), pp 247-250.
[25] Bruce M. Rothschild, Larry D. Martin, Galit Lev, Helen Bercovier, Gila Kahila Bar-Gal, Charles Greenblatt, Helen Donoghue, Mark Spigelman and David Brittain, 'Mycobacterium tuberculosis complex DNA from an extinct bison dated 17,000 years before the present' in *Clinical Infectious Diseases,* xxxiii, no. 3 (2001), pp 305-311.
[26] Daniel, *Captain of death*, pp 9-13.
[27] Jean Dubos and Rene Dubos, *The white plague* (Boston, 1952).

tuberculous infection. They plotted the course of the disease from ancient Greece to the mid-twentieth century by relating biographical incidents from the lives of sufferers, physicians and scientists and having recourse to early writers on consumption. Their study covers the discovery of the tuberculosis bacillus and the development of vaccination schemes and early chemotherapeutic treatments to counteract it. Unexpectedly, having regard to Rene Dubos' research background, little coverage is given to the development of the chemotherapeutic treatment of the disease, with both streptomycin and para-amino-salicylic acid (PAS) being dismissed as 'rarely bringing about a permanent and complete cure of pulmonary tuberculosis'. Similarly little hope was held out for isonicotinic acid hydrazid (isonazid), which was undergoing clinical trials as the book was being written.[28]

The Dubos have described the development by the French scientists Albert Calmette and Camille Guerin of a vaccine (BCG), to combat the disease. However like many American medics from that era, they dismissed its efficacy, countering statistical evidence of its success in the Nordic countries with details of a similar drop in tuberculosis mortality statistics from Minnesota where the vaccine was not in use.[29] Opposition to the vaccine was also found in Britain. Bryder in reviewing this opposition adduced evidence that would appear to support Calmette's contention that it was the British authorities, not the public, who opposed the introduction of the vaccine.[30] She has shown how the general introduction of the vaccine in Britain from 1949 was politically inspired as part of the Labour government's attempts to 'introduce a greater equality in health provision' as it strove for 'greater state intervention into all aspects of life'.[31] Margaret O'hOgartaigh maintained that in Ireland it was the endeavours of Dr Dorothy Price rather than any political initiatives that led to the establishment of the National BCG centre at St Ultan's Hospital in 1949 and the subsequent initiation of a national BCG vaccination scheme.[32]

The successful chemotherapeutic treatment of the disease forms a key element of any modern tuberculosis study. This has been addressed by the English physician and

[28] Ibid., pp 155-6.
[29] Rene and Jean Dubos, *The white plague* (3rd paperback printing, Boston, 1996), pp 154-171.
[30]Linda Bryder, *Below the magic mountain* (Oxford, 1988), pp 138-142.
[31] Linda Bryder, "We shall not find salvation in inoculation': BCG vaccination in Scandinavia, Britain and the USA, 1921-1960' in *Social Science and Medicine,* il (1999), 1157-1167.
[32] Margaret O'hOgartaigh, 'Dr. Dorothy Price and the elimination of childhood tuberculosis' in Joost Augusteijn ed., *Ireland in the 1930s* (Dublin, 1999), pp 67-82.

academic Frank Ryan in his comprehensive history of the search for drugs to cure the disease, which incorporates biographical details of the main participants. He explains how multi-drug treatment regimes, introduced by the Edinburgh based physician John Crofton, made the surgical treatment of pulmonary tuberculosis redundant and prolonged bed rest unnecessary. These treatment changes were to prove a key element in the demise of Irish sanatoria.[33] The journalist Peter Pringle, based on extensive archival research and William Kingston following a review of published sources have detailed the processes that led to the discovery and therapeutic application of the antibiotic anti-tuberculosis drug streptomycin.[34] Christoph Gradmann and Thomas G. Benedek have examined the failure of tuberculin treatment and gold therapy, earlier forms of chemotherapeutic treatment, which were used extensively in Irish treatment facilities.[35] Francis B. Smith's history of tuberculosis in the British Isles, in assessing the medical responses to these ineffective early chemotherapeutic treatments and detailing practitioners' doubts concerning immunisation, has presented a valuable aid to understanding mid- twentieth century Irish tuberculosis treatment practices.[36] Simon Carter has detailed how heliotherapy, a practice engaged in by many Irish institutions especially in the treatment of children, developed as a treatment for surgical tuberculosis.[37]

Valuable insights into Irish tuberculosis medical practices can be obtained from institutional histories and practitioners' biographies and provide an essential background to the study of tuberculosis treatment facilities in Ireland. T. M. Healy's history of Peamount sanatorium, County Dublin, assesses the impact of treatment practices engaged in over the years.[38] These varied from rest with graduated labour to attempted chemical solutions with Fingard's treatment[39], Sanocrysin[40] and tuberculin[41] and from the use of

[33] Frank Ryan, *Tuberculosis the greatest story never told* (Bromsgrove, Worcester, 1992).
[34] Peter Pringle, *Experiment eleven* (London, 2012). William Kingston, 'Streptomycin, Schatz v. Waksman, and the balance of credit for discovery' in *Journal of the History of Medicine and Allied Sciences*, lix, no. 3 (2004), pp 441-62.
[35] Christoph Gradmann, 'Robert Koch and the pressures of scientific research: tuberculosis and tuberculin' in *Medical History*, xlv, no. 1 (2001), pp 1-32. G. Benedek, 'The history of gold therapy for tuberculosis' in *Journal of the History of Medicine and Allied Sciences*, lix, no. 1 (2004), pp 50-89.
[36] Francis B. Smith, *The retreat of tuberculosis 1850-1950* (London, 1988).
[37] Simon Carter, 'The medicalization of sunlight in the early twentieth century' in *Journal of Historical Sociology*, xxv, no. 1 (2012), pp 83-105.
[38] T. M. Healy, *From sanatorium to hospital* (Dublin, 2002).
[39] A treatment developed by a Canadian chemist David Fingard in 1935, which involved the inhalation of 'mysterious ingredients in a vapourised form'. It was quickly discredited as a treatment for tuberculosis. 'The Duke-Fingard method in respiratory diseases' in *The Journal of the American Medical Association*, cix, no. 10 (1937), pp 794-5.
[40] Injections of gold salts.

ultraviolet light to surgical intervention in the form of artificial pneumothorax[42], thoracoplasty[43] and pneumonectomy[44]. Harry Hitchcock has provided a similar evaluation of the practices in Newcastle sanatorium, County Wicklow.[45] Histories of Dublin's Meath Hospital and The Royal Hospital, Donnybrook are revealing of the attitudes of medical staff in non-specialist hospitals to tuberculosis patients in the late nineteenth and early twentieth centuries.[46] The biography of James Deeny, former chief medical advisor to the Irish Department of Health provides insights into the role of the Department in the post Second World War campaign against tuberculosis and the part played by various politicians in securing and also delaying the provision of facilities.[47]

The locus of treatment has attracted research from scholars working in a wide range of disciplines such as historical geography, medical history, architectural history and political studies. Francis Smith in tracing the history of the German sanatorium movement has demonstrated how it influenced the development of sanatoria in Britain and British tuberculosis therapeutic practices.[48] Linda Bryder's history of tuberculosis in twentieth-century Britain, has discussed how German influences dictated the location and design of British sanatoria while illustrating the significant role in their provision played by the National Association for the Prevention of Tuberculosis, voluntary and charitable organisations, boards of guardians and local authorities.[49] Greta Jones' history of tuberculosis in nineteenth and twentieth-century Ireland, has detailed how early twentieth-century legislative reform facilitated the development of Irish sanatoria.[50] In providing a chronology of the construction of various Irish institutions she has shown how continental developments influenced site selection and design. Jones has provided valuable insights into the role played by public health campaigns, politicians and the Catholic church in both promoting and holding back attempts to tackle the disease in Ireland.

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[41] An anti-tuberculosis vaccine developed by Robert Koch in the 1890. Helen Bynum, *Spitting Blood* (Oxford, 2012), pp 146-52.
[42] The collapse of the diseased lung by the introduction of nitrogen into the pleural cavity.
[43] The collapse of the lung after the permanent removal of ribs.
[44] The removal of the diseased parts of the lung.
[45] Harry Hitchcock, *TB or not TB* (Galway, 1995).
[46] Peter Gatenby, *Dublin's Meath Hospital* (Dublin, 1996). Helen Burke, *The Royal Hospital Donnybrook* (Dublin, 1993).
[47] James Deeny, *To cure and to care* (Dublin, 1989).
[48] Francis B. Smith, *The retreat of tuberculosis .Extra space here*
[49] Linda Bryder, *Below the magic mountain* (Oxford, 1988).
[50] Greta Jones, *Captain of all these men of death* (Amsterdam, 2001).

Anti-tuberculosis organisations, public health campaigns and educational programmes played a key role in the awakening of community awareness to the disease in the late nineteenth and early twentieth centuries. Barbara Bates, based on his extensive personal correspondence, has provided a detailed account of the role of the Philadelphian physician Laurence F. Flick in setting up the Pennsylvania Society for the Prevention of Tuberculosis in 1892.[51] She also deals with the establishment of the White Haven sanatorium by that society. The financing of the sanatorium, the treatment regimes and the role of staff and patients are all discussed in detail. Bates further elaborates on how these were influenced by and in turn shaped practices in the American sanatorium and anti-tuberculosis movements. This study provides a framework for examining similar developments in Ireland.

The complex Irish hospital and dispensary set-up in which tuberculosis services were embedded had its origins in the poor law system. Laurence M. Geary has provided a detailed history of how this system developed.[52] Helen Burke and Virginia Crossman have elaborated on the role played by the poor law dispensaries and workhouse infirmaries in the treatment of the poor.[53] Their works provide an overview of the facilities available for the treatment of tuberculosis patients in Ireland prior to the advent of the sanatoria and tuberculosis dispensaries. Matthew Potter, in examining the history of Irish local government, has detailed the administrative structures charged with managing these public health facilities and explained how legislative reform impacted on their delivery of services.[54] Harold O'Sullivan's history of the evolution of local government in County Louth provides insights into the involvement of one particular local authority in developing medical treatment facilities at local level.[55]

The lack of clarity around the respective responsibilities of central and local government authorities in the provision of tuberculosis facilities in Ireland is a recurring theme. Katherine McCuaig, in examining the campaign against tuberculosis in Canada from 1900 to 1950, has assessed how the division of such responsibilities between central and regional authorities in Canada retarded the development of tuberculosis services in that

[51] Barbara Bates, *Bargaining for life* (Philadelphia, 1992).
[52] Laurence M. Geary, *Medicine and charity in Ireland 1718-1851* (Dublin, 2004).
[53] Helen Burke, *The people and the poor law in 19th century Ireland* (Dublin, 1987). Virginia Crossman, *The poor law in Ireland 1838-1948* (Dublin, 2006).
[54] Matthew Potter, *The municipal revolution in Ireland* (Dublin 2011).
[55] Harold O'Sullivan, *History of local government in the county of Louth* (Dublin, 2000).

country.[56] From a political perspective, the provincial authorities with their limited tax base could not afford to deal with the problem on their own, while for the central authority providing health services 'for sufferers of a chronic disease would have been costly and would have no obvious political benefits to outweigh the expense'.[57] McCuaigs analysis has provided a useful framework whereby similar political organizational difficulties in Ireland may be contextualized. Marie Coleman has demonstrated how successive Irish politicians charged with health matters effectively hijacked the proceeds of the Irish Hospital's Sweep, originally set up to meet the continuing current deficits incurred by the voluntary hospitals, to fund a capital construction programme for sanatoria. In doing so, she has addressed how Irish central government exercised financial power to consolidate its control over the sanatorium movement.[58]

Primary sources and methodologies

Establishing the chronology of events, identifying key agents and ascertaining why events happened, or not, required substantial cross-referencing and the matching up of information held in correspondence, reports, memoirs, medical texts and commentary created by different parties and now widely dispersed among repositories, databases and publications, in traditional and electronic formats.

Medical perceptions of tuberculosis and its treatment and how these facilitated the development of the sanatoria movement are to be found in medical journals and textbooks supplemented by international conference reports and papers of campaigners in this field. The published works of the founders of sanatoria are particularly revealing of the circumstances surrounding their conception, construction, governance and the medical practices instituted therein. Statistical data regarding the prevalence of the disease, shifting government responses to it in answer to changing pressures and the provision of facilities are found in the annual reports of the Registrar General in Ireland (1868-1920), the annual reports of the Irish poor law commissioners (1852-1870), the annual reports of the Irish Local Government Board (1875-1921), the royal commissions

[56] Katherine McCuaig, *The weariness, the fever and the fret* (Quebec, 1999).
[57] Ibid., pp 259-60.
[58] Marie Coleman, *The Irish Sweep* (Dublin, 2009).

on tuberculosis (1895-98 and 1902-16) and the departmental committees on tuberculosis (1888 and 1912-13). The interpretation of medical statistics derived from these reports and from the medical reports of individual institutions treating tuberculosis requires an awareness of their inherent limitations. These limitations arise from the lack of definition of subject matter, the absence of control groups for comparison purposes, errors in compilation and transcription and inconsistent practices across institutions and over time. Many institutions prior to the early twentieth century, in order to improve their mortality figures and thus protect their public reputation and ability to raise funds, released terminally ill patients to the care of relatives or hospices for the dying.

Debates in the House of Commons and in Dáil Éireann throw light on political aspects of the treatment of tuberculosis before and after independence. A review of primary and secondary legislation illustrates how effective the input of politicians was in securing, or blocking, change.[59] Analysis of the records of the departments of Health, Local Government and the Taoiseach reveal the impact of the political processes on the provision of treatment and facilities. However the incomplete and fragmentary nature of these files poses particular problems. The annual reports of the Department of Local Government and Public Health (1925-37), the reports of the Department of Health (1949-58), the general reports of the Hospitals Commission (1935-47) together with specifically-commissioned health reports were consulted to provide additional information regarding institutions, treatment practices and government policies.

Departmental files, held in the National Archives of Ireland, pertaining to the provision of facilities illustrate the extent and nature of the interactions between central and local government and voluntary bodies. Further details concerning the development of local authority institutions were obtained from the archives of the various local authorities. However it is only since the passing of legislation in 1994 that local authorities are obliged to conserve their records.[60] Many records predating the passing of this legislation were destroyed or passed over to new health authorities upon their formation between 1960 and 1970. Having no statutory archival obligations these health authorities

[59] Primary legislation refers to that body of law in the form of acts passed directly by the Oireachtas (the national parliament of Ireland). Secondary legislation refers to subordinate legislation authorised by acts of the Oireachtas. It normally takes the form of statutory instruments made by government ministers but may include bye-laws and regulations made by bodies such as local authorities authorised to do so.
[60] Local Government Act, 1994, 8/1994 [R.I.] (29 Apr. 1994).

destroyed many of these historical records. Even where they have been retained access may be refused on data protection grounds. With local authorities having responsibility for over 100 years of their own record making as well as the records of their predecessor bodies much remains uncatalogued in accordance with normal archival standards. This presented significant difficulties in compiling information.

The development and evolution of particular institutions were determined by an examination of the extant files of the individual hospitals. The archival holdings of the National Hospital for Consumption for Ireland (Newcastle Sanatorium) and Cork Street Fever Hospital were consulted in situ and being unsorted presented particular difficulties. These have recently been transferred to the Royal College of Physicians of Ireland where they are being catalogued. That repository also holds the records of St Ultan's Hospital. The records of Peamount Sanatorium, being part of the Women's National Health Association collection, are held in the National Archives of Ireland. The records of these institutions, consisting largely of original minutes and annual reports together with some patient details, provide valuable information in relation to the development of the institutions and their treatment practices. Information relating to Ballyroan Preventorium and Cappagh Hospital was obtained from the archives of the Sisters of Mercy and the Religious Sisters of Charity respectively. Those records in the form of annals were generally found to be deficient in detailing matters of a medical, political, architectural or construction nature. However correspondence files pertaining to the institutions provided valuable insights into their development.

Because of the incomplete nature of the information available from reports and correspondence it was necessary to supplement it with further information from national and local newspapers. In addition, a number of former staff and patients of sanatoria were interviewed, following the National University of Ireland Maynooth's research ethics protocol, to clarify and confirm written accounts and provide alternative insights into institutional practices.[61]

[61] NUI Maynooth research ethics policy (www.nuim.ie) (26 Mar. 2014)

Thesis structure

This thesis is a study of the role of the tuberculosis movement in Leinster from its development in the 1890s to its demise in the 1970s.

Chapter one, in investigating the philosophical and medical underpinning of the sanatorium movement internationally, reviews how tuberculosis treatments were developed by the earliest classical physicians onwards, with practitioners championing their favoured, and strikingly different, methodologies. How these in turn led to the sanatorium movement and determined the architectural design of the institutions, their medical practices, their treatment regimes and their governance is assessed with reference to a small selection of sanatoria. The development of the tuberculosis dispensary and how it reinforced the sanatorium movement is reviewed.

In examining how new concepts regarding the treatment of tuberculosis were imported into Ireland in the late nineteenth century the focus shifts to Leinster. In chapter two the key individuals involved in the opening of the early Leinster sanatoria, together with how their involvement was procured, are identified. The significant role members of the aristocracy played in this process is highlighted especially in regard to the procurement of funds.

In the early years of the twentieth century national organisations with a specific focus on tuberculosis exerted pressure for legislative reform to help combat the disease. Chapters three and four critically examine the role played by newly-formed organisations such as the National Association for the Prevention of Tuberculosis (NAPT) and the Women's National Health Association (WNHA) pertaining to the development of the sanatoria and the treatment regimes they embodied. In particular, how these organisations shaped public attitudes, raised political awareness and successfully secured the enactment of new legislation regarding tuberculosis and its treatment is examined. The impact of such legislative provisions is assessed.

The early twentieth-century legislative reform opened up fresh sources of finance to establish new institutions and assisted in the ongoing financing of existing ones. The role of local authorities and the WNHA in the development of these facilities and how local

politicians influenced this process receives detailed consideration in chapters five and six.

In the 1920s the newly-independent Irish government sought to dismantle the health system it had inherited. Chapter seven examines how this affected the development and delivery of tuberculosis services. It assesses the impact of micro-management of the provision of treatment and facilities at national and local level by a powerful central government department.

The treatment of children who suffered from various forms of surgical tuberculosis merits specific consideration. Chapter eight explores the role of voluntary hospitals in the treatment of tubercular children and how these institutions adopted the most up-to-date medical practices and also addressed their young patients' religious and educational needs.

Chapter nine examines how in the post-war period regional sanatoria evolved. It addresses how the implementation of interim solutions pending more ambitious schemes proved costly and wasteful. It elucidates how improved methods of diagnosis, preventative vaccination and the effective chemotherapeutic treatment of tuberculosis led to the eventual demise of the sanatoria.

Certain themes recur throughout the thesis and there is some inevitable overlap in chronology and geography. The constant difficulties in securing finance to provide facilities for tuberculosis sufferers is highlighted throughout the thesis as the effective treatment of the disease was never cheap. Another recurring theme is the care taken to provide for the religious needs of patients and the involvement of church authorities and religious bodies in the provision and management of facilities. The inherent conflict between local and national politics in the development of tuberculosis services also features as a theme throughout the thesis.

The thesis concludes by drawing together the main findings from the research. . It demonstrates how continental and British influences shaped the design of the first Irish sanatoria and their treatment regimes and ultimately determined the structure of Irish tuberculosis services. A key finding is that the active participation of female members of

the British aristocracy in procuring sites and acting as fundraisers, organisers, administrators and managers was a crucial catalyst in the development of the early tuberculosis treatment facilities and services in Ireland. In detailing the role of religion and especially female religious orders in the provision, staffing and management of tuberculosis treatment facilities and how religious ethos determined practices within institutions this thesis highlights a hitherto unexplored aspect of tuberculosis treatment. New insights are provided into how the political process intervened in the provision of facilities and services, with central government micro-management and lack of financial support delaying their delivery while considerably adding to their costs. A central argument is that the state abdicated its responsibility for tubercular children relying on religious orders and private philanthropy to provide the necessary facilities. In illustrating the role of dispensaries in the identification of sufferers and their referral to sanatoria, where in many cases their bodies' natural defences counteracted the disease, the key part these institutions played in the tuberculosis service is revealed. The combined interaction of chemotherapy, preventative vaccination and mass x-ray is shown to provide a decisive contribution to the demise of the sanatoria.

Chapter 1
The international origins of the sanatoria movement

From the time of the Roman Empire until the twentieth century the works of physicians have displayed a common understanding of the symptoms of tuberculosis and of the benefits of fresh air and nutrition in its treatment. Advancements in diagnostic medicine and pathology enhanced knowledge of the disease and facilitated the development of treatment regimes, which ultimately led to the evolution of sanatoria and tuberculosis dispensaries.

Roman physicians recognised pulmonary tuberculosis as a distinctive disease. Their description of the physical manifestations of the disease and recommended treatment regimes, primarily involving fresh air and good nutrition with medicines applied to relieve symptoms, formed a medical philosophy that was followed by later physicians. Medical advances led to a greater although disputed understanding of the immediate causes of the disease, improved diagnostic methods and more advanced treatment practices.

Aretaeus, the first century AD Cappadocian physician, described the effect pulmonary tuberculosis would have on a patient's appearance as

> voice hoarse […] of the bones alone the figure remains, for the fleshy parts are wasted […] nose sharp, slender; cheeks prominent and red; eyes hollow, brilliant and glittering […] the slender parts of the jaws rest on the teeth, as if smiling, otherwise of a cadaverous aspect […] joints clearly developed, prominent devoid of flesh [...] the spine […] now protrudes the muscles on either side being wasted; the whole shoulder blades apparent like the wings of birds. [1]

In the second century AD, Galen advised consumptive patients to live on an elevated hill outside Naples and to drink as much milk as possible. His near-contemporary Aretaeus recommended the benefits of living beside the sea and taking sea voyages. He declared milk 'sufficeth in place of all food [...] and should prove both food and medicine'.[2]

[1] Quoted in John Bessner Huber, *Consumption its relation to man and his civilization, its prevention and cure* (Philadelphia, 1906), p. 42.
[2] Quoted in C. H. Vrooman, 'The development of our knowledge concerning tuberculosis', Part 1 in *The Canadian Medical Association Journal*, xviii, no. 5 (1928), pp 594-9.

In the fourteenth century John Gaddesden compiled *Rosa angelica practica medicinae a capite ad pedes*, a compendium describing medieval medical knowledge and practices.[3] Manuscripts of Irish translations of the text are held in Trinity College, the Royal Irish Academy and the British Library.[4] The existence of an Irish medical lexicon on the subject is evidence of the endemic nature of the disease in Ireland in this period. Gaddesden described 'hectic fever' as a wasting disease, originating in the heart, which consumed the fat surrounding the organs of the body. He envisaged the disease as having three stages. The first was characterised by a dry withered skin hard to recognise but easy to cure. In the second stage the dryness was more pronounced, accompanied by a weakening of the pulse. This stage was easy to recognise but difficult to cure. The recommended treatment involved a regimen of food and drink accompanied by syrups and herbal medicines, rest and moderate exercise. The third stage featured sunken eyes, the belly adhering to the back, the pulse weak and rapid, urine like oil, skin drawn, dry and wrinkled, the nose pinched and the shoulders drawn up. Patients who reached this stage could be cured only by divine intervention. [5]

Little is known about the prevalence of the disease during the Middle Ages. However the bills of mortality of Dublin reveal that in the mid seventeenth century pulmonary tuberculosis was endemic in the city. Between the 6-7 July and 2 August 1661, of twenty recorded Protestant deaths in the city eight were as a result of the disease, while for the year 1684, 332 of the 2,158 recorded deaths were attributable to the disease.[6]

The German physician Franciscus Sylvius de la Boe, in his 1679 treatise *Opera Medica*, was the first to recognise glandulous tubercles.[7] These he discovered, while carrying out post mortem examinations, in the lungs of deceased consumptives. He speculated that it was from these tubercules that phthisis originated. He also concluded that the disease, running in certain families, was hereditary.[8]

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[3] Martha Carlin, 'John Gaddesden' in *Oxford dictionary of national biography* (www.oxforddnb.com) (26 Nov. 2011).
[4] Rosa Angelica (www.ucc.ie/celt) (26 Nov. 2010).
[5] John Gaddesden, *Rosa Anglica sev rosa medicinae Johannis Anglici an early modern Irish translation of a section of the medieval medical text-book of John of Gaddesden*, Winifred Wulff ed., (London, 1929), pp 69-119.
[6] James Deeny *The end of an epidemic* (Dublin, 1995), pp 103-4.
[7] Rene Dubos and Jean Dubos, *The white plague* (3rd paperback ed., New Brunswick, 1996), p. 73.
[8] C. S. Breathnach, 'Richard Morton's *Phthisiologia*' in *Journal of the Royal Society of Medicine*, xci (1998), pp 551-2. Glandulous tubercles are nodules of hardened swollen tissues.

Richard Morton, the English physician, in *Phthisilogia*, published in 1689, described in greater detail these tubercules stating that they were indeed 'the whole immediate cause of a consumption of the lungs and of the dry cough which attends it'.[9] He detailed the prevalent beliefs regarding the causes of consumption as the lack of exercise, studying during the night, a hereditary disposition, ill formation of the breast, the catching of colds and infection. Convinced of the contagious nature of the disease, he believed that no one who has survived childhood can subsequently die without at some stage being touched by consumption.[10] He described the early manifestations of the disease as cough, fever and loss of weight and provided the following vivid description of night-sweats, a classic symptom of sufferers:

> this fever comes at a certain hour (which is about noon, or a little later) with a manifest chilness, but then proceeding for some hours with a burning heat, drought, restlessness, vomiting, shortness of breath, a continual fierce and violent cough, want of sleep, yes sometimes light-headedness and a very red colour in the cheeks [...] at length about mid-night, it ends in vast and colliquative sweats.[11]

Morton promoted prevention, holding that care in eating, drinking, sleep, exercise, evacuations and passions of the mind together with the use of fresh air would act to prevent the onset of the disease. For treatment he recommended bleeding followed by the use of chalybeate water,[12] a milk diet supplemented with shell fish and testaceous[13] medicines, with laudanum used to alleviate the cough and Peruvian bark to reduce the fevers. He believed that early-stage consumption could be cured but was apt to return unless the consumptive governed himself very regularly.[14]

The English doctor Gideon Harvey in 1699 realised that 'to pretend to cure a confirmed consumptive is equal to make a new man, new bowels and new humours. It is in the beginning only that this disease admits of a cure'. Once the disease was established one

[9] Richard Morton, *Phthisiologia or a treatise of consumptions* (London, 1694), p. 89.
[10] William Ostler, 'The *Phthisiologia'* of Richard Morton M. D.' in *Medical Library and Historical Journal*, ii, no. 1 (1904), pp 1-7.
[11] Morton, *Phthisiologia*, p. 107.
[12] Iron bearing water.
[13] Derived mainly from crustaceans.
[14] William Ostler,The *Phthisiologia* of Richard Morton M. D. pp 1-7.

was under a sentence of death. He recommended the use of clean dry fresh air 'not low because subject to damps nor high and mountainous because exposed to sharp winds' as being beneficial to the protracted and palliative care of consumptives.[15]

In 1720 the London doctor Benjamin Marten published his theories on tuberculosis. He elucidated the common observation that the children of consumptive parents were much more likely to develop the disease while acknowledging that certain physicians considered the disease to be contagious, passed from person to person by breath, spittle, drinking from vessels used by consumptives or from wearing the clothes of such persons. He believed that those with a hereditary disposition were amongst the first to succumb to infection. He attributed infection to 'some certain species of animalcula or wonderfully minute living creatures' hostile to humans yet capable of subsisting in the body. These were conveyed to the lungs, by blood circulation or breathing, where they caused the disorders symptomatic of consumption. He believed that microscopic examination could reveal these creatures. He conjectured that conveyance of the animalcula through the umbilical cord to the foetus and through the digestion of infected food were other methods of transmitting infection.[16]

In the mid 1800s changes in medical practice introduced in Dublin had a profound impact on the diagnosis of tuberculosis. At that time Dublin had achieved prominence as a centre for the teaching of medicine, largely due to the influence of the physicians Robert James Graves and William Stokes. In expanding Boerhaave's idea of delivering medical lectures at the bedside and allowing students to develop expertise by examining patients themselves, they changed the then system of students qualifying by attending lectures without ever coming into contact with patients.[17] They introduced their students to the practices of percussion[18] and auscultation[19], as physical examination tools.[20] Both

[15] Gideon Harvey, *The vanities of philosophy & physick* (London, 1699), introduction, pp 75, 82.
[16] Benjamin Marten, *A new theory of consumptions* (2nd ed., London, 1722), pp 5-9, 40-7.
[17] David Riesman, 'The Dublin Medical School and its influence upon medicine in America' in *Annals of Medical History*, iv, no.1 (1922), pp 86-96. Boerhaave originally introduced his practice in Leiden, Holland in the early eighteenth century.
[18] Percussion is the determination of diseases of the chest by distinguishing the different sounds produced when the thorax is tapped with fingers. It was discovered by the physician Auenbrugger as a medical diagnostic tool when he observed his innkeeper father tap barrels to determine the amount of liquid therein. Dubos and Dubos, *The white plague*, pp 77-8.
[19] Listening to the internal sounds of the body by means of a stethoscope and determining the health of the body and its organs therefrom. Stokes as a twenty-one year old had written the first book in English on the use of the stethoscope, while Graves is credited with its introduction into Ireland. Riesman, 'The Dublin

percussion and auscultation were to form the chief means of diagnosing tuberculosis prior to the use of x-rays.[21]

Grave's writing on phthisis is revealing of the mid-eighteenth-century public attitude to the disease. Being a disease which attacked persons 'in the bloom of youth' without affecting their physical beauty or impairing their intellectual functions but rather developing their amiable qualities, it effected in observers 'feelings of commiseration (of) a more than ordinary intensity'. Graves dismissed the belief that consumption was caused by tubercles believing that the disease developed as a consequence of a debilitated state of constitution termed the 'scrofulous habit', which brought about morbid changes in the body. He maintained that neglecting common ailments acted as a catalyst for the development of consumption. Identifying scrofulous joints as the same basic disease as consumption because of their shared symptoms, he believed that any injury producing joint inflammation could lead to the development of the scrofolous habit. [22]

Graves contested the theory that the climate of Great Britain influenced the high incidence of the disease found in the British Isles by comparing the prevalence of the disease there with its occurrence in continental locations. He concluded that, statistically, phthisis depended on confinement, poverty and vice, all associated with the condensed population of towns. Comparison of rates between rural and urban populations, where the frequency of the disease was much higher, led him to speculate that the crowded conditions in manufactories with their imperfect ventilation, long hours of work and lack of time devoted to amusement and healthy exercise caused excessive consumption mortality rates amongst workers.[23]

Graves was critical of the usual treatment, which required the patient to be confined to his room in 'Madeira like' temperatures, wrapped in flannel, bled and not allowed animal food. He believed that such treatment further debilitated patients leading to their demise.

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medical school'; Helen Andrews, 'Robert James Graves' and 'William Stokes' in *Dictionary of Irish biography* (www.dib.cambridge.org) (28 Feb. 2011).
[20] Riesman, 'The Dublin medical school'.
[21] Dubos and Dubos, *The white plague*, pp 77-93.
[22] Robert James Graves, *Clinical lectures on the practice of medicine* (2nd ed., Dublin, 1864), p.508-19; 'Clinical lectures delivered by Dr. Graves, M.R.I.A. at the Meath Hospital, or County Dublin Infirmary, session 1832-33. Lecture xv. Pathology of phthisis-formation of tubercles' in *The London Medical and Surgical Journal*, iii, no. 60 (1833), pp 230-4.
[23] Graves, *Cinical lectures*, pp 509-19.

He recommended a nutritious diet and open air exercise. To facilitate sleep and to check perspiration he suggested taking a draught consisting of an infusion of cascarilla and sulphate of quinine, both in common use for fever treatment, combined with dilute sulphuric acid and tincture of hyoscyamus,[24] a sedative. His treatment regime requiring a specific diet, daily exercise in conveyances and expensive imported medicines would have been available only to the wealthier classes. For advanced cases he advised treatment with mercury aided by a decoction of sarsaparilla and nitric acid.[25] This treatment he developed from experiments carried out in 1833-4 by the Dublin surgeon James O'Beirne, who successfully treated the affected joints of scrofulous patients with mercury in the Richmond Surgical Hospital.[26]

Graves accepted that to preserve the patient or alleviate phthisis it was sometimes necessary to recommend a complete change of climate; one the same or nearly the same would not be adequate. Thus he ruled out sending any of his patients to Italy, France or Madeira, all places of common resort which he did not consider sufficiently different. His expressed preference was for the East and West Indies, the southern United States of America, the northern states of South America and Egypt.[27]

Stokes' beliefs regarding phthisis were broadly aligned with those of Graves. However he differed in the detail of his treatment, which he divided into curative and palliative. To be cured his patients were confined to their room with complete rest, avoiding 'all exertions of the lung'. Their diet consisted of milk, farinaceous substances and vegetables. They were bled with leeches followed by blisters, which after a number of weeks were converted into issues.[28] Mild sedatives were administered to alleviate coughs. In mild weather horse riding was recommended for exercise and to perfect recovery the patient 'should remove to a milder climate and frequently change his situation'.[29]

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[24] Henbane.
[25] Graves, *Cinical lectures*, pp 520-36.
[26] James O'Beirne, 'On the use of mercury in ulceration of the cartilages of joints' in *The Dublin Journal of Medical and Chemical Science*, v, no. 14 (1834), pp 159-84.
[27] Graves, *Cinical lectures*, p. 521.
[28] An issue is a small ulcer produced and kept open by inserting a foreign body into tissue for the purpose of relieving irritation or morbid actions in an adjoining part of the body. Joseph Thomas, *A complete pronouncing medical dictionary* (London, 1889), p. 512; Thomas Lathrop Stedman, *A practical medical dictionary* (6th revised ed., New York, 1920), p. 512.
[29] William Stokes, *Treatise on the diagnosis and treatment of diseases of the chest part 1* (Dublin, 1837), pp 437-51. In recommending horse riding he was following the advice of the seventeenth-century English

For patients with advanced disease, where excavations had formed in the lungs, Stokes advised the use of setons,[30] together with frequent changes of air or sea voyaging. Physical symptoms could be relieved by bleeding, blistering, bark preparations, ointment of morphia, belladonna, demulcents and opiates. He acknowledged that such palliative care would not lead to recovery but would probably prolong life. He preferred patients to spend winter in a temperate climate and the summer and autumn travelling. Easily accessible winter resorts included the coastal towns of Devon and Cornwall and, in Ireland, Mallow and Cove [Cobh].[31]

Influenced by such eminent physicians, in the 1860s it became the regular practice of doctors in Britain and Ireland to send their patients to the southern hemisphere colonies 'as the most probable means of arresting tubercular disease'. Every ship arriving into Port Phillip,[32] Victoria, contained two, three or more such patients. The climate there was 'as dissimilar as possible' to that in which they formerly resided and a 'large portion of such cases' enjoyed the additional beneficial health effects produced by the long sea voyage.[33] Others with first hand experience took an alternative view of the benefits of sea travel. In 1900 the physician Louisa Martindale, observing a young female consumptive patient on a voyage from India to Australia, queried whether her specialist had ever been on a sea voyage, as the patient dealt with 'the utter misery of sea-sickness' while 'she had to battle with phthisis as well'. Martindale resolved to 'never, never send a patient of mine on a sea voyage to benefit her health'.[34]

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physician Thomas Sydenham who recommended to sufferers that the 'most excellent and efficacious' cure was to take exercise in the form of long journeys on horseback. Thomas Sydenham, *The compleat method of curing almost all diseases* (English translation from original Latin, London, 1694), p. 94.

[30] A seton was a method of producing issues whereby a seton needle with thread attached was passed through the flesh to produce an ulcer. In order to keep the wound open a fresh portion of the thread would be drawn through the aperture daily. Robley Dunglison, *A dictionary of medical science* (13th revised ed., Philadelphia, 1856), p. 786.

[31] Stokes, *Diseases of the chest*, pp 451-4.

[32] Modern day Melbourne.

[33] Samuel Dougan Bird, *Climate and consumption* (Melbourne, 1870), p. 6.

[34] L. Martindale, *A woman surgeon* (London, 1951), pp 79-80. Martindale was for many years senior surgeon at the New Sussex Hospital, one of only five general women's hospitals in Britain. She was prominent in medical-political circles serving as honorary secretary to the obstetrics and gynaecology section of the British Medical Association. She was a co-founder of the Medical Women's International Association serving as secretary, treasurer and president of the organisation. Sara Delamont 'Louisa Martindale 1872-1966' in *Oxford dictionary of national biography* (www.oxforddnb.com) (4 Feb. 2014).

In 1855 the Belfast physician Henry McCormac postulated that rebreathed air was the root cause of pulmonary consumption.[35] He set out how carbon from rebreathed air was not adequately discharged from the body but conveyed by the circulatory system to the lungs where it was deposited as tubercules causing the disease. He attributed the frequent occurrence of the disease to 'insufficient exercise, indoor sedentary occupations, unventilated habitations and impure air'. The prevalence of such conditions amongst the poorer classes he advanced as the reason why working-class mortality from tuberculosis was double that of the rich. He dismissed as ineffective popular treatments with cod liver oil, digitalis, antimony and various inhalations. He recommended, as the only effective treatment and means of avoidance of the disease, living in open air by night and by day. This was to be achieved by three to four hours daily outdoor exercise. Indoors, windows were to be opened at all times to prevent re-breathing the same atmosphere. Body temperature could be maintained with adequate clothing, coverlets and open fires. He envisaged instructing 'the masses' in this required lifestyle in schools, lecture rooms and through person-to-person contact. [36]

McCormac's papers on the subject were read at medical gatherings in Belfast, Dublin and Glasgow. In 1861 his paper was presented to the Royal Medical and Chirurgical Society of London. However it was attacked by members of the audience as 'a waste of time' with a declaration that 'the society ought to be protected against the reading of such productions'. Even the customary vote of thanks for delivery of a paper was not proposed.[37] The Dublin medical press attributed this reception to anti- Irish prejudice and an 'intolerance of instruction from sources not relished by learned Londoners'.[38] Despite this reception a second edition of his book was printed and translated into Dutch and German. His theories were accepted in France, Belgium, Germany and Denmark. Both

[35] This was an expansion of the theory developed by the French physician August Baudelocque in 1834 that the essential condition for the development of scrofula was the breathing of air which had not been sufficiently renewed and thus polluted. August C. Baudelocque, *Etudes sur la maladie scrophuleuse* (Paris, 1834), pp 176-230.
[36] Henry McCormac, *On the nature, treatment and prevention of pulmonary consumption* (London, 1855), pp 23, 51-2, 60, 71-3, 78, 107.
[37] *The Lancet*, lxxvii, no. 1966 (1861), p. 434; quoted in Robert Marshall, 'The open window' in *The Ulster Medical Journal*, xvii, no. 2 (1948), pp 189-98. In McCormac's absence the paper was read by a Dr. Sieveking.
[38] *BMJ*, i, no. 19 (1861), p. 502.

Ian Fraser and Helen Andrews have speculated that his writings influenced 'the vogue of the open-air treatment of tuberculosis in Germany and Switzerland'.[39]

German Sanatoria

The German sanatoria movement provided the catalyst for the late-nineteenth/early-twentieth-century worldwide sanatoria movement. Its origins can be traced to Gobersdorf in 1854, when Hermann Brehmer began treating consumptives there. It subsequently developed through the work of Peter Dettweiler at Falkenstein sanatorium founded in 1876 and Otto Walther in his sanatorium at Nordrach in Baden, established in 1888.

As a medical student, Hermann Brehmer developed an interest in tuberculosis. In 1853 he published his final thesis on the disease, which recommended that high altitudes should form part of any tuberculosis cure regime because of the favourable impact of diminished atmospheric pressure on the lungs. His further studies showed a marked absence of phthisis in mountainous populations. An absence of the disease in certain lowland populations, revealed by the studies, he attributed to the mode of living of the inhabitants, which involved a 'hygienic' lifestyle incorporating exercise and proper diet.[40]

In 1849 Brehmer's sister-in-law established a hydropathic institution at Gorbersdorf, an elevated town situated in a Silesian mountain valley 561 metres above sea level. This cottage establishment failed despite financial support from Brehmer, who assumed responsibility for the premises in 1854 and began to put his tuberculosis theories into practice for paying patients.[41] His regime consisted of good nutrition and unsupervised exercise in the mountain air. In the belief that it would invigorate the system, Brehmer

[39] *BMJ*, i, no. 4243 (1942), p. 560; Ian Fraser, 'Father and son – a tale of two cities' in *The Ulster Medical Journal*, xxxvii, no. 1 (1968), pp 1-39; Helen Andrews, 'Henry MacCormac' available at *Dictionary of Irish biography* (www.dib.cambridge.org) (20 Nov 2010).

[40] S. A. Knopf, *Hermann Brehmer and the semi-centennial celebration of Brehmer's sanatorium for the treatment of consumptives; the first institution of its kind (July2 1854- July 2 1904)* (New York, 1904), pp 2-5; Hugh M. Kinghorn, 'Hermann Brehmer' in *Transactions of the American Clinical and Climatological Association*, xxxvii (1921), pp 193-210. The thesis, titled *De legibus ad initium atque progressum tuberculosis pulmonium spectantibus* (Observations on the principles regarding pulmonary tuberculosis from its beginning through its development), was written in Latin, as was the nineteenth-century practice for medical theses.

[41] Kinghorn, 'Hermann Brehmer'; Frederick Rufenacht Walters, *Sanatoria for consumptives; a critical and detailed description, together with an exposition of the open air or hygienic treatment of phthisis* (2nd ed., London, 1902), p. 151. Walters having served as physician to the North London Hospital for Consumptives at Mount Vernon established and managed Crooksbury sanatorium near Farnham in Surrey in 1900. 'Biographical entry Walters, Frederick Rufenacht (1857-1946)' (http://livesonline.rcseng.ac.uk/biogs) (3 Feb. 2014).

created a forest douche, where every morning for thirty seconds, ice-cold water descended upon his patients, from a height of five metres.[42]

The Gobersdorf regime was apparently effective, resulting in the arrival of increased numbers of patients, whom Brehmer boarded out in private houses. No individual consultations with the physician regarding complications of the disease or the administration of drugs to relieve symptoms were offered as part of the standard regime. If such additional services were administered they were billed separately, a practice which was to become the norm as sanatoria developed.[43]

Success at Gobersdorf encouraged Brehmer to construct a forty-bedroom 'Kurhaus' with entertainment rooms, in which concerts and theatricals were arranged. This building was completed in 1862. A further extension added in 1878 resulted in eighty-eight bedrooms, containing one hundred and four beds, being available for patients.[44] This extension incorporated glazed galleries forming a cold conservatory and a warm palm house, which facilitated indoor exercise in adverse weather conditions. No open-air verandahs were provided. Brehmer objected to them, laying stress on open-air exercise as an essential element in his cure. Following his death in 1889 his successor Dr Kobert added fresh air galleries to the buildings.[45]

To facilitate patient exercise, Brehmer acquired 300 acres of adjoining land, on which he provided over nine miles of walks. Some walks were level while others had various gradients. Sloped walks commenced with an uphill walk returning downhill, to prevent patients overexerting themselves when returning. [46] To avoid straining patients, hundreds of benches were provided, placed twenty paces apart, together with a number of garden houses and five or six covered pavilions.[47] Having provided the walks, Brehmer had a change of mind regarding unsupervised exercise, introducing personally-supervised, individually-tailored, exercise programmes. These programmes provided for increasingly intensified exercises as the patient's strength grew. To monitor their effect and to

[42] Kinghorn, 'Hermann Brehmer'.
[43] Ibid.
[44] Ibid.
[45] Walters, *Sanatoria*, pp 151-2.
[46] Ibid., p. 151.
[47] Paul H. Kretzschmar, 'Public health resorts versus institutions for the treatment of bacillary phthisis' in *Transactions of the Annual Meeting of the American Climatological Association*, v (1888), pp 69-83; Kinghorn, 'Hermann Brehmer'.

determine the fitness of patients for exercise, he required their temperature, taken rectally, to be recorded at two hourly intervals.[48]

Nutrition formed an essential element in Brehmer's treatment. Five meals were provided daily, a continental breakfast at 8am followed by a substantial breakfast incorporating bouillon and cold meats at 10am. Dinner served at 1pm consisted of soup, fish, roast, vegetables, salads and dessert. Afternoon coffee was served at 4pm and at 7pm a supper of soup and meat dishes. All patients were required to consume large quantities of milk, with febrile patients obliged to drink a pint of milk every hour. Wine was provided at all meals. Brehmer believed that the alcohol in wine counteracted the wasting effects of consumption and reduced the chills of hectic fever, while phosphates of lime and magnesium in the wine assisted in building up the body. He advocated the use of cognac to lessen the effects of night-sweats. The meals were served in a room, equipped with 'Kosmos ventilators', which changed the air five times an hour. Concerned with the effects of tobacco on the lungs, Brehmer banned smoking inside the sanatorium. He extended the ban to those areas in front of the glazed galleries and to locations in the grounds where patients tended to congregate. The religious needs of the Protestant patients were met in an adajacent chapel, while a priest from the Roman Catholic church at nearby Friedland visited the establishment once a fortnight. [49]

Brehmer's treatment regime brought all aspects of the patients' lives under the strict control of the physician.[50] His treatment methods were considered a success in European and American medical circles. Of the 700 patients treated at the sanatorium in 1887, 13% were recorded on discharge as cured, that is all symptoms of the disease had disappeared and sputum tests for tubercular bacilli proved negative over a five week period. The success rate was greater when applied to patients in the first stage of the disease, with 53% reported as cured on discharge.[51] A report on the first 5,000 patients treated revealed 27.8% in the first stage of the disease and 6.83% in the second stage of the disease cured and 31% of those in the first stage and 14.6% in the second stage almost cured. From

[48] The clinical thermometers then in use were too cumbersome to provide accurate mouth temperature recordings. Kinghorn, 'Hermann Brehmer'.
[49] Kretzschmar, 'Public health resorts'; Walters, *Sanatoria*, p. 151-3; Kinghorn, 'Hermann Brehmer'.
[50] The form of life style that could be anticipated by patients was illustrated by the motto which Brehmer had prominently displayed 'Die patienten kommen nicht um sich zu amusiren sondern um geheilt zu werden' (The patients do not come here to amuse themselves but to be cured). Kretzschmar, 'Public health resorts'.
[51] Kretzschmar, 'Public health resorts'.

these figures T. F. S. Caverhill concluded that every fourth consumptive of the well-to-do class treated by Brehmer was cured 'sufficiently to return to work with every appearance of good health'.[52]

A further development in the sanatorium movement occurred in 1876 when Peter Dettweiler, Brehmer's former patient and assistant, opened a sanatorium at Falkenstein in the Taunus Mountains.[53] Dettweiler was not at one with Brehmer regarding the treatment of patients. He believed that the 'Leigekur'[54] was an essential element in the treatment of consumptives. To facilitate this he designed special cane chairs where patients could rest while reclining. For patients with fever he insisted on 'cadaver ruhe'.[55] Believing that patients would find it easier to take the cure in company he developed 'Liegehallen',[56] which could be specially customised and fitted with weather protection covers against sun, rain, snow and wind.[57] In these the patients could spend from seven to eleven hours daily resting, in winter temperatures as low as –12°F, moving only for meals and for exercise. While exercising Dettweiler obliged patients to engage in lung gymnastics or forced respiration. This involved taking five or six deep breaths through the nose every 100 to 150 paces while walking or ten to twelve breaths every five or ten minutes while lying down.[58] With his emphasis on educating patients in the habits of healthy, clean living, Dettweiler developed a special receptacle for expectoration, which he presented at the German Medical Congress in April 1889.[59] The 'Dettweiler flask' became standard world-wide issue in sanatoria. He placed great emphasis on the laundering and disinfection of linen and handkerchiefs and the disinfection of rooms vacated by patients.[60]

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[52] Paper on 'The value of sanatoria and the need for their establishment in Great Britain' read by T. F. S. Caverhill medical officer of health to the County of Haddington at the sixty-sixth annual meeting of the British Medical Association held in Edinburgh 26-29 July 1898, reported in *BMJ*, ii, no. 1970 (1898), pp 946-7.
[53] Walters, *Sanatoria*, p. 177; Kinghorn, 'Hermann Brehmer'.
[54] Rest cure.
[55] Clive Riviere, 'A lecture on the principles of treatment of pulmonary tuberculosis' in *BMJ*, i, no. 3409 (1926), pp 771-5. Cadaver ruhe was absolute rest.
[56] Liegehallen (lying halls) were large porches, balconies or pavilions some of which rotated.
[57] C. Theodore Williams, 'Remarks on the open-air cure or hygienic treatment of consumption' in *BMJ*, i, no. 1997 (1899), pp 833-5.
[58] C. Theodore Williams, 'A lecture on the open-air treatment of pulmonary tuberculosis as practised in German sanatoria' in *BMJ*, i, no. 1951 (1898), pp 1309-11; Arthur Von Jaruntowsky, *The private sanatoria for consumptives and the treatment adopted within them*, trans. E. Clifford Beale (London, undated, original German edition Berlin, 1896), p. 17.
[59] Kinghorn, 'Hermann Brehmer'; Paul H. Kretzschmar, 'Notes on the prevention of pulmonary consumption' in *Public Health Papers and Reports*, xv (1889), pp 128-35.
[60] Walters, *Sanatoria*, p. 181.

The Falkenstein sanatorium, reflecting Dettweiler's beliefs, comprised a central block with two wings diverging at obtuse angles, which provided wind protection to an enclosed courtyard flanked by deep verandahs used as 'liegehallen'.[61] The building, set in only fourteen acres of ground on which walks were laid out and revolving shelters located, demonstrated Dettweiler's preference for rest over exercise.[62] The treatment followed similar lines to Gobersdorf in terms of hydrotherapy and nutrition but with more emphasis on adapting the programme to the individual needs of patients. Religious needs were met at the Roman Catholic church and synagogue in the village with Protestant services held twice a month in the boardroom.[63]

The efficacy of Dettweiler's treatment was demonstrated by follow-up enquiries made in 1898 on 132 patients, who had been discharged from Falkenstein completely cured ten years previously. He located 99 of these and received 95 replies. 11 of them had died allegedly from diseases other than tuberculosis. 12 had relapsed. The remaining 72 enjoyed sufficient good health to enable them to work although four had required further treatment at Falkenstein.[64] Even if the 33 missing patients were all counted as dead, an apparent long-term success rate of almost 55% in this category of patient could be considered a vindication of his methods. The natural defensive mechanisms of the body to halt the advance of tuberculosis, as demonstrated in Carl Rokitansky's post-mortem findings,[65] could however have brought about similar results. In the absence of statistical data from a cohort of untreated sufferers forming a control group an accurate determination of the efficiency of his treatment is not possible.

In 1888 Dr Otto Walther opened his sanatorium at Nordrach in Baden in the Black Forest. The location was chosen following an eighteen-month search through the Schwarzwald region to identify a site which met his specifications. His site required a subsoil capable of absorbing moisture, complete wind shelter, a southerly aspect to guarantee sunshine, pure dust-free air, an abundant supply of fresh water, means of

[61] Arnold C. Klebs, 'The construction and management of small cottage sanatoria for consumptives' in *Transactions of the American Climatological Association*, xvi (1900), pp 105-25.
[62] Walters, *Sanatoria*, pp 178-80; Williams, 'Remarks'.
[63] Walters, *Sanatoria*, p. 181.
[64] Caverhill, 'The value of sanatoria'.
[65] Rokitansky was the Viennese professor of pathological anatomy. His post-mortem work had revealed the existence of healed tuberculosis lesions in the healthy lung tissue of ninety per cent of those who had died from other causes. Kinghorn, 'Hermann Brehmer'.

transport and isolation from adjacent communities to enable patients to enjoy rest and tranquillity with no outside interference. The sanatorium commenced with one house of ten rooms. It was located in eighty acres of grounds at an elevation of 450 metres above sea level and surrounded by forests, through which the public enjoyed access via walking trails.[66]

By the mid 1890s Walther's Nordrach facility had expanded to four houses accommodating forty-one patients, with a 1898 extension housing a further four patients.[67] To prevent patients from attempting to exclude fresh air from their rooms no windows were provided. Instead window opes were equipped with shutters to exclude rain and light if required.[68] Walls and ceilings were faced with varnished wood, which was revarnished every time a room was vacated. Floors were covered with linoleum, which was washed daily.[69] There were no 'Liegehallen' and few bedroom balconies, reflecting Walther's belief that 'when patients are resting they should be segregated and quiet and not have the excitement of conversation or argument'. [70]

The Nordrach system entailed strict open-air treatment at all hours in all weather. Upon arrival patients were confined to bed to ensure that the disease was not in an active stage. If their temperature was within normal limits for eight successive days, a sign that the disease was quiescent, they were allowed to move to a couch. Following a further period of rest graduated exercise was commenced. This involved walking initially a few yards, gradually increasing to six or seven miles, as the body strengthened and occasionally extending to ten or fifteen miles. Walther required that the walk be conducted at a slow uniform pace, not exceeding two miles an hour, interspaced with frequent stops for rest. Only three or four patients were permitted to walk together and only three shelters were provided to prevent congregation, thus ensuring as little excitement as possible. To achieve the same objective, visits from friends or relations were discouraged. Leisure took the form of reading light literature. Occasionally music was provided. Objections

[66] Walters, *Sanatoria*, p. 190-1; 'A report on the open-air treatment of phthisis in sanatoria 1' in *BMJ*, i, no. 1948 (1898), pp 1164-6.
[67] 'A report on the open-air treatment of phthisis in sanatoria 1' in *BMJ*, i, no. 1948 (1898), pp 1164-6.
[68] C. Reinhardt, 'Notes on health resorts and sanatoria' in *BMJ*, ii, no. 1910 (1897), pp 362-3.
[69] Walters, *Sanatoria*, pp 191-2.
[70] Peverell S. Hichens, 'The sanatorium treatment of pulmonary tuberculosis with especial reference to Nordrach methods' in *BMJ*, i, no. 2202 (1903), pp 602-5.

were raised to attending religious services in Nordrach village although no regular services were provided at the sanatorium.[71]

Walther provided only three meals a day. Breakfast at 8am consisted of large quantities of bread and butter, coffee and cold meats. A three-course dinner served at 1pm provided meat or fish for the first course and meat or fowl for the second course, both accompanied by large quantities of potatoes and vegetables, followed by dessert and coffee. Supper at 7pm consisted of two courses, one cold as at breakfast and one hot as at dinner with occasionally soup, pancakes or cheese substituted for the cold dish. A half litre of milk was provided at all meals until sufficient weight gain had been achieved. Both dinner and supper were taken under the doctor's supervision, who insisted that everything was eaten under threat of dismissal from the sanatorium. Patients on this diet initially increased their weight by between two and four pounds a week with smaller gains of about a pound a week being experienced as time progressed. Total weight increments of forty to fifty pounds were not uncommon. [72]

Although Walther never published statistics of his results, the reputation in the British Isles of the Nordrach system of treatment appeared to exceed that of other continental sanatoria.[73] This was probably occasioned by the similarity of climate between the Black Forest and the British Isles and by the published observations of visitors to Walther's facility and comments on his regime by writers who had worked or been patients in the institution. These included R. Mander Smyth, a former patient of and later assistant to Dr Walther. He became house-physician to the Brompton Hospital for Consumption and Diseases of the Chest and subsequently proprietor of Linford Sanatorium.[74] Other English doctors, who had been treated at Nordrach, imported Walther's treatment methods into England or referred patients to the German facility.[75] Nordrach was held in such high regard that some newly-opened British sanatoria such as Nordrach-on-Dee, Nordrach-upon-Mendip and Nordrach-in-Wales, Pendyffryn Hall incorporated the name in their title. Many sanatoria adopted Dr Walther's treatment

[71] Walters, *Sanatoria*, pp 193-5; Hichens, 'The sanatorium treatment'; 'A report on the open-air treatment of phthisis in sanatoria 1' in *BMJ*, i, no. 1948 (1898), pp 1164-6.
[72] Walters, *Sanatoria*, p. 195; 'A report on the open-air treatment of phthisis in sanatoria 1' in *BMJ*, i, no. 1948 (1898), pp 1164-6; R. Mander Smyth, 'Remarks on the rational treatment of phthisis, with reference to Nordrach sanatorium' in *BMJ*, ii, no. 1970 (1898), pp 983-6; Hichens, 'The sanatorium treatment'.
[73] Hichens, 'The sanatorium treatment'.
[74] Mander Smyth, 'Remarks'.
[75] 'Obituary' in *BMJ*, ii, no. 3129 (1920), p. 955.

regime with suitable modifications to suit the food tastes of British patients (see appendix 1). Included in these were Moorcote, Brinkley. Pendyffryn and Timbercombe, which were under the control of and undoubtedly influenced by the experiences of former Nordrach patients while others, namely Linford, Nordrach upon Mendip and Nordrach on Dee were constructed specifically to mirror the German facilities.[76] The appreciation of the general public and the medical profession for Walther and his methods is evidenced by the Welsh sanatoria Nordrach in Wales and the Vale of Clwyd Sanatorium, which opened in 1901 advertising that their treatment was based on Nordrach principles, where their respective physicians had been patients.[77]

Swiss sanatoria

The Swiss sanatorium movement commenced in the 1860s. Based on the climatic advantages provided by their Alpine locations, these sanatoria became the treatment centres of choice of wealthy Irish, British and European tuberculosis sufferers.

On 8 November 1853 Dr Alexander Spengler, was appointed district doctor for the commune of Davos in the Swiss canton of Grisons. Davos is a sheltered Alpine valley situated *c*. 5000 feet above sea level. Located in this ten-mile long valley were the villages of Davos Dorfli, Davos Platz, Davos Frauenkirch and Glaris, with Monstein located in a side valley. While practising there, Spengler observed the almost complete absence of pulmonary tuberculosis. Incidents of the disease, which did occur, were found amongst natives who had returned from employment elsewhere. Upon their return they appeared to recover quickly with many regaining full health. This Spengler attributed to the effects of the Davos' air upon lung complaints. He conveyed his beliefs to Dr Meyer-Ahrens a balneologist who in 1862 published articles on the topic.[78] These articles were summarised in the German press. This brought the therapeutic nature of the Alpine climate to the attention of the public and German physicians, who began to refer tubercular patients to Davos. Similar observations had been made by Dr Lucius Ruedi in respect of Davos and by Dr Brugger in respect of the adjacent Upper Engadine valley, where he practised in St Moritz. These claims were brought to the attention of United

[76] Walters, *Sanatoria*, pp 333, 342-3, 351-2, 355, 358, 363, 369, 373-381, 386-391.
[77] *The Dublin Journal of Medical Science*, third series, no. 399 (1905), p. iii; *The Practitioner*, xc, no. 535 (1913), p. xviii.
[78] Balneology is the scientific study of bathing and mineral springs, focussing largely on the therapeutic use of such facilities in the treatment of disease.

Kingdom practitioners by Dr Herman Weber, then physician to the German Hospital in London. [79]

Initially consumptives spent only the spring and summer months at Davos, where they were accommodated in an old rathaus,[80] the twenty-room Hotel Strela the sole hotel in the village or in the houses of the inhabitants, as the local inns declined to admit such patients. In February 1865 two patients, who had been unsuccessfully treated at Gobersdorf, Dr Friedrich Unger and Hugo Richter arrived and spent the winter at the location.[81] Both these patients found themselves much improved in the Alpine climate.[82] Subsequent publicity led to a year-round demand from consumptives for accommodation at Davos. To meet this demand Dr Spengler, in 1867, commenced building a fifty-bed 'curhaus', a hotel specifically designed for invalids.[83] Although destroyed by fire in 1872, it was replaced by a larger building incorporating meeting rooms, a theatre and a dining room with accommodation for one hundred and eighty people.[84] To facilitate the open air treatment of consumptives 'every window has in its upper part a movable sash for ventilation, which may be opened at pleasure'. [85] By the end of the 1880s accommodation had expanded with five large and seven smaller hotels located in the two-mile-long strip incorporating Davos Platz and Davos Dorfli.[86]

Commensurate with the growth in accommodation was a rapid growth in winter visitor numbers rising from 70 visitors during the winter of 1869-70 to 700 in 1878-9.[87] In the winter of 1884-5 the number of visitors exceeded 1,000. Most of the visitors were German with English, Dutch, French, Belgian and American nationals well represented,

[79] J. Hauri, 'Historical Davos as commune and health resort' in *Davos as health resort, a handbook* (Davos, 1907), pp 1-56. Hermann Weber, 'Notes on the climate of the Swiss Alps and on some of their health resorts and spas' in *The Dublin Quarterly Journal of Medical Science*, lxxiii (1864), pp 15-43, 333-64. Weber was later knighted for his work on consumption.
[80] Townhall.
[81] Hauri, 'Historical Davos'.
[82] Hauri, 'Historical Davos'; 'Gemeinde Davos'('Municipality Davos') (www.regionalinfo-schweiz.ch) (13 June 2011). Unger survived until 1893 and Richter until 1921.
[83] Hauri, 'Historical Davos'.
[84] Hauri, 'Historical Davos'; E. De La Harpe, 'A winter visit to Davos' in *BMJ*, ii, no. 1299 (1885), pp 961-2.
[85] De La Harpe, 'A winter visit'.
[86] D. B. St John Roosa, 'The Engadine and Davos' in *Transactions of the Fifth Annual Meeting of the American Climatological Association*, v (1888), pp 221-8; A Tucker Wise, *Alpine winter in its medical aspects with notes on Davos Platz, Wiesen, St Moritz and the Maloja* (4th ed., London, 1888), p. 19.
[87] J. Burney Yeo, *Health resorts and their uses* (London, 1882) pp 114, 118. J. Burney Yeo was physician to King's College Hospital and professor of clinical therapeutics in Kings College London.

although very few of the visitors were Swiss.[88] By the late 1880s over 6,000 persons a year visited the resort, the majority in the winter months.[89] Of the 650 visitors present in December 1879, 180 were English, half of whom were consumptives, the balance composed mainly of travelling companions.[90] Hotels such as the Belvedere, the Buol and the Angleterre specifically catered for the English visitor's needs.[91] These establishments imposed an additional burden upon the relatives of dead consumptives by imposing a levy of between 300 and 1,000 francs for the complete destruction of the bed and bedding in rooms occupied by the deceased.[92] However 'in order to give a false impression as to the marvellous powers of the climate to delay death' local medical practitioners with the connivance of other locals suppressed the number of deaths occurring annually and it was not unknown for terminally ill patients to be rushed elsewhere to maintain the illusion of low death rates.[93]

Entertainment for visitors took the form of daily orchestral performances, weekly symphony concerts and theatrical productions.[94] Exercise in the form of walking, often incorporating mountain ascents, was most frequently engaged in. Without medical supervision tailoring exercise to the graduated needs of patients, the walking was frequently overdone to the detriment of the patient.[95] A Davos English Library Society was founded in 1886, providing patients with books of general interest.[96] By 1907 the Society's collection contained over five thousand volumes housed in a separate library building.[97] In winter skating was available. This, it was reported, had the beneficial effect of ridding 'the patient of that slouching carriage, which is too often among the prodromata of phthisis'.[98]

[88] De La Harpe, 'A winter visit'.
[89] Hauri, 'Historical Davos'.
[90] C. Theodore Williams, 'Christmas at Davos Platz' in *BMJ*, i, no. 940 (1879), pp 10-11.
[91] Roosa, 'The Engadine and Davos'; J. E. Muddock, *Davos-Platz as an Alpine winter station for consumptive patients* (London, 1881), p. 13; De La Harpe, 'A winter visit'.
[92] Muddock, *Davos-Platz*, p. 13; Alfred Wise, 'Destruction of bedding etc and disinfection for phthisis on the continent' in *BMJ*, i, no. 1154 (1883), p.277.
[93] Muddock, *Davos-Platz*, p. 13.
[94] Hauri, 'Historical Davos'.
[95] Weber, 'Notes on the climate'; Editorial 'Open –air treatment of phthisis' in *BMJ*, i, no. 1507 (1889), p.1108.
[96] 'Switzerland' in *BMJ*, i, no.1381 (1887), p.1359.
[97] Hauri, 'Historical Davos'.
[98] De La Harpe, 'A winter visit'; A. F. Bill, 'Phthisis and sport' in *Davos as health resort, a handbook* (Davos, 1907), pp 305-16.

In 1869 the Davos Evangelische Kurgemeinde[99] was founded to meet the religious needs of visiting German speakers. Initially its services were conducted in the various hotels until a permanent chapel was erected in 1883. From 1870 this association made deaconesses available to provide a nursing service for invalids.[100] To cater for the growing number of English visitors, in 1871 the Colonial and Continental Church Society dispatched a chaplain to hold services at the Curhaus during the summer months. He found no English members amongst the congregation, which was comprised solely of foreigners seeking to improve their English. As a result the service was abandoned but reinstated in 1874 with similar results. However it was decided to persist and in 1876 a winter service was introduced. In 1878 the service was transferred to the Belevedere Hotel with 144 persons attending the Christmas morning service there in 1881.[101] In 1878 the Boul family owners of the Hotel Boul donated a plot of ground to the English congregation. Following the raising of £3,000 by voluntary subscriptions, a church was constructed on the site, opening for services in March 1883. The church was dedicated to St Luke the physician, as the majority of the congregation were tuberculosis sufferers.[102] In 1879 a French visitor founded a Catholic chapel, which was later replaced by St Mary's Church, also funded by voluntary subscription. Nearby St Joseph's home was constructed from which Catholic nuns provided a nursing service. Under the auspices of the Evangelical Home Mission, St Paul's Church was constructed in1902.[103] Thus by the early twentieth century the religious needs of consumptives of many different religious persuasions were catered for.

In 1880 Dr Theodore Williams[104] accorded with many other physicians, including T. Clifford Allbutt[105] in maintaining that the antiseptic qualities of the high altitude found at Davos was an important means of cure, especially in its ability to reduce the discharge from ulcers and abscesses present in tuberculous lungs.[106] He also postulated that it was

[99] Davos Evangelical Invalids' Association.
[100] Hauri, 'Historical Davos'.
[101] W. G. Lockett, 'The English colony at Davos' in *Davos as health resort, a handbook* (Davos, 1907), pp 57-80.
[102] 'Freie Evangelische Gemeinde Davos' (www.feg-davos.ch) (16 June 2011).
[103] Hauri, 'Historical Davos'.
[104] Theodore Williams was the physician to the Brompton hospital.
[105] T. Clifford Allbutt was then physician to Leeds Infirmary and later professor of physic in the University of Cambridge.
[106] Theodore Williams, 'The curability of phthisis at high altitudes' in *BMJ*, ii, no. 1094 (1881), pp 975-6; T. Clifford Allbutt, 'Mountain air in the treatment of phthisis' in *BMJ*, ii, no. 982 (1879), p. 676; 'Obituary,

the diminished atmospheric pressure found at such high altitude that accounted for the improved chest condition of many patients.[107] He found that in Davos patients displayed 'a marked increase of appetite and gain of weight with augmentation of muscular strength'.[108] In 1883 Dr James Lindsay addressing the Ulster Medical Society stated that 'the proofs of the efficacy of the climate of Davos are yearly accumulating and can no longer be disregarded by the most prejudiced person'.[109]

However the unsupervised life style of invalid visitors drew criticism. One visitor in 1870 is quoted as querying the safety of accommodating large numbers of consumptives in hotels 'which are really consumptive hospitals, though not subject to the precautions used in consumptive hospitals'.[110] In 1902 Frederick Rufenacht Walters observed that 'many of the consumptives there are scarcely, if at all, under medical control and are apt to disregard the directions of their medical advisors, to their own hurt and possibly to the disadvantage of others'.[111] In February 1906 Dr Vere Pearson, arriving in Davos to complete his recuperation having been treated at Nordrach, found that 'medical supervision was never as close as at Nordrach […] and the temptations were great extending to dances, evening smoking, concerts and late card parties'.[112] In 1906 Dr William Huggard[113] observed large numbers of perfectly healthy people at Davos engaged in the many forms of recreation and social entertainments available. This active social milieu attracted 'invalids without much strength of character' who through engagement in these activities suffered from over excitement and fatigue thus obviating the very reasons for their presence at Davos.[114]

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the Right Hon. Sir T. Clifford Allbutt' in *BMJ*, i, no. 3348 (1925), pp 428-31;'Obituary, Charles Theodore Williams' in *BMJ*, ii, no. 2712 (1912), pp 1735-6.

[107] Williams, 'The curability of phthisis'.

[108] Williams, 'Christmas at Davos Platz'.

[109] James Alex Lindsay, 'The climatic treatment of phthisis' in *The Dublin Journal of Medical Science*, lxxvii (1884), pp 110-20. Lindsay was the physician to the Ulster Hospital Belfast.

[110] Yeo, *Health resorts*, p.122; J. Burney Yeo, *Climate and health resorts* (London, 1890), title page.

[111] Walters, *Sanatoria*, p. 288; Frederick Rufenacht Walters *British sanatoria for the open air treatment of tuberculosis* (London, 1899), pp 11-13.

[112] S. Vere Pearson, *Men, medicine and Myself* (London, 1946), p. 41. Pearson became one of the foremost British experts on tuberculosis. He served as medical superintendent in Mundesley sanatorium from 1905 to 1949 and was credited with building the hospital 'up to one of the most renowned sanatoria in the world'. 'Obituary, Sidney Vere Pearson' in *BMJ*, i, no. 4656 (1950), p.790.

[113] Dr William Richard Huggard, a native of Kilcock, Co. Kildare was the first British doctor to practice at Davos, having passed the Swiss medical examination in 1885, a prerequisite to practising in that country. He was later appointed English consul in Davos. Coester Brothers, 'English medical practitioners in the Grisons' in *BMJ*, i, no. 1434 (1888), p.1362. W. G. Lockett, 'A great Irishman Dr. W. R. Huggard' in *The Torque* (Apr., 1930), pp 14-23.

[114] William R. Huggard, *A handbook of climatic treatment including balneology* (London, 1906), pp 288-9.

A new phase in the treatment of tuberculosis at Davos commenced in 1888 when a sanatorium opened under the direction of Dr Karl Turban. The four-storey building, fronted with 80-metre long galleries where the patients took their rest cure, faced south to facilitate the maximum penetration of sunlight. The building was designed to accommodate 85 patients. Extensions in 1894 provided two villas linked to the main building by closed galleries, one occupied by patients and the other by Dr Turban's family. By 1890 this building had become the model for Alpine sanatoria and was visited by many architects and doctors planning such sanatoria. The addition of a new wing in 1905 increased the accommodation to 130 beds. This wing attached to the main building by a covered gallery was used to house the severest cases and by their isolation achieved two objectives. Firstly it prevented these virulent patients from re-infecting those in whom the disease was in a quiescent phase and secondly it provided seriously ill patients with quiet surroundings, in which constant medical supervision and intensive nursing could be provided. Titled Deutsche Heilstatte fur minderbemittelte Lungenkranke,[115] the institution treated mainly lower middle class patients although it also included a small number of students and professional men. The total weekly charge for accommodation, treatment and medicines in the sanatorium was between £4 and £5. Treatment followed the methods laid down by Brehmer and Dettweiler. Certain patients were allowed to do light gardening but generally outdoor amusements were prohibited and exercise restricted. From the early 1900s tuberculin was prescribed for patients with its use becoming obligatory from the middle of that decade. [116]

In 1899 Dr Turban published statistics showing that during the previous seven years 66.1% of the patients he treated were 'absolutely or relatively cured' being discharged in a 'normal state of health'. This state was retained by 48% of them from one to seven years after discharge.[117] The success rate amongst those only slightly affected with tuberculosis (the first stage), showed a rate of 97.5% permanently cured.[118] Of the

[115] German sanatorium for people of limited means suffering from lung disease.
[116] S. A. Knopf, *Pulmonary tuberculosis its modern prophylaxis and treatment in special institutions and at home* (London, 1899), p.121; 'Davos Platz II sanatoriums and hotels' in *BMJ*, ii, no. 2394 (1906), pp 1407-10; Dave Lathi 'The influence of good air on architecture. A «Formal Cure» ? The appearance of the Alpine sanatorium in Switzerland, 1880-1914' in *Revue de geographie alpine*, xciii, no. 1 (2005), pp 53-60; Von Jaruntowsky, *The private sanatoria*, p. 45.
[117] Herman Weber and F. Parkes Weber, *Climatotherapy and balneotherapy* (London, 1907), p. 676; Edward H. Doughty, 'Climate and the cure of consumption' in *BMJ*, i, no. 2001 (1899), pp 1128-9.
[118] Doughty, 'Climate and the cure of consumption'.

combined total of patients in the first and second stages of the disease 89% were described as showing benefit from the treatment.[119] Even amongst those in the third stage of the disease, with extensive and serious disease of the lungs, 17.4% were permanently cured.[120] Results published of the 187 patients discharged in 1905 revealed that 155 (82.9%) were improved with 81 fit for work and 60 partially fit for work.[121]

In 1893, under the auspices of the Basle Medical Association, the Basler Gesellschaft fur das gute und Gemeinmutzige[122] was founded to counteract the prolonged health and economic effects of tuberculosis on the local working class. Having purchased a suitable plot of ground at Davos its sanatorium opened on 14 December 1896. [123] The sanatorium with accommodation for 90 patients benefited those from the working and small shopkeeper classes with occasional middle-class pastors, missionaries, students and schoolmasters admitted.[124] In October 1896 the Association established the Basler Hilfsverein fur Brustkranke[125] to receive subscriptions to offset any financial shortfall from their operations, inevitable because of the class of patient treated.[126] The association funded educational programmes on the prevention of tuberculosis and found suitable employment for released patients.[127] With drugs used only for palliative purposes treatment was based on diet (five meals a day and milk at bedtime), fresh air and graduated exercise. A minimum stay of three months was required, although no maximum period was prescribed.[128]

In 1905 Dr Burckhardt carried out a comparative study in Basle of those who had been treated in the sanatorium and those who had received other forms of treatment in the general neighbourhood. He found that at the end of three years following the completion of treatment, 79% of those who had been treated in the sanatorium were able to work, 7% of the ex-sanatorium patients were invalids and 14% had died. The comparative figures

[119] 269 out of a total of 302 patients. S. Edwin Solly, 'Sanatorium treatment and its relation to climate' in *The Philadelphia Medical Journal*, vi, no. 22 (1900), pp 1039-43.
[120] Doughty, 'Climate and the cure of consumption'.
[121] 'Davos Platz II sanatoriums and hotels'.
[122] Basle Association for the Common Good.
[123] Daniel Gredig, 'Tuberculosis welfare in Basle; institutionalising and professionalising social work in the context of middle and upper class charity' in Gisela Hauss and Dagmar Schulte (eds), *Amid social contradictions; towards a history of social work in Europe* (Leverkusen Opladen, 2009), pp 47-68.
[124] 'Davos Platz III. The Basle Sanatorium' in *BMJ*, ii, no. 2395 (1906), pp 1497-8.
[125] Basle Auxiliary for Pulmonary Diseases.
[126] Gredig, 'Tuberculosis welfare in Basle'.
[127] Walters, *Sanatoria*, pp 302-3.
[128] 'Davos Platz III. The Basle Sanatorium'.

for the non-sanatorium patients were 39% working, 23% invalided and 33% dead. At the end of six years following treatment the relevant figures for ex-sanatorium patients were 58% working, 7% invalided and 24% dead whilst of those patients treated otherwise than in sanatoria 21% were working, 21% invalided and 55% dead.[129] Even allowing for greater selectivity of sanatorium patients, the fact that Davos sanatorium treatment facilitated a return to economic activity and prolonged the lifespan of former patients could not be denied.

The initial success of these two sanatoria encouraged the development of others along similar lines at Davos. In 1897 a Dutch society, funded by voluntary subscribers, leased a private house and adopted it as a sanatorium exclusively for poor Dutch nationals.[130] The same year the 'international sanatorium', a kosher sanatorium for members of the Jewish faith, opened.[131] Also that year the fifty-five bed 'New Davos Sanatorium' for the reception of 'well-to-do' patients opened.[132] Constructed between 1898 and 1900, at a cost of $500,000, on a small plateau on the slopes of the Schartz Alp and connected to the town of Davos by a funicular railroad was the Schatzalp sanatorium. 'A palatial institute with a marble floor and every scientific apparatus of the latest date' it was intended for members of the richer class.[133] By 1906 there were eleven private and three public sanatoria in operation at Davos.[134]

In 1881 Mrs J. W. Lord established an invalids' home at Davos for the reception of ladies and gentlemen of limited means who required treatment in an Alpine climate.[135] Her aim was to develop the home into an English national sanatorium.[136] When in 1895 illness prevented Mrs Lord's participation in the project, a committee was appointed to run the home, thenceforth titled 'The Davos Invalids Home', as a public institution funded by public subscriptions. [137] In 1898 the committee acquired a 5 acre site, elevated some

[129] W. C. Rucker and R. A. Kearny, 'Tuberculosis in Switzerland, results of the campaign against the disease' in *Public Health Reports*, xxviii, no. 52 (1913), pp 2815-29.
[130] Walters, *Sanatoria*, pp 304-5.
[131] 'Davos Jewish history from the end of the 19th century until around 1920: Jewish spa/formation of a Jewish community' (www.alemannia-judaica.de/davos_juedgeschichte.htm) (21 Sept. 2011).
[132] Walters, *Sanatoria*, p. 291; Solly , 'Sanatorium treatment'.
[133] Solly , 'Sanatorium treatment'; Edward Jepson, 'The treatment of consumption at Davos Platz' in *BMJ*, ii, no. 2548 (1909), p. 1314.
[134] 'Davos Platz II sanatoriums and hotels'.
[135] *The Times*, 2 Feb. 1903.
[136] 'The Queen Alexandra Sanatorium Davos' in *BMJ*, ii, no. 2535 (1909), p. 292.
[137] Walters, *Sanatoria*, p. 306.

300ft above the town, for £6,000.[138] With Princess Alexandra of Wales granting her royal patronage to the project in 1899, the project was retitled. 'The Queen Alexandra Sanatorium Davos' upon the accession of her husband to the throne in 1901.[139]

A local fund-raising committee was charged with managing the new institution under the presidency of Dr William Huggard.[140] A London-based committee under the chairmanship of Lord Balfour was established, with a view to seeking contributions to construct the hospital which would 'secure sanatorium treatment in an Alpine climate for English-speaking people suffering from curable forms of pulmonary disease unable to bear the entire expense of treatment'.[141] The target sum required to complete the project was £38,000. Despite not achieving the target, contracts were placed and construction commenced with an expected completion date of mid 1909. The anticipated shortfall was of the order of £5,000. However in July 1909 an anonymous donor 'his interest…stirred by the fact that the Queen had given her name to the sanatorium and was taking a personal interest in its success' made a contribution of £25,000'.[142] This provides a striking example of the importance of royal patronage. The sanatorium opened on 15 November 1909. Its fifty-four separate bedrooms, which had been pre-engaged, were occupied by the end of the opening week. A further seventeen patients were awaiting accommodation.[143]

The development of sanatoria at Davos was soon mirrored at other Swiss Alpine locations such as Arosa, Wiesen, Montana, Leysin, Les Avants and St. Moritz. In 1902 Dr Auguste Rollier settled as a general practitioner in Leysin, a Swiss Alpine village 4,500 feet above sea level. There he observed the healing properties of the sunrays particularly on non-pulmonary tuberculosis. [144] He began to study the role 'played by the skin in the functioning of the whole organism'. Resulting from his observations he advocated applying sun-rays to the whole of the patient's naked body (heliotherapy). His methods centred on his theory 'that in whatever part of the body it may occur tuberculosis is never, as was so long believed, a local ailment but on the contrary a

[138] *The Times*, 2 Feb. 1903; 'Medical News' in *BMJ*, ii, no. 2270 (1904), p. 26.
[139] 'The Queen Alexandra Sanatorium Davos'; William Ewart, 'Alpine or home climates for early tuberculosis' in *BMJ*, i, no. 2507 (1909), pp 133-6.
[140] 'A new sanatorium at Davos' in *BMJ*, i, no. 2250 (1904), p. 403.
[141] 'Medical News' in *BMJ*, ii, no. 2270 (1904), p. 26.
[142] *The Times*, 17 July 1909.
[143] Ibid., 15 Nov. 1909.
[144] 'Obituary Auguste Rollier' in *BMJ*, ii, no. 4897 (1954), pp 1169-70.

generalised disease involving the whole body therefore treatment must first be directed towards the reconstruction of the entire organism'.[145] Exposing the organism to the beneficent action of the sun would progressively increase its defence 'making it better fit for the fight against tuberculous infection'. The sun also had an edifying effect on patients' mental well-being, which Rollier considered extremely important for those who had to spend long periods in bed. To give effect to his theories he opened his first clinic combining air-cure with systematic heliotherapy at Leysin in 1903.[146]

Rollier's treatment was aimed at restoring to the world individuals 'no longer maimed or deformed but normal and vigorous and capable of working for their living'.[147] The treatment was achieved by the gradual exposure of the patient to direct sunlight and air, initially while resting in bed. The average time from commencement of treatment, when only the feet were uncovered, until full body exposure was achieved was fifteen days, after which daily sunbathing of 2-3 hours in summer and 3-4 hours in winter was applied.[148]

The perceived success of his methods was such that by the mid 1930s Rollier had developed thirty-four separate clinics at Leysin, each with its own on-site director. Leysin had both Catholic and Protestant churches and the local Roman Catholic priest and the resident English chaplain were willing to visit all patients who desired their ministrations.[149] By 1941 the number of clinics had increased to forty-one at which stage Rollier claimed an 80% cured success rate with a further 16% discharged considerably improved. The reason advanced for the failure to completely cure this 16% was that most of them had secondary septic infections thus making the disease 'very intractable and difficult to cure'. Only 3% of the patients' health remained unchanged and 1% had died.[150]

[145] 'The sun cure in Professor Rollier's clinics at Leysin', brochure, 1936 (LMA, PH/GEN/04/142)
[146] A. Rollier,'The share of the sun in the prevention and treatment of tuberculosis' in *BMJ*, ii, no. 3225 (1922), pp 741-5.
[147] A. Rollier, 'Heliotherapy: its therapeutic, prophylatic and social value' in *The American Journal of Nursing*, xxvii, no. 10 (1927), 815-23.
[148] R. A. Hobday, 'Sunlight therapy and solar architecture' in *Medical History*, xli, no. 4 (1997), pp 455-72.
[149] 'The sun cure in Professor Rollier's clinics at Leysin', brochure, 1936 (LMA, PH/GEN/04/142)
[150] S.N. Sinha, *Tuberculosis and the sun treatment* (Calcutta, 1941), p. 29.

The methods of treating surgical tuberculosis developed by Auguste Rollier at Leysin formed the basis of the therapies subsequently used by Irish orthopaedic institutions as discussed in chapter 8.

The evolution of the tuberculosis dispensary

The concept of providing tuberculosis dispensaries as key adjuncts to sanatoria was developed by Robert Philip. These dispensaries, wherein the disease could be diagnosed and treatment and advice provided, became a central element in many European treatment schemes.

In 1883, the year following his qualification to practice medicine, the Edinburgh-born Robert William Philip undertook postgraduate work in Leipzig, Vienna and Berlin.[151] In Vienna he observed for the first time the tubercle bacillus. This awoke his interest in tuberculosis.[152] Upon returning home he was appointed as a house physician in the Edinburgh Royal Infirmary and in 1885 physician to the New Town Dispensary.[153] He observed how poorer consumptive patients were treated in the outpatients department of these institutions and similar hospital outpatient departments and general dispensaries in the city. Due to lack of space in hospitals, allied to an unwillingness to admit tuberculosis patients, these were the only facilities available to the poor. If consumption was diagnosed, patients were prescribed 'some form of cough mixture' and cod-liver oil to alleviate symptoms and invited to visit from time to time for similar treatment. Upon becoming too ill to attend they were relegated to a list of chronic or troublesome patients whose only recourse to treatment was occasional visits 'by a frequently-changing series of medical students, whose conception of treatment [...] did not extend very far'.[154]

Philip concluded that existing practices largely ignored the aetiology of the disease, the impact of environmental factors and 'its tractability when efficiently handled for a sufficient period'.[155] He believed that a 'fresh line of procedure' was required, which

[151] 'Obituary, Sir Robert Philip' in *BMJ*, i, no. 4074 (1939), pp 251-4.
[152] Robert Philip, 'Musings in the garden, fifty years' association with the tubercle bacillus' in *BMJ*, i, no. 3833 (1934), pp 1105-10.
[153] 'Obituary, Sir Robert Philip'; A. T. Wallace 'Sir Robert Philip: a pioneer in the campaign against tuberculosis' in *Medical History*, v, no. 1 (1961), pp 56-64.
[154] Robert Philip, 'The actual place and function of the tuberculous dispensary in the tuberculosis scheme' in *BMJ*, ii, no. 3418 (1926), pp 55-7; R.W. Philip, 'An address on the organization of the home treatment of pulmonary tuberculosis' in *BMJ*, i, no. 2267 (1904), pp 1357-60.
[155] Philip, 'The actual place'.

necessitated the scrapping of existing methods and the institution of 'a new order of things'. This required a well-equipped dispensary, to which poorer patients and their friends could be directed to receive supervised treatment, either there or at home, coupled with advice, instruction and, for suitable individuals, referral to appropriate institutions.[156] In 1887 he approached the Edinburgh authorities to provide such an institution in honour of Queen Victoria's jubilee. However a 'wet blanket was thrown on the project' when the authorities adopted an alternative scheme to send tubercular patients to country cottages. This led Philip to successfully seek voluntary aid to realise his project.[157]

Having secured funds, Philip began a multi-faceted comprehensive programme, containing both diagnostic and educational aspects, by leasing three upstairs rooms at Bank Street, Edinburgh, moving in 1891 to larger premises at Lauriston Place.[158] The new premises contained two consulting rooms, a dark room for laryngoscopical examination, a waiting room, two dressing rooms, an office, a laboratory and a pharmacy.[159] The programme instituted by Philip required the compilation of a detailed history of the patient's illness, their present condition and environmental surroundings, at home and at work. Bacteriological examination of the patient's sputum and other discharges was undertaken to determine the presence of tuberculosis. Patients and their friends were instructed in the proper precautions required to maximise the benefits of their treatment and to minimise the risk of infection to others. The educational remit also involved the systematic distribution of leaflets on the precautions to be taken by consumptives and their associates. Medicine, sputum flasks, disinfectants and food were distributed to patients. Home visits were made for the dual purpose of treatment and ascertaining environmental conditions and the risk of infection to others. Patients were selected for sanatorium treatment or for incurable homes as appropriate.[160]

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[156] Robert W. Philip, 'Present day outlook on tuberculosis' in *Edinburgh Medical Journal*, xx, no. 5 (1918), pp 289-306; Robert Philip, 'The actual place'.
[157] Robert Philip, 'Malcolm Morris memorial lecture on the outlook on tuberculosis: changing orientation' in *BMJ*, i, no. 3653 (1931), pp 43-9.
[158] Wallace 'Sir Robert Philip'.
[159] Philip, 'An address on the organization'.
[160] R. W. Philip, 'An address on the public aspects of the prevention of consumption' in *BMJ*, ii, no. 2396 (1906), pp 1529-35: R. W. Philip, 'The erection of municipal dispensaries and a completer organization against tuberculosis' in *Edinburgh Medical Journal*, xix, no. 1 (1906), pp 7-12; R. W. Philip, 'A lecture on the anti-tuberculosis programme: co-ordination of preventative measures' in *BMJ*, ii, no. 2494 (1908), pp 1141-4; R. W. Philip, 'The tuberculosis dispensary' in 'Discussion on the administrative control of tuberculosis' in *BMJ*, ii, no. 2640 (1911), pp 260-7.

Philip's Edinburgh programme was supervised by four physicians, three being employed on an honorary basis. The paid physician, in addition to dispensary duties, was responsible for making home visits. He was assisted by a trained nurse, who assumed many of the duties of advising patients and compiling reports on their home conditions. A voluntary ladies' samaritan committee was established to 'take charge of the more distressing cases'. With many affected families in financial distress, members of this committee visited them at home and through contact with the numerous charitable organisations operating in the city adapted relief programmes tailored to individual family needs. Such programmes sought employment for sufferers unable to engage in their former occupations or able to partake only of part-time work.[161]

Observing the insanitary and overcrowded conditions in which many consumptive patients lived, frequently sharing a room or bed with other persons, Philip introduced an examination regime referred to as the 'march past'. Under this regime family members and other contacts of consumptives, received a thorough medical examination with a view to detecting 'particularly minor degrees of tuberculosis'. Initially this involved a 'thorough examination of the lymphatic system at every available point' with any minor degree of glandular enlargement been taken as an indicator of the existence of the disease. This system detected many early tuberculosis cases which otherwise would have been missed and provided early treatment by distributing suitable cases amongst the institutions available. However the 'majority were well treated at home'.[162]

From the experience gained at the dispensary, Philip developed his concept for a complete tuberculosis service, operated by the municipal authority, with the dispensary at its core. Under the system named 'The Edinburgh Scheme' all tuberculosis patients were referred to the dispensary, which acted as a clearing house determining the appropriate form and location of treatment.[163] This dispensary-centred scheme required an association with a sanatorium to which selected patients could be referred, 'with a view to the effective arrest of the disease'.[164] In 1894 supporters of the dispensary established

[161] Philip, 'An address on the public aspects'; Philip, 'A lecture'.
[162] Philip, 'An address on the public aspects'; Philip, 'The tuberculosis dispensary'; Philip, 'The actual place'; Philip, 'Musings in the garden'.
[163] Philip, 'Musings in the garden'.
[164] Philip, 'The erection of municipal dispensaries'.

the Victoria Hospital Tuberculosis Trust and raised funds to lease Craigleith House, a Georgian mansion located a mile north of Edinburgh. On 22 November 1894 a twelve-bed sanatorium was opened there.[165] Early cases formed two distinctive groups. The first consisted of patients treated for 'a prolonged period until complete cure or definite arrest of the disease is effected'. The other group was those patients accommodated for a short time, sufficient to learn the methods of treatment, which would subsequently be carried out at home.[166]

Philip believed that advanced cases constituted 'the greatest source of infection'. As these patients often shared one or two rooms with an entire family, he insisted that 'all such patients require immediate removal to a hospital reserved for advanced and dying cases of consumption'. In 1899 he sought the agreement of the municipal authorities to reserve a portion of the City Hospital for such purposes. In 1900 a report by Bailie Pollard, recommending reserving 100 beds in the hospital for such patients, was ignored. However in 1906 a fifty-bed unit in the new City Hospital was allocated for their reception. To protect public health Philip considered, that 'save for quite exceptional circumstances', such patients, once hospitalised, must not be discharged but rather retained until their demise.[167]

In 1898, observing that a former patient, who had suffered from severe pulmonary and laryngeal tuberculosis, was thriving in employment as an auxiliary gardener at the Victoria Hospital, Philip conceived the idea of a tuberculosis colony. The colony would provide a place where poor patients, in whom the disease had been arrested but were unable to return to former employment, could maintain themselves under medical supervision for prolonged periods.[168] By 1906 Philip had formed a 'kind of working colony' at the Royal Victoria Hospital, where two-thirds of the eighty patients in the institution were engaged as joiners, painters, engineers, gardeners, bath attendants, laboratory assistants, grooms, handymen and in various branches of household work.[169] In 1910, in association with the Victoria Hospital, Polton farm colony was opened seven

[165] Alan Ross, 'History of the Royal Victoria Hospital, Craigleith Road, Edinburgh', 2012 (www.craigleithhill.co.uk) (20 June 2012).
[166] R. W. Philip, 'Organization and co-ordination of effort against tuberculosis' in *BMJ*, i, no. 2356 (1906), p. 472.
[167] Philip, 'An address on the public aspects'.
[168] R. W. Philip, 'Remarks on the universal applicability of the open-air treatment of pulmonary tuberculosis' in *BMJ*, ii, no. 1960 (1898), pp 217-20.
[169] Philip, 'An address on the public aspects'.

miles south of Edinburgh for the training of patients.[170] This provided the final element in Philip's scheme of a dispensary allocating patients to sanatoria, to hospitals for advanced cases and to worker colonies.

Although Philip's concept of a tuberculosis dispensary was slow to be adopted, a dispensary was opened in Glasgow in 1898, in association with the Bridge of Weir sanatorium.[171] European authorities soon followed, with a dispensary opened by Dr Malvoz in Liege in Belgium in July 1900. In the following months, dispensaries were established in the Belgian cities of Verviers, Huy and Mons. On 1 February 1901, Albert Calmette opened an anti-tubercular dispensary at Lille, in association with the Pasteur Institute. The dispensary largely followed Philip's ideas, however greater emphasis was placed on welfare measures, which included the provision of food, bedding and clothing, the payment of rent and if required relocation from unhealthy tenements to better quarters 'in an airy district'. In July 1901, a dispensary was opened at Montmartre in Paris, funded by a local industrialist and funds had been raised to provide similar institutions at Arras and Nantes.[172] Further support for the development of dispensaries was provided in July 1901 when the international British Congress on Tuberculosis in London resolved

> That while recognising the great importance of sanatoria in combating tuberculosis in every country, the attention of Governments should be directed towards informing charitable and philanthropic individuals and societies of the necessity for anti-tuberculous dispensaries as the best means of checking tuberculous disease amongst the industrial indigent classes. [173]

By 1905 over fifty dispensaries had been opened in France.[174] In Germany, in the six years following the opening of the first dispensary in Berlin in 1905, local associations

[170] Wallace 'Sir Robert Philip'. Philip provides 1909 as the date of opening however the records of the hospital held in the Lothian Health Services archive at the University of Edinburgh gives the date as 1910 (http://archiveshub.ac.uk/features/tb.shtml) (20 June 2012). Similarly Wallace states that the colony was for the training of men but photographic evidence retrieved from the Lothian Health Services archive and available on the Royal Commission on the Ancient and Historical Monuments of Scotland website (www.scran.ac.uk) (20 June 2012) show female tuberculosis patients planting potatoes on the farm, although from their clothing this may be from a later period.
[171] Neil Munroe McFarlane, 'Tuberculosis in Scotland 1870-1960' (PhD thesis in history, University of Glasgow, 1990), p. 24.
[172] A. Calmette, 'The 'Emile Roux' anti-tubercular dispensary at Lille' in *Transactions of the British Congress on Tuberculosis for the prevention of consumption, London, July 22nd to 26th 1901* (4 vols. London, 1902), ii, pp 447-61. (*Transactions etc.* Henceforth *Transactions of the British Congress 1901*).
[173] R. W. Philip, 'The tuberculosis problem as effected by the British Congress on Tuberculosis' in *Edinburgh Medical Journal*, x, no. 3 (1901), pp 205-22.
[174] Neil Munroe McFarlane, 'Tuberculosis in Scotland 1870-1960' (PhD thesis in history, University of Glasgow, 1990), p. 24.

provided over 600 dispensaries. With the exception of the dispensing of medicines, although occasional tuberculin treatment was provided, these followed the Edinburgh programme including the 'march past'.[175] In 1909 the first dispensary in England, following Philip's regime, was founded at Paddington, London.[176] In 1912 the departmental committee on tuberculosis, under the chairmanship of Lord Astor and with Philip included in its membership, was established to report upon general policy in relation to tuberculosis, which would guide the government and local bodies in making provision for the treatment of the disease. The committee recommended the implementation of the Philips scheme, under the management of county councils and county boroughs or joint committee of such bodies, throughout the United Kingdom.[177]

Conclusions

During the time of the Roman Empire physicians developed an understanding of the symptoms of tuberculosis and the benefits derived from fresh air and good diet in its treatment. Advances in diagnostic medicine and pathology in the ensuing two millennia enabled practitioners to build on this early medical knowledge and its treatment philosophies. A general concurrence developed that treatment of the disease could best be effected through the exposure of patients to fresh air, possibly in a changed climate, while ensuring proper rest, graduated exercise and adequate nutrition. This treatment philosophy underpinned the sanatorium movement.

From the mid 1850s, the emergence of the German sanatorium movement of specifically-constructed institutions, in which to apply and expand the then existing tuberculosis therapies, paved the way for their replication elsewhere. In the late 1860s, based on the climatic advantages provided by their Alpine locations, a sanatorium movement developed in Switzerland, extolling the benefits of high-altitude treatment. Switzerland became by the early twentieth century an important location in which mainly wealthy patients sought a cure for the disease. From the early 1900s to the 1940s Dr Auguste

[175] *Departmental Committee on Tuberculosis. Final report of the Departmental Committee on Tuberculosis, Volume II. Appendix*, 1 [Cd 6654], H.C. 1912-13, xlviii, 47. (Henceforth *Final report of the Departmental Committee on Tuberculosis. Volume II*.).
[176] Linda Bryder, *Below the magic mountain* (Oxford, 1988), pp 33-4.
[177] *Departmental Committee on Tuberculosis. Interim report of the Departmental Committee on Tuberculosis*, 1 [Cd 6164], H.C. 1912-13, xlviii, 1. (Henceforth *Interim report of the Departmental Committee on Tuberculosis*). *Departmental Committee on Tuberculosis. Final report of the Departmental Committee on Tuberculosis. Volume I. Report*, 1 [Cd 6641], H.C. 1912-13, xlviii, 29. (Henceforth *Final report of the Departmental Committee on Tuberculosis. Volume I*).

Rollier developed his institution at Leysin Switzerland centred on the benefits of heliotherapy as a treatment for all forms of tuberculosis. An important function of both the German and Swiss movements was administering to the religious needs of patients.

In the early 1890s Dr Robert Philip commenced developing his tuberculosis treatment scheme in Edinburgh, with the tuberculosis dispensary at its core providing a locus for patient education and initial diagnosis and treatment pending allocation to sanatoria. His scheme incorporated hospitals for advanced cases and worker's colonies. As his concept was adopted internationally, the tuberculosis dispensary formed the cornerstone of many schemes for the treatment of tuberculosis, especially those ministering to poorer patients.

Chapter 2
The establishment and early years of the National Hospital for Consumption for Ireland 1891-1907

The German sanatorium model came to Ireland via Ventnor (Isle of Wight) in the 1890s. Mirroring its European counterparts the National Hospital for Consumption for Ireland was constructed at Newcastle County Wicklow. Crucial to its development was the role played by members of the aristocracy although religious conflict and disputes over site selection had to be overcome before the project commenced. Replicating British and continental developments small private sanatoria also opened.

Ventnor a model for Ireland

The Royal National Hospital in Ventnor, Isle of Wight, developed in the 1860s and 1870s, in terms of design and governance provided the model for the development of Ireland's first national sanatorium.

In E. F. Laidlaw's history of the Royal National Hospital Ventnor, he describes how prior to Koch's discovery of the tuberculosis bacillus, Arthur Hassall was convinced of the infectious nature of the disease. Believing that large numbers of patients at various stages of the disease should not be housed together in large wards, Hassall developed the concept of the 'separate principle', whereby every patient had their own separate bedroom. Applying this principle, in 1868 he constructed a pair of cottages at Ventnor on the Isle of Wight with twelve individual bedrooms available for patients. It was in Ventnor that Hassall, a former pulmonary tuberculosis sufferer, had seemingly recovered due to its location and sunny sheltered climate. To assist with the finances each patient was required to make a small contribution, initially set at 10/- per week. The treatment employed was the 'sanatorium regime', an ample diet to counteract the wasting nature of the disease coupled with plenty of rest and exposure to as much fresh air as possible. [1]

The hospital, on a 6.5 acre site, augmented in 1873 by the acquisition of a further fifteen acres, was designed to be built in a modular fashion.[2] The initial plan provided for two

[1] E. F. Laidlaw, *The story of the Royal National Hospital Ventnor* (Newport, Isle of Wight, 1990), pp 10-11, 14, 19, 28. Laidlaw was a member of the hospital's medical staff from 1947 until its closure in 1964. His history is based on the annual reports of the hospital extant for the period 1869 to 1923, incomplete minutes, medical journals, newspaper archives, the biography of the founder Arthur Hill Hassall '*The Narrative of a busy life*', two biographies of Hassall written by E.G. Clayton and E. A. Gray and his own personal recollections.
[2] Laidlaw, *Royal National Hospital,* pp 37, 39.

groups of four blocks separated by a chapel. Each block comprised two three-storey cottages. Each cottage contained two ground floor sitting rooms with three bedrooms on each of the upper floors. The bedrooms were south facing and equipped with French windows, which opened to provide access to verandahs, sufficiently wide to allow febrile patients spend all day and, weather permitting, night reclining there.[3] In 1875 a £70,000 bequest allowed work commence on a block providing a large dining hall, a central kitchen and further bedroom accommodation.[4] Additional blocks, providing bedroom and sitting room accommodation, were completed in 1883 and 1897. Although at first heated by inadequate hot water pipes supplemented by open fires, on the advice of Professor de Chaumont a new ventilation system was installed. This system provided for the drawing into each bedroom, at a rate of 5,000 cubic feet an hour, air warmed to a temperature of 62°F. The stale air was evacuated through a system of interconnected vents.[5]

The layout of the hospital provided for the complete separation of male and female patients. As the blocks were constructed they were successively occupied solely by either male or female patients. When the large dining room was provided strict segregation at tables was applied with separate routes dictated for accessing the dining premises.[6] Segregation also applied to staff with the males dining in the administration block and the females in block eight.[7] The gardens were laid out so that the western half was available only to male patients, whilst the eastern half was restricted to female patients.[8] To encourage patients to spend time outdoors the gardens were provided with sheltered seats and lawns suitable for games.[9]

As only patients in the early stages of the disease were admitted, medical practice dictated that they required good nursing with medical comforts in a suitable climate rather than active medical treatment.[10] Accordingly overly-generous rations of good food

[3] 'A report on the open air treatment of phthisis in sanatoria 111' in *BMJ*, i, no. 1951 (1898), pp 1356-7; J. G. Sinclair Coghill, 'Sanatoria for the open air treatment of consumption' in *BMJ*, ii, no. 1959 (1898), pp 206-7; Walters, *Sanatoria*, p. 330.
[4] Laidlaw, *Royal National Hospital*, p. 41.
[5] Ibid., pp 44-5; 'A report on the open air treatment of phthisis in sanatoria 111' in *BMJ*, i, no. 1951 (1898), pp 1356-7.
[6] Laidlaw, *Royal National Hospital*, pp 53-4, 57.
[7] Ibid., p. 50.
[8] Ibid., p. 38.
[9] 'A report on the open air treatment of phthisis in sanatoria 111' in *BMJ*, i, no. 1951 (1898), pp 1356-7.
[10] 'The Ventnor hospital for consumption' in *BMJ*, i, no. 948 (1879), p. 322.

were prescribed. The diet demanded the drinking of large volumes of milk, with bacon, eggs and sausages or fish accompanied by bread served for breakfast, meat and vegetables followed by dessert for dinner and bread and butter with beverages for tea. Patients were also expected to consume nourishment at elevenses and supper with emphasis placed upon the benefits of two-hourly feeding.[11] This was subsequently amended to four meals daily to be taken at 8.30am, 1pm, 5pm and 8pm. The main medicine prescribed was cod–liver oil with other drugs used to relieve symptoms according to necessity.[12] Patients were given special instruction concerning the dangers of infection by careless expectoration.[13]

A Church of England chaplain, who was obliged to attend the hospital daily, was appointed. However, in an era when compulsory attendance at divine service was the norm in English institutions, on Hassall's insistence no such obligations were imposed on patients. Rather provision was made for attendance by ministers on members of their congregations, with the chapel made available if required.[14]

Foundation of the National Hospital for Consumption for Ireland, Newcastle

It was Florence Wynne who concieved the idea of constructing a national sanatorium for consumption for Ireland and set about putting in place an organisation to secure its development. However her religious beliefs and forceful personality almost derailed the project.

In September 1891 an article appeared in the *Fortnightly Review* by Professor John Tyndall entitled 'On the origin propagation and prevention of phthisis'. The article described the work of Dr. Georg Cornet a colleague of Robert Koch in relation to the air borne nature of the tuberculosis bacillus. Having tested the infectivity of dust, he found that sputum was the real source of tuberculosis infection and that in the houses of the poor where spitting upon the floor was common, the dried sputum would produce bacilli ridden dust, which would prove highly infectious when the floor was swept. In the houses of the wealthy, the use of pocket-handkerchiefs to spit into would produce similar

[11] Laidlaw, *Royal National Hospital*, pp 56, 58.
[12] Walters, *Sanatoria*, pp 330-1.
[13] 'A German opinion of the Ventnor sanatorium' in *BMJ*, ii, no. 1976 (1898), pp 1510-11.
[14] Laidlaw, *Royal National Hospital*, pp 23, 50.

virulent dust, which would be released upon subsequent use of the handkerchief, the sputum having dried in the warm pocket. Through his experiments he found that 'in no ward or room where the organism was found did the patients confine themselves to expectoration into spittoons but were in the habit of spitting either upon the floors or into pocket handkerchiefs'. But where prohibition of such practices was enforced no evidence of tuberculosis bacilli was found in the dust. Cornet concluded that the prevention of the drying of the sputum by the assiduous use of spittoons under the strictest surveillance of physicians and attendants in addition to boiling without delay soiled bed cloths and handkerchiefs used to wipe patients' mouths would lead to a diminution if not elimination of infection from hospital patients and that notices to this effect should be posted in every sick room with stern punishment administered for infringement of the rules.[15]

According to her own account, on 16 September 1891, while discussing the Tyndall article with her sister Emily, Florence Wynne conceived the idea of setting up a National hospital for consumption for Ireland.[16] She wrote to the *Irish Times* and the *Daily Express* suggesting the establishment of such an institution. However only the *Daily Express* published her letter. Although many people spoke to her on the subject, no one came forward to advance the idea. Having neither the means or the influence to carry the project to fruition and 'trusting entirely to God' she embarked on a series of letter writing and personal visits which resulted in the formation of a twelve person provisional committee, which met for the first time on 20 November 1891(see appendix 2).[17]

Wynne addressed the meeting explaining that she had brought forward the project for three motives: -

1. The Glory of God.
2. To arrest the spread of an infectious disease.

[15] John Tyndall, *New fragments* (New York, 1896), pp 398-423.
[16] Florence Wynne, *Protest regarding the founding of the National Hospital for Consumption for Ireland from the Foundress Miss Florence Wynne, April 1st 1896* (Newcastle Hospital Archives (NHA), uncatalogued) (Henceforth Florence Wynne, *Protest*). At the time of carrying out the research this collection was uncatalogued hence there are no file numbers. Following their mother's death from tuberculosis, when Florence was six years old, she and Emily had developed a lasting interest in the disease.
[17] Florence Wynne, *Protest*; Minutes of first meeting of the provisional committee of the project for the erection of the NHCI. 20 Nov. 1891 (NHA).

3. To relieve suffering.[18]

She produced a draft of the project drawn up conjointly with her sister Emily, which proposed the establishment of a hospital of at least 100 beds together with administrative accommodation and recreation grounds 'not for Dublin alone, but with a national character for the whole of Ireland' She proposed funding the project by public subscriptions. The management of the hospital and its properties would be vested in a board of trustees under the general direction of a board of governors. In pursuance of her first objective while maintaining the principle that 'patients of all creeds should have equal religious privileges' she proposed two chapels, one for Church of Ireland members and 'one for the members of the Church of Rome'. These would be built using 'separate funds subscribed to by the earnest and religious members of both Communions.' [19]

The second meeting of the provisional committee, which had been augmented by the recruitment of additional members (see appendix 3), was held on 8 December 1891 with Dr Thomas Wrigley Grimshaw, the registrar general for Ireland, in the chair. At this meeting, Grimshaw, aware of the number of Dublin voluntary hospitals relying on charitable funding (none of whom catered for the specific needs of consumptive patients) and faced with the probable opposition from these hospitals to any proposal to establish a new hospital, a potential competitor for the limited funds available, secured agreement to amend the original proposal.

The amendment in the form of a conciliatory statement sought to secure the support of the voluntary hospitals by declaring that

> The promoters of the proposed hospital fully appreciate the fact that a large number of hospitals already exist in Ireland, especially in Dublin, and, that it is with difficulty the funds are obtained for maintaining these hospitals in efficiency. It is, therefore, asked, why found another hospital, and add to the burdens already borne by the pockets of the charitable, the answer is that none of the hospitals already in existence afford the necessary accommodation for consumptive patients. By nursing such patients in general hospitals, especially in general medical wards, they, owing to the infective nature of their malady, become a danger to those around them, they are also a danger to one another, and even to themselves.

[18] Florence Wynne, *Protest*.
[19] Minutes of first meeting of the provisional committee of the project for the erection of the NHCI, 20 Nov. 1891 (NHA).

The statement averted to the need for the isolation of tuberculous patients and for the necessity of providing open-air treatment for them, neither of which could be met by existing institutions. It also pointed out that if general hospitals could 'get rid of their consumptive cases' they could be managed more efficiently and more importantly more economically.

In order to cast the appeal for funds as widely as possible, to ensure that resources were devoted to the primary objective of providing hospital accommodation and to avoid religious conflict, Grimshaw obtained agreement to delete the objective of erecting churches for the members of the Church of Ireland and Roman Catholics.[20]

At the sixth meeting of the general committee held on 27th January 1892 an executive committee, in whom the administrative and executive powers were vested, was appointed by resolution (see appendix 4).[21] Critical to the success of the project was the appointment of this committee, composed of individuals of high standing and influence in the general and medical communities, including Thomas Stafford the inspector to the Local Government Board, the Chamberlain to the lord lieutenant Gerald Richard Dease, and the prominent businessmen and philanthropists Thomas Plunkett Cairns and William Watson. At the first meeting of the executive held on 24 February 1892 it was agreed to add Mr. W. P. O'Brien and Florence Wynne to the committee. Miss Wynne was appointed as honorary secretary.[22]

Fund raising

Upon commencing work on her proposals Florence Wynne wrote to Lady Scarborough, with whom she had become acquainted while working for the Bishop of Durham, requesting her to interest her daughter Lady Zetland, wife of the Irish viceroy, in the proposal. Shortly thereafter she received a visit from John Mulhall, the Roman Catholic secretary to the Earl of Zetland. His brief was to assess the possibility of the project achieving a successful outcome, as Lady Zetland, having regard to her position as the highest ranking female member of the aristocracy in the country, could not have her name associated with any dubious project or one whose success was not guaranteed.

[20] Minutes of second meeting of the provisional committee of the project for the erection of the NHCI, 8 Dec. 1891 (NHA).
[21] Minutes of sixth meeting of general committee, 27 Jan. 1892 (NHA).
[22] Minutes of first meeting of executive committee, 24 Feb. 1892 (NHA).

Florence Wynne later regarded this visit as a Roman Catholic attempt 'to wipe out the whole project'.[23]

Satisfied with Mulhall's report, Lady Zetland committed herself to the project. Her ability as an organiser and fundraiser had been confirmed when, following the announcement of the engagement of the Duke of Clarence to Princess Victoria Mary of Teck, she presided over a representative committee established to raise funds to purchase a wedding gift from Ireland for the royal couple. Under her auspices she established a ladies' committee in each county, presided over by a leading member of society, charged with arranging the collection for that county. The death of the duke on 14 January 1892 from influenza brought the fundraising to a premature end.[24] She then turned her attention to raising funds for the proposed hospital.

At the inaugural meeting to establish the hospital held on 17 February 1892, attended by Lady Zetland, Mulhall announced that she had already collected £1,500. He also read out a letter from the lord lieutenant promising to contribute £500 provided that £10,000 was subscribed within six months.[25] This common form of fundraising involved approaching persons who either signed a card similar to sponsorship cards used today or produced a promissory letter. It was only when commitments necessary to fund the proposed hospital were in hand that people were asked to pay although some people, especially where small amounts were involved, made immediate cash payments. It was considered a matter of principle to honour such commitments. Social pressure would be brought to bear upon defaulters to ensure their compliance. By the end of February Lady Zetland had raised £3,366. In addition she had received from Lord Fitzwilliam an offer to contribute £500 to the building fund and a suggestion from him for a site. Wynne had collected an additional £2,481 for the building fund. £1,900 of this sum was subscribed in response to a circular, 10,000 copies of which had being distributed during January and February 1892, soliciting funds.[26]

[23] Florence Wynne, *Protest.*
[24] *Irish Times*, 24 Dec. 1891-14 Jan. 1892, *Weekly Irish Times*, 26 Dec. 1891.
[25] *National Hospital for Consumption, report of inaugural meeting*, 17 Feb. 1892 (NHA). It was considered that the project could be completed for £10,000.
[26] Minutes of second meeting of executive committee, 2 Mar. 1892 (NHA).

On 23 February Lady Zetland made a press appeal for funds, which contained details of subscriptions already promised including a promise of £1,000 from Lord Iveagh.[27] Her appeal resulted in a nation-wide system of local-collection committees being established. The most successful of these local committees was that established by Lady Arnott in Cork. Her network of forty-nine 'lady collectors' had raised £1,164 by 28 February 1893.[28] As upwards of £10,000 had been subscribed by mid August 1892 advertisements were placed in several papers calling on subscribers to lodge their subscriptions directly to the building fund account.[29]

Denominational worship

On 25 May 1892 the chairman drew attention to notices that had appeared in the *Irish Times* and the C*hurch Gazette*, to the effect that funds were being sought for the erection of a chapel, to provide for approximately 150 Church of Ireland members, in conjunction with the development of the hospital. The estimated cost was £1,500. Funds were to be sent to Florence Wynne.[30] The notice drew attention to the interest shown by the lord lieutenant and Lady Zetland in the overall proposal and trusted 'that they will not forget the spiritual needs of the afflicted of their own communion'.[31] Wynne, while acknowledging that she had been working on the church proposal and had received contributions towards it, denied that she had authorised the notices. However she declined to write or sign any letters which would disassociate her from the proposal. Accordingly the chairman wrote to the papers stating that the notices were unauthorised as the only decision made by the board was that the hospital should be run on a non-sectarian basis.[32]

On 13 June 1892 Wynne again sought sanction from the committee for the erection of two chapels. However the committee closed the issue by resolving that the hospital

[27] *Daily Express*, 23 Feb. 1892.
[28] Report of executive committee, 28 Feb. 1893 (NHA).
[29] Minutes of fourteenth meeting of executive committee, 12 Aug. 1892 (NHA).
[30] Minutes of seventh meeting of executive committee, 25 May 1892 (NHA).
[31] *Irish Times*, 6 May 1892.
[32] Minutes of seventh meeting of executive committee, 25 May 1892 (NHA).

'should include suitable provision for the religious wants of the several denominations who may be inmates of it'.[33]

Site selection

In addressing the inaugural meeting Dr Magee Finny stated that the location of the proposed hospital should be one with 'fresh, pure air, free from the dangers of town atmosphere in as sheltered and sunny a spot as possible'.[34] In order to secure a site meeting these criteria a site committee was appointed. Through Lady Zetland, Lord Fitzwilliam offered a free site for the hospital near Newcastle, County Wicklow. It was agreed that the committee would visit this site and others that might be available.[35]

In all fourteen sites received detailed examination by the committee. Following 'careful inquiry into the circumstances of each' all except a site at Ticknock, Ballycorus and Lord Fitzwilliam's site were eliminated from further consideration. The medical members of the committee were then requested to produce technical reports on these two sites as to their fitness from a professional point of view.[36]

On the 13 July 1892 they produced a report on the forty-four acre site at Ballycorus. They found the site in the valley of the Cherrywood River, which sloped from 475 feet to 275 feet above sea level to be in many ways suitable. Dr Magee Finny took strong exception to this finding, stating that the site was seriously exposed to easterly winds, which especially during the spring months would make it quite unsuitable for a consumption hospital. However the committee considered that he was over estimating the degree of exposure and that this problem could be 'effectively obviated by planting'. The site had added advantages of being within easy reach of Shankill railway station, which enjoyed an hourly train service to Dublin and of being close to the Vartry public water supply. The lessee Mr Graham agreed to dispose of his interest for £600 and Lord

[33] Minutes of ninth meeting of executive committee, 13 June 1892 (NHA).
[34] National hospital for consumption, report of inaugural meeting, 17 Feb. 1892 (NHA).
[35] Minutes of second meeting of executive committee, 2 Mar. 1892 (NHA).
[36] Minutes of adjourned eleventh meeting of executive committee, 21 July 1892 (NHA).

Carysfort the lessor indicated his willingness to grant a 999 year lease, presumably at the existing rent of £35 per annum.[37]

Following discussion on the report Lieutenant Colonel Thomas Garrett, aide de camp to Lady Zetland and attending the meeting at her behest, expressed her views as to the advisability of selecting the Newcastle site.[38] Garret was there to ensure that Lady Zetland's interests and her reputation among her peers was protected. As it was her persuasive powers that had elicited the offer from Lord Fitzwilliam a rejection of his site would be taken as a personal slight. A rebuff by a voluntary committee to a lady of her status could not be countenanced.

Further meetings took place on 19 and 21 July 1892 to discuss the relative advantages and disadvantages of the two sites. The drawbacks of the Newcastle site included its small size, twelve statute acres, its inaccessibility from Dublin, its distance from the local railway station and the inadequate train service. The narrowness of the site precluded recreation grounds for patients. It overlooked the graveyard of the ruined Killadreenan church, the existence of which, it was held, would have a detrimental effect on the morale of patients.[39] However medical opinion was that the graveyard provided no sanitary grounds for objection, was 'scarcely visible and could be rendered invisible by a little more planting'. The site standing on slate was likely to furnish a plentiful supply of well water, which could be supplemented with supplies from the public main located nearby. At an elevation of between 150 and 200 feet above sea level the site was well sheltered from cold winds by a combination of hills, mounds and planting. Despite a summons delivered to the chairman to attend upon Lady Zetland at the vice regal lodge on 22 July, the committee unanimously determined to proceed with the Ballycorus site.[40]

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[37] Minutes of tenth meeting of executive committee, 13 July 1892; Minutes of adjourned eleventh meeting of executive committee, 21 July 1892 (NHA).
[38] Minutes of tenth meeting of executive committee, 13 July 1892 (NHA).
[39] Minutes of eleventh meeting of executive committee, 19 July 1892; Minutes of adjourned eleventh meeting of executive committee, 21 July 1892; Minutes of meeting held at vice regal lodge 22 July 1892 (NHA). Thomas Mann , based on his experiences of a sanatorium at Davos, where his wife underwent treatment in 1912, relates the proprietor's concerns that the mental welfare of patients would be effected by exposure to death. He described how the bodies of deceased patients were removed in coffins while the patients were dining in the canteen. The coffins were delivered while the patients slept at night. Thomas Mann, *The magic mountain* (Vintage ed., London, 1999), pp 52-3.
[40] Minutes of adjourned eleventh meeting of executive committee, 21 July 1892 (NHA).

At the meeting, on 22 July 1892, Garrett explained that Lady Zetland had familiarised herself with the reports and read a statement expressing her favourable views on the Newcastle site and asking that the matter be reconsidered by the committee. Social constraints prevented Lady Zetland from directly addressing the meeting. Garrett explained that, with five daily trains from Dublin, Newcastle was not as isolated as originally thought and that Lady Zetland was willing to ascertain from Mr Brooke, Lord Fitzwilliam's land agent, if additional lands could be made available.[41] Lord Fitzwilliam was one of the wealthiest landowners in the British Isles. His estate in Wicklow measured 89,891 acres and he also owned much of south Dublin city and suburbs.[42] When he died in February 1902 he left an estate valued at £2,950,000.[43] The discussion clearly became heated when Lady Zetland personally intervened to state that she was in favour of the Newcastle site, which she had seen and that Lord Fitzwilliam was desirous of having the hospital built there. Wynne responded that she was opposed to Newcastle considering that the hospital 'would be buried and lost sight of there' whereas the Ballycorus site seemed to her in every way most desirable.[44] The committee met again on 27 July to consider the points raised by Lady Zetland and not waiting for a response from Lord Fitzwilliam regarding additional land reaffirmed their decision to proceed with the Ballycorus site.[45]

On 29 July Garrett wrote to Wynne enquiring as to the up to date position on collections. Lady Zetland required the information for an impending visit to Fitzwilliam. Clearly a strategy of exerting social pressures on unforthcoming subscribers was to be discussed. The letter warned 'that she (Lady Zetland) is very greatly disappointed at the present attitude of the committee regarding the site. It is most disappointing to her after all the labour of collecting etc. and I do not see how the thing can be carried on without her most active aid'.[46]

[41] Minutes of meeting held at vice regal lodge, 22 July 1892 (NHA).
[42] John Bateman, *The great landowners of Great Britain and Ireland* (4th ed., London, 1883), p. 168.
[43] George E. Cokayne, *The complete peerage of England, Scotland, Ireland, Great Britain and the United Kingdom, extant, extinct or dormant* (Microprint ed., Gloucester, 1987), p. 525.
[44] Minutes of meeting held at vice regal lodge, 22 July 1892 (NHA).
[45] Minutes of twelfth meeting of executive committee, 27 July 1892 (NHA).
[46] Thomas Garrett to Florence Wynne, 29 July 1892 (NHA).

Wynne responded stating that in her opinion there was not 'the slightest reason to have any apprehensions as to the future of the hospital' as, when people returned from summer holidays, it was intended to embark on further fund raising. Regretting that the committee was unable to meet Lady Zetland's wishes she felt that 'it would be a grave and fatal mistake to place [the hospital] anywhere it was unlikely to be supported'. She concluded by stating that 'if however under these circumstances Her Excellency would rather not have any function I hope you will not hesitate to say so and I will lay it before the next meeting of the committee'. [47]

On 2 August 1892 Lord Fitzwilliam offered Lady Zetland additional land and stated that having to purchase land would be a serious drain on the funds at her command and would curtail her efforts.[48] His offer, together with a telegram from him to Garrett, to the effect that, if the Newcastle site was not accepted and funds wasted on procuring alternative lands he would withdraw his proposed subscription of £500, was tabled at the next meeting of the committee on 3 August.[49] Garrett informed the meeting that any delay in responding would be considered by Lady Zetland as a refusal and would result in her withdrawing from the scheme. George Symes pointed out that, if Lord Fitzwilliam refused to pay his subscription, others would follow suit, thus jeopardising the entire project. Faced with this dilemma the committee accepted the Newcastle site.[50] The site was leased to the committee for a term of 999 years at a nominal rent of £1 per annum.[51] Lord Fitzwilliam was elected chairman of the executive committee on 9 November 1892.[52]

Having been again thwarted, Wynne circulated a letter, laden with religious allusions and accusations of slander, to members of the executive committee. Her letter alleged a conspiracy between certain committee members and Lady Zetland to usurp Florence's position as foundress of the hospital and to frustrate her religious endeavours regarding provision of places of worship. The committee disapproved of the 'tone and tenor' of the letter feeling that it was 'calculated to destroy the confidence and harmony that should

[47] Florence Wynne to Thomas Garrett, 29 July 1892 (NHA).
[48] Lord Fitzwilliam to Lady Zetland, 2 Aug. 1892 (NHA).
[49] Telegram Lord Fitzwilliam to Thomas Garrett, 3 Aug. 1892 (NHA).
[50] Minutes of thirteenth meeting of executive committee, 3 Aug. 1892 (NHA).
[51] Minutes of twenty-first meeting of executive committee, 23 Nov. 1892 (NHA).
[52] Minutes of twentieth meeting of executive committee, 9 Nov. 1892 (NHA).

prevail among the members of the committee'. Having listened to this condemnation of her, Wynne tendered her resignation, which was accepted.[53]

It was effectively Wynne's inability to deliver on her religious proposals that caused her resignation. By contrast in the development of other secular, non-state institutions for the treatment of tuberculosis the proposals had been advanced by powerful individuals who had the means and influence to secure their aspirations. Thus, in Ventnor, Arthur Hassall had provided facilities to be shared by all denominations and in Peamount, Lady Aberdeen had provided separate church facilities for Roman Catholics and Protestants (see chapter 5).

Design and construction

At the inaugural meeting to establish the hospital Dr Magee Finny announced that it was the intention to build a hospital, to accommodate 100 patients, in the style of Ventnor Hospital. William Kenny explained that, as the hospital was intended not for incurables but for those sufferers whose consumption was preventable and curative, it would operate admission procedures similar to Ventnor, accepting only patients in the early stages of lung disease. They would be accommodated in individual houses as in Ventnor.[54] Each patient would be allocated a separate bedroom, following Ventnor's 'separate principle'.[55]

Having secured initial funding, during October 1892 the executive committee prepared an architectural brief for a design competition. The preparation of the brief was assisted by Earnest Morgan the secretary of Ventnor Hospital who supplied details of the Ventnor buildings. Among the stipulations of the brief was a requirement that competing architects must visit Ventnor. Compensation of ten guineas was offered to unsuccessful architects as reimbursement of expenses incurred in such a visit. The plans were to allow for building in a modular fashion on a block system. Initially two houses of not more than sixteen bedrooms each for male and female patients and an administration block were to be provided. Each bedroom was to have a capacity of 1,500 cubic feet. The

[53] Florence Wynne to members of executive committee, 28 Sept. 1892. Minutes of fifteenth meeting of executive committee, 5 Oct. 1892 (NHA).
[54] National hospital for consumption, report of inaugural meeting, 17 Feb. 1892 (NHA).
[55] *NHCI, a short statement of the objects of the institution with descriptive particulars, 30 Mar. 1895* (NHA).

houses were to be heated by hot water pipes or air heated over hot pipes, with provision made for introducing fresh air and evacuating stale air. To provide exercise facilities for patients in bad weather the plans were to incorporate a glass building with southern aspect to accommodate twenty-five patients at a time. The maximum construction cost of the initial phase was set at £7,750. Five Dublin-based firms were invited to participate in the competition.[56] Following correspondence from the participating architects, estimating construction costs at £9,000, it was decided to omit the administrative block and provide temporary offices in one of the residential blocks. Resulting from this change the executive committee revised the maximum construction budget to £6,500.[57]

The committee chose the design of T. Deane and Son's, which provided for buildings 'sufficiently ornate for the purposes for which they are intended'. Deane's proposed use of local stone, as the principal construction material, effected economies as did his incorporation of the indoor glass exercise area into the corridors, an inventive architectural adaptation of Gobersdorf's glazed galleries. Deane's construction costs were estimated at £2,340 for a twelve-bedroom residential block, £200 for the glass building and £2,200 for a reduced administrative block, the £4,000 cost of a full-scale administrative block being considered excessive. An additional twelve-bedroom residential block with connecting glass corridor could be added for £2,500. Lady Zetland, having examined and amended the plans, approved seeking tenders for one administrative and two residential blocks.[58] When tenders were higher than anticipated expensive ornamental work was omitted and 20oz glass substituted for plate glass in the exercise corridors. The savings thus achieved, £3,040, enabled the board to sign a contract for £8,956, with Messrs. Collen Brothers of Portadown, to erect the hospital.[59]

[56] Minutes of seventeenth meeting of executive committee, 19 Oct. 1892; Minutes of eighteenth meeting of executive committee, 26 Oct. 1892; Minutes of twentieth meeting of executive committee, 9 Nov. 1892; Minutes of twenty-first meeting of executive committee, 23 Nov. 1892; Minutes of twenty-second meeting of executive committee, 7 Dec. 1892 (NHA).
[57] Minutes of twenty-fourth meeting of executive committee, 10 Jan. 1893 (NHA).
[58] Minutes of twenty-sixth meeting of executive committee, 17 Feb. 1893; Minutes of first meeting of board of governors, 18 July 1893 (NHA). The Deanes came from a long established Cork family of architects and builders. The firm had an extensive practice designing residential, commercial (including many bank premises) and institutional buildings. The most prominent buildings designed by the practice were the National Museum, Kildare Street, Dublin (constructed 1884-90, cost *c.* £70,000) and the National Library, Kildare Street, Dublin (constructed 1885-90, cost *c.* £40,000). Irish Architectural Archive, Dictionary of Irish Architects 1720-1940 'Thomas Newenham Deane and Son, works ' (www.dia.ie) (18 June 2014).
[59] Minutes of meetings of board of governors, 19 Dec. 1893, 2 Jan. 1894, 16 Jan. 1894 (NHA); *Daily Express*, 8 Feb. 1894.

A subcommittee of the board having reviewed the heating and ventilation system in operation at Ventnor commissioned the Leicester engineering firm Ashwell and Nesbitt to design a system for Newcastle. This firm, in 1890, had developed the 'plenum system' of propelling heated air into a building with the aid of fans while the force of the propulsion removed the stale air through windows or vents. Its plan required the construction of a central engine and boiler house behind the administration block. This was to house a dynamo, which delivered the added advantage of sufficient electricity to light the new hospital. The London electrical engineering firm Messrs. Lund Brothers was engaged to design and install the electrical system. Steam from the central engine would warm air to 62°F as had been advised by Ventnor. This warm air would be delivered to the patient blocks at a rate of 5000 cubic feet per patient per hour by means of electric fans. To facilitate this air distribution, the walls and corridor floors were honeycombed with ample flue chambers. The total cost of implementing the plan was £2731. This cost was not considered excessive by the board as the proposed plant and machinery was of sufficient power to serve all future extensions to the hospital. The administration block was heated by radiators.[60]

Collen Brothers commenced work in early March 1894.[61] Delays were caused by the large quantities of water encountered during excavation. However this water was found to be of exceptional purity. The board purchased a steam pump capable of pumping 800 gallons an hour to a central tower to meet all the hospitals needs. Construction was completed in March 1896.

The finished red roof tiled building with red brick facings contained three large blocks. The central block was composed of a three-storey tower with two projecting two-storey gables measuring some eighty-nine feet in length. On the ground floor it contained a boardroom, separate sitting rooms for the doctor, matron, nurses and servants, waiting rooms and a pharmacy. The kitchen, dairy and similar apartments were located to the rear. The first floor contained the staff bedrooms and the upper floor of the tower was divided into nurses' and servants' bedrooms. The central block was connected to the

[60] Minutes of meetings of board of governors, 5 June 1894, 9 Oct. 1894, 20 Mar. 1895 (NHA); Laidlaw, *Royal National Hospital*, p. 45; *Daily Express*, 21 June 1895; ' The National Hospital for Consumption' in *The Irish Builder*, xxxviii, no. 870 (1896), pp 57-8; 'History of Ashwell Engineering Services Ltd' (www.ashwellengineering.com) (3 Mar. 2011).
[61] *Daily Express*, 16 Mar. 1894.

seventy-two feet long, three-storey residential blocks on either side by two forty-foot long conservatories. In the opinion of Dr Grimshaw these conservatories, in providing 'for the fullest possible exposure to sunlight and ample supply of fresh air when the patients could not spend their time out of doors', accorded with the best practice in continental sanatoria. The male and female residential blocks contained ward kitchens and sitting rooms opening onto an ornamental covered wooden verandah at ground floor level. The first floor of each block contained six patients' bedrooms to the front with a southerly aspect opening onto a covered verandah. To the rear of this floor were located nurses' bedrooms and bathrooms. The top floor consisted of six patients' bedrooms with a southerly aspect opening onto an open verandah. Patients' bathrooms were located at either end of the corridor at this level. [62] Thus following on the model established in Ventnor the best ventilated rooms with a southerly aspect, ensuring the maximum amount of sunlight, were reserved for patient use. The verandahs facilitated open-air treatment for patients. Staff accommodation with the exception of that provided for the doctor and matron was considerably inferior with staff expected to share bedrooms. This reflected the master servant relationship existing between hospital boards of governors and staff at that time.

Governance

In October 1892 the barrister T. P. Law was engaged to advise on the constitution and management of the new hospital.[63] On his recommendation the hospital was constituted as a company under the provisions of the Companies Act 1867, a newly instituted departure for voluntary hospitals.[64] Following extensive correspondence the Board of Trade in London formally approved the memorandum and articles of association, which set out the scope and objects of the institution.

The principle object was to provide and furnish a hospital for 'patients suffering from pulmonary consumption, whose cases may be considered capable of cure or alleviation', without religious distinction. The terms and conditions to be observed by the patients,

[62] *Short account of the opening by the Most Hon. The Marchioness of Zetland of the Royal National Hospital for Consumption for Ireland, Newcastle, County Wicklow, July 1896,* pp 3-4 (NHA) (Henceforth *Short account of the opening)*; 'The National Hospital for Consumption' in *The Irish Builder,* xxxviii, no. 870 (1896), pp 57-8. Newcastle Hospital photograph, early twentieth century (NHA); Dr Grimshaw addressing the sixty-fourth annual meeting of the British Medical Association held at Carlisle 28-31 July 1896, reported in *BMJ*, ii, no. 1867 (1896), p. 1011.
[63] Minutes of sixteenth meeting of executive committee, 12 Oct. 1892 (NHA).
[64] Report of executive committee, 28 Feb. 1893 (NHA).

including the period of stay, were to be determined by the board of governors. The paternalistic nature of the relationship between the board and the patients was evident in the obligation imposed on the board to provide 'for the care, comfort, health, and moral and spiritual welfare' of the patients. To achieve this objective they were authorised to engage or remove or dismiss if warranted honorary or paid physicians or surgeons, apothecaries, dispensers, matrons, superintendents, nurses and servants and to provide them with necessary requisites. The board could provide for the religious needs of patients by appointing honorary chaplains and by regulating the times for religious services in connection with the hospital and its inmates and for religious and other visiting.[65]

The articles set out the qualifications for members, namely donators of £20 and upwards, annual subscribers of £2, a member of a partnership firm subscribing £5 annually, the chairman of a body subscribing £10 annually and an executor or trustee of an estate donating £50 or £5 annually. This was to be an important source of ongoing funding. The articles replaced the executive committee with a board of governors consisting of not more than twenty-one members. The members were responsible for electing governors to the board. The board was responsible for appointing patrons, patronesses, a president and vice-presidents and for the appointment of a secretary and treasurer.[66]

As the hospital was designed to deal with the 'suffering poor' the board determined to treat these patients, nominally charging them 5*s*. per week.[67] This system of payment had been established at Ventnor and appeared to work very well there.[68] It was also agreed to admit a number of paying patients at a weekly charge of 30*s*. However to ensure that only those whose disease was 'in an incipient or early stage' were admitted, patients were obliged to obtain a 'medical certificate of fitness', together with a letter of recommendation from a donor or subscriber. Every donor of thirty guineas or annual subscriber of three guineas was entitled to recommend one patient annually. Every annual subscriber of two guineas was entitled to recommend one patient biannually, while every annual subscriber of one guinea was entitled to recommend one patient

[65] Memorandum of association of the NHCI, incorporated 6 July 1893; Articles of association of the NHCI, incorporated 6 July 1893 (NHA).
[66] Articles of association of the NHCI, incorporated 6 July 1893 (NHA).
[67] *A short statement of the objects of the institution with descriptive particulars, 30 Mar. 1895* (NHA).
[68] *Short account of the opening*, p. 13 (NHA).

triennially. Following this procedure examination by one of the hospital's physicians was necessary and if deemed suitable the patient's name was entered on a register from which all vacancies were filled in order of application.[69]

Staff

With the building nearing completion, the board decided to recruit a matron and other necessary staff, to prepare the hospital for the reception of patients. The matron's first duty was to superintend the furnishing and other internal arrangements and to ensure that the entire machinery was in proper working order.[70] Candidates for the post were required to be certified trained nurses with previous relevant experience. In return a salary of £60 per annum together with full board was offered.[71] A short list of six candidates was invited to attend the board meeting on 25 February 1896. As an added inducement to encourage candidates to face the daunting prospect of an interview conducted by fourteen prominent male board members, it was agreed to defray half the travelling expenses of the unsuccessful candidates. Following the interview process during which the applications and testimonials of the candidates were read and the applicants were 'interrogated' by the board, Miss Jessie Gertrude Powell was appointed.[72] Powell had been a staff sister at Sir Patrick Dun's Hospital and had spent time in charge of the Special Smallpox Hospital at Kilmainham.[73] The matron's duties included the recruitment of subservient staff. On 16 March she advertised for a staff nurse aged between twenty-five and thirty-five years. The salary offered for the post was £25 per annum in addition to an indoor uniform.[74]

Having appointed a matron the board sought a resident medical officer. On 2 March 1896 they advertised for a fully qualified physician to fill the post for which a salary of £100 per annum together with apartments and board was offered.[75] Four candidates were called before the board for interview on 14 April following which Dr Benjamin Hosford Steede was unanimously appointed.[76] This was his first medical appointment. He had spent the

[69] *A short statement of the objects of the institution with descriptive particulars, 30 Mar. 1895* (NHA).
[70] *Report of the board of governors presented to the fourth AGM 29 Jan. 1896* (NHA).
[71] *Daily Express*, 1 Feb. 1896.
[72] Minutes of meeting of board of governors, 11 and 25 Feb. 1896 (NHA).
[73] *Report of the board of governors presented to the fifth AGM 10 Feb. 1897* (NHA).
[74] *The Irish Times*, 16 Mar. 1896.
[75] Ibid., 2 Mar. 1896.
[76] Minutes of meeting of board of governors, 14 Apr. 1896 (NHA).

previous year in Vienna on a medical travelling scholarship which he had obtained from Trinity College Dublin upon graduating from there in 1895.[77]

To assist and supervise Dr Steede in the performance of his duties, Dublin voluntary hospitals nominated eight voluntary consultant physicians (see appendix 5).[78] More significant appointments were those of Dr Joseph O'Carroll physician to the Richmond Whitworth and Hardwicke Hospitals and Dr Alfred R. Parsons physician to the Royal City of Dublin Hospital as visiting physicians to Newcastle. Included in the duties undertaken by them were visiting the hospital once a week, examining all applicants for admission, assisting in the preparation of the annual medical report and advising the board generally on medical matters of concern. [79]

Maintenance funding

From its inception members were aware that considerable funds would be required to secure the annual running costs, as the hospital could not be self supporting[80]. Lady Zetland relocated to Yorkshire in 1892. However she continued to work for and solicit funds on behalf of the hospital. Together with the Countess Fitzwilliam she personally undertook the task of collecting subscriptions towards the annual support of the hospital and prepared a pamphlet to this effect, 500 copies of which were circulated.[81] In February 1893 a committee member offered a sum of £100 secured in perpetuity for this purpose. This promise formed the basis of an advertising campaign to obtain further funding.[82] By the end of 1894 annual subscriptions of over £400 had been secured or promised.[83] During 1895 an additional sum of £255 was collected and further annual subscriptions amounting to £271 promised.[84]

As patroness the board asked the now Marchioness of Zetland to officiate at the opening ceremony, set for 19 March 1896. However it was first necessary to furnish the premises, a task for which the board had no funds. Again the Marchioness of Zetland, together with

[77] *Report of the board of governors presented to the fifth AGM 10 Feb. 1897* (NHA); *The Irish Times*, 27 Sept. 1920.
[78] Minutes of meetings of board of governors, 28 Apr. 1896, 12 May 1896, 9 June 1896 (NHA).
[79] *Report of the board of governors presented to the fifth AGM 10 Feb. 1897* (NHA).
[80] *The Irish Times*, 30 Jan. 1896.
[81] *Daily Express*, 5 Dec. 1894; Minutes of meetings of board of governors, 9 and 27 Oct. 1894 (NHA).
[82] Minutes of twenty-fifth meeting of executive committee, 14 Feb. 1893 (NHA).
[83] *Report of the board of governors presented to the third AGM 26 Mar. 1895* (NHA).
[84] *Report of the board of governors presented to the fourth AGM 29 Jan. 189*6 (NHA).

Lady Alice Fitzwilliam[85], organised a fundraising campaign to obtain the £600-£700 that was necessary.[86] As part of their fundraising drive collection cards were sent to the ladies who had organised county subscriptions.[87] Their endeavours raised £235. The balance of the furnishing expenditure, totalling £844, fell to be met from the building account. The shortfall together with overruns on completion of the building works resulted in a total deficit of £1,800 on that fund at the end of the year.[88] To alleviate this debt and bolster the annual maintenance fund in December 1896 Lord Fitzwilliam offered a further sum of £1,000 conditional on £3,000 being raised in public subscriptions.[89] It was felt that by advertising Lord Fitzwilliam's offer others might be encouraged to make subscriptions in order to secure his contribution. Subsequently Lord Fitzwilliam made the gift of £1,000 unconditional.[90]

Eight days before the official opening the impecunious situation of the board forced it to publicly appeal for gifts of flowers, plants, pictures, engravings and assistance in decorating the premises in time for the opening. The appeal also sought bound volumes of illustrated papers or other periodicals and literature for the patients.[91] The governors agreed to provide the luncheon for the opening and Lord Fitzwilliam met the cost of the wine.[92]

The opening ceremony

Over 500 invitations were issued to the opening ceremony resulting in an attendance of over 200. Many of the visitors were conveyed on a special train, laid on free of charge by the Dublin, Wicklow and Wexford Railway Company at the instigation of Frank Brooke, a director of the railway company and governor of the hospital. He was probably also responsible for the decision in October 1897 by the railway company to provide tickets at greatly reduced rates to staff and patients travelling to and from Newcastle. The train departed from Harcourt Street station at midday stopping at Bray to pick up additional

[85] Lady Alice Fitzwilliam had taken up the mantle of hospital fundraiser following the death of her mother in June 1895.
[86] *Daily Express*, 1 Feb. 1896.
[87] Minutes of meeting of board of governors, 14 Jan. 1896 (NHA).
[88] *Report of the board of governors presented to the fifth AGM 10 Feb. 1897* (NHA).
[89] Minutes of meeting of board of governors, 30 Dec. 1896 (NHA).
[90] *Fifth annual report of the board of governors presented to the AGM 22 Mar. 1898* (NHA).
[91] *The Irish Times*, 11 and 13 Mar. 1896.
[92] *Short account of the opening*, p. 16 (NHA).

passengers. According to the published accounts, upon arrival at Newcastle station the guests, with the assistance of the local constabulary, were conveyed, without confusion or delay, by a collection of carriages, jaunting cars, wagonettes and other vehicles, the three miles to the hospital. All arrived in time for the official ceremony, which was performed by the marchioness in one of the glass conservatories at 1.15 p.m.[93]

The religious question resolved

In July 1896 the religious wants of the patients again exercised the board members. They appointed a deputation to confer with the Roman Catholic and Protestant archbishops to determine what arrangements could be made.[94] Following this deputation the Catholic archbishop William Walsh visited the hospital and was greatly pleased with what he found.[95] Subsequently Dr Steede entered into discussions with Father James Walsh the parish priest of Kilquade regarding the provision of religious services.[96] In January 1897 he reported to the board that arrangements had been made with Fr Walsh and the Rev. Canon Henry William Gayer the rector of Newcastle to hold religious services for their respective communions in the hospital.[97] However by mid February it was apparent that the provision did not meet the needs of Catholic patients and staff. Accordingly John Orpen the honorary secretary met Fr Walsh requesting him to approach the archbishop with a view to having a second mass said at Newtown, a nearby church.[98] Another demonstration of the board's concern with religious matters, was provided in 1897 when Countess Cardogan donated books. Board members examined the books and placed those with any religious tendency in separate presses, according as they were judged suitable for use by Protestant or Roman Catholic patients.[99] By 1899 the assistance of a further Catholic clergyman the Rev. W. Doherty the curate from Newtownmountkennedy was engaged.[100]

[93] *The Irish Times*, 20 Mar. 1896; *Short account of the opening,* pp 4-6; minutes of meeting of board of governors, 12 Oct. 1897 (NHA).
[94] Minutes of meeting of board of governors, 14 July 1896 (NHA).
[95] Ibid., 10 Nov. 1896.
[96] Ibid., 12 Jan. 1897.
[97] Ibid., 26 Jan. 1897.
[98] Ibid., 9 Mar. 1897.
[99] Ibid., 15 June 1897.
[100] *Seventh annual report of the board of governors presented to the AGM 5 April 1900,* p. 11 (NHA).

In recognition of the services provided in December 1900 the board gave a donation of £3 to the sustentation fund of Newcastle parish and a similar amount to Fr Walsh.[101] Reflecting a dominant Catholic balance in patients and staff the services of another Catholic clergyman Rev. G. M. Drought of Newtownmountkennedy were engaged in 1900, although this may have been a division of labour amongst parish clergy.[102] In 1903 at the request of the Rev. Montgomery John Palmer, the replacement rector of Newcastle parish, a harmonium was ordered for the hospital at a cost of £5 16*s*. 6*d*. to aid in the singing of hymns at his services.[103] In June 1904 both the Rev. Palmer and Rev. Bernard O'Reilly, the replacement parish priest for Kilquade, corresponded with the board regarding the attendance of patients at public services at Newcastle and Newtownmountkennedy. Members of both congregations had expressed unease at having an increased number of consumptive patients in attendance at their churches, brought about by pressure on existing provisions at the hospital on account of increased patient numbers. As the financial position of the hospital had improved it was agreed to pay both ministers £25 per annum in return for providing increased services at the hospital, thus obviating the need for outside attendance by patients. For the Rev. Palmer this involved providing a service at the hospital each Sunday instead of or in addition to a weekday service which theretofore had been his practice.[104]

Expansion of Newcastle hospital

In its first full year of operation, 1897, the hospital successfully treated ninety-six patients with 'pure air, plenty of sunshine and plenty of good food'. Only two deaths were recorded.[105] The average stay was 109 days. According to the hospital's own account, most patients exhibited 'a remarkable gain in weight and strength' and many showed 'a very marked alleviation of the symptoms of the disease', including many instances of complete disappearance of all signs of active disease. Such was the improvement experienced by patients that a 'large proportion' upon discharge were able to return to work or household duties. Impressed by results amongst early cases of consumption, while acknowledging that 'the benefit to be derived in the later stages is

[101] Minutes of meeting of board of governors, 11 Dec. 1900 (NHA).
[102] *Eighth annual report of the board of governors presented to the AGM 28 Feb. 1901*, p. 10 (NHA).
[103] Minutes of meeting of board of governors, 9 June 1903 (NHA); Robert Jennings, *Newcastle down the years* (Newcastle, 2008), p. 26.
[104] Minutes of meeting of board of governors, 14 June 1904 (NHA).
[105] The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1897*, p. 31; Address by Dr Joseph O'Carroll visiting physician in minutes of AGM 22 Mar. 1898 (NHA).

less likely to be permanent' the visiting and resident physicians found themselves 'inclined to be more stringent than heretofore in certifying for admission only cases of incipient disease'. The public benefitted from the work of the hospital in making poorer patients familiar with methods of preventing the spread of consumption and inculcating in them preventative habits.[106]

With pressure on bed spaces mounting, despite the stringent admission tests, the board, in July 1898, had to consider 'the question of retaining in hospital cases in which the physicians are satisfied there is no hope of permanent improvement'. It determined 'that when the visiting physicians entertain no doubt that a patient affords no reasonable expectation of marked alleviation or cure such patient should be removed from the hospital with as little delay as possible'.[107] However the shortage of bed spaces continued and waiting lists grew. Thus many patients, approved for admission to the hospital, found themselves experiencing considerable delays, which 'unhappily in many of the cases means a verdict of 'too late''. To address this situation the board launched a new building fund appeal seeking to raise £6000 which would enable the provision of accommodation for forty or fifty additional patients in two new residential blocks.[108] As an interim measure the male and female sitting rooms were converted to bedroom accommodation, each providing four bed spaces.[109]

A legacy of £5,000 left to the hospital following the death of the Dublin merchant James Weir in October 1898 provided the funds to commence the new extension.[110] Initially the board decided to construct the new blocks on the 'separate system'.[111] However to validate this decision Dr Alfred Parsons, a visiting physician, was asked to visit and report on the up-to-date methods of accommodating and treating patients employed by the most prominent British, French and German sanatoria. Parsons, finding that most

[106] The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1897*, pp 31-4 (NHA).
[107] Minutes of meeting of board of governors, 12 July 1898 (NHA).
[108] The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1898*, p. 12; Minutes of AGM 13 Mar. 1899; minutes of adjourned meeting of board of governors, 28 Mar. 1899 (NHA).
[109] Minutes of adjourned meeting of board of governors, 28 Mar. 1899; minutes of meeting of board of governors, 13 June 1899 (NHA).
[110] Minutes of meeting of board of governors, 13 July 1899 (NHA). Weir had also funded the James Weir Home for Nurses, Cork Street built in 1903 at a cost of £8,862 to provide accommodation for up to fifty nurses employed in the nearby fever hospital.
[111] Minutes of meetings of board of governors, 31 Oct. and 12 Dec. 1899 (NHA).

sanatoria proprietors had implemented multi-occupancy of bedrooms for poor patients, recommended that to economise 'the new blocks should contain rooms capable of holding not more than 4 beds per room' especially having regard to the hospitals existing provision of twenty-four single bedrooms 'available for patients suffering from high fever, troublesome cough or haemorrhage'.[112] His recommendation was adopted by the board in October 1900.[113]

With a building fund of almost £7,000 available in March 1901, £900 of which had been committed to the provision of a new dining room, the board decided to economise by erecting a wooden structure for male patients in lieu of the heretofore stone buildings.[114] In July the tender of the Manchester based Portable Building Company in the sum of £1,265 was accepted for the construction of this structure, containing 4 large wards, 2 smaller wards and four staff rooms providing 26 patient bed spaces.[115] The new facility began accepting patients on 4 January 1902.[116] Further reorganisation of space within the hospital brought the total bed capacity to 66. These enhanced facilities enabled 289 patients to be treated in 1902, an increase of 125 on the previous year. Of the 217 patients discharged during the year 183 were in an improved condition.[117] Despite the provision of this extra accommodation, the admission waiting list contained between 80 and 90 patients.[118]

Satisfied with the wooden structure, the board, in October 1903, decided to provide similar accommodation for female patients.[119] Pending provision of the premises, in April 1904, with between sixty and seventy patients awaiting admission for several months and thus creating a demand for admission, which was 'producing a state of congestion at the hospital', the board purchased and erected two floored tents. The tents

[112] Alfred R. Parsons, *Report on a recent visit to some British and continental sanatoria* (Undated but board request made July 1900 and subcommittee report on Dr Parsons report dated 19 Oct. 1900).
[113] Minutes of special meeting of board of governors, 30 Oct. 1900 (NHA).
[114] Minutes of meeting of board of governors, 26 Mar. 1901 (NHA).
[115] Ibid., 2 July 1901; The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1901*, p. 10 (NHA).
[116] Minutes of meeting of board of governors, 14 Jan. 1902 (NHA).
[117] The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1902*, pp 8-17 (NHA).
[118] *Irish Times*, 15 Mar. 1902.
[119] Minutes of meetings of board of governors, 11 June and 14 Oct. 1903 (NHA).

Plate 2.1 National Hospital for Consumption for Ireland, Newcastle, County Wicklow showing central administration block on left, twelve-bedroom patient block on right and connecting glass corridor, undated but probably early 1900s (Newcastle Hospital archive)

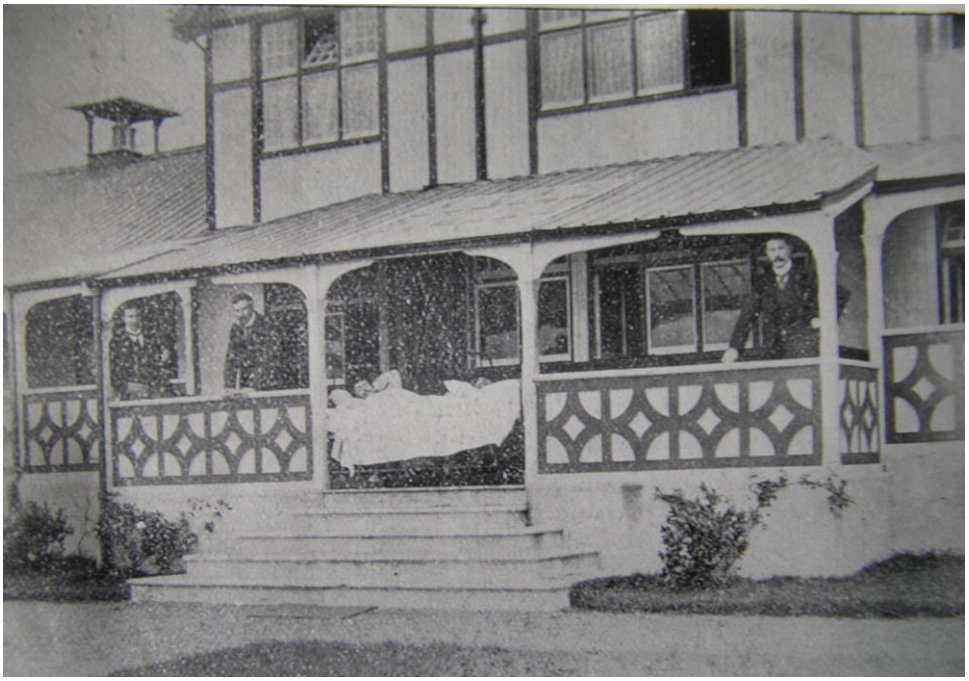

Plate 2.2 Male patients on verandah in wooden block of National Hospital for Consumption for Ireland, Newcastle, County Wicklow in 1904 (Newcastle Hospital archive)

were outfitted to provide beds for ten female and ten male patients.[120] Dr Steede reported that 'the tents were popular with the patients and, except when the weather was unusually stormy, they answered their purpose admirably'.[121] The new women's block was not available for occupation until February 1905. This block contained five six-bed wards and three single rooms, bringing the total hospital accommodation to 100 beds. All except one ward on the second floor opened onto spacious verandahs. The under croft of the block was outfitted as a chapel enabling the clergymen of the different denominations to hold their religious services there.[122] The £1,500 required to build this block and the £1,000 to equip it was raised by voluntary subscription, facilitated by individual donations of £500 from Lord Fitzwilliam and £250 from the Earl of Dudley the lord lieutenant.[123] The expanded facilities enabled the hospital to treat 496 patients during 1906 of whom 402 were discharged, 77% of these reportedly in an improved condition. However the physicians bemoaned the fact that many of the discharged patients had 'too often to return to unhealthy homes and unhealthy occupations, thus to a large extent nullifying the results of sanatorium treatment'.[124]

All patients admitted to the hospital had to abide by a strict set of rules. These rules set the timetables by which life in the hospital was conducted. They required obligatory attendance at religious services provided for patient's respective denominations. They prohibited spitting, gambling, profane or unseemly language and practical joking. A ban was enforced on taking their own food or drink into the hospital. Following the example set by Brehmer in Gobersdorf smoking was only permitted outside the hospital and only at specified times. In order to allay the fears of local residents patients were only permitted outside the grounds at certain hours or with express permission and they were forbidden from going to local villages without the consent of the resident medical officer, breaching these rules warranted instant dismissal. The same penalty applied to breaking the absolute ban on entering public houses or procuring alcohol. To obtain maximum benefit from fresh air patients were not permitted to remain indoors unless permitted by

[120] Ibid., 22 Mar. and 12 Apr. 1904. Although equipment to provide for twelve beds in each tent were purchased only ten were provided in each tent as per the 1904 annual report.
[121] The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1904*, p. 17 (NHA).
[122] The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1905*, pp 7-8 (NHA).
[123] *Irish Times*, 25 Feb. 1904.
[124] The NHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1906*, pp 15, 21 (NHA).

the sister-in-charge. While outdoors male and female patients were restricted to those parts of the respectively allocated to them. Any patient breaching the rules or refusing to obey staff orders would be liable to dismissal.[125]It was commonplace for patients to be dismissed for breaking the rules. Most of the dismissals were for patients breaking grounds or consuming alcohol with misconduct and insubordination also being advanced as reasons for their exclusion (see appendix 21)

Private Sanatoria

The success of the large German private sanatoria encouraged doctors to emulate them on a smaller scale. Several of these small private sanatoria were based in Leinster. (Appendix 1 lists the British sanatoria attempting to emulate Nordrach).

In 1898 the Dopping-Hepenstal Estate offered to let Altidore house, located *c*. 1½ miles north–west of Newtownmountkennedy County Wicklow to Colonel W. D. Marsh for a suggested rent of £150 to £160.[126] The house, containing 10 bedrooms, 3 servants' rooms a parlour, a drawing room, a library and morning-room, had been refurbished from 'foundation to roof' around 1891 to provide it with hot and cold water and the most modern sanitary improvements.[127] When Marsh declined the offer, the estate's agent drew attention to an advertisement from an English doctor in the *Irish Times*, seeking to rent 'a modern well-built residence in the neighbourhood of Greystones and Delgany with from 40 to 100 acres of grazing land'.[128] The doctor was Joshua Charles Smyth who practiced at Glastonbury, Somerset. He had received training in the treatment of tuberculosis from Dr Otto Walther at Nordrach.[129] Smyth firstly ascertained that the house was located on a site, at a suitable elevation above sea level (750 feet[130]), well sheltered from prevailing winds by the hills to the rear of the house, on soil consisting of freestone and gravel (important to dry out walks quickly after rain) and with good rail

[125] Minutes of meetings of board of governors, 8 Dec. 1896, 12 Jan. 1897, 25 July 1904 and 31 July 1913 (NHA).
[126] Major Lambert John Dopping-Hepenstal to Colonel Willoughby Digby Marsh, 19 Mar. 1898 (NLI, Dopping-Hepenstal papers MS 35847(22)).
[127] *Daily Express*, 29 Mar. 1890 and 5 Feb. 1891.
[128] *Irish Times*, 21 Aug. 1899.
[129] John W. Moore, 'The climate of Ireland' in *The climates and baths of Great Britain, being the report of a committee of the Royal Medical and Chirurgical Society of London* (2 vols, London, 1902), ii, pp 381-581; Walters, *Sanatoria*, p. 390.
[130] John W. Moore, 'The climate of Ireland'.

links available at Greystones four miles away and Bray eight miles away.[131] Having secured rights to walk over the demesne, to build wire houses and bungalows at a future date and having satisfied the owners as to the class of patient to be treated, Smyth entered into a lease of the premises and twenty acres for twenty-one years at a yearly rent of £200 from 25 March 1901.[132]

From May 1901 Smyth began advertising the sanatorium for the open-air treatment of consumption based on the Nordrach system with the exaggerated claim that the premises was set in 480 acres of woodland.[133] In 1902 Smyth rented adjoining lands on which he established a tuberculin tested herd, which supplied the sanatorium with milk and butter.[134] There was considerable controversy at this time regarding humans becoming infected with tuberculosis from cattle contaminated with bovine tuberculosis. The tuberculin testing of herds and the elimination therefrom of cattle reacting positively to tests ensured a supply of milk free from the tuberculosis bacillus. The existence of this herd was to feature in Smyth's advertisements. Smyth initially catered for nine patients charging them an inclusive fee of three guineas per week.[135] His advertisements appeared very infrequently in these early years, an indication that accommodation at the sanatorium was full.

In 1905 Smyth's landlord granted permission to construct a 1,008 sq. ft bungalow fronted by a verandah with glass roof and sides. The additional accommodation was required, according to Smyth, as he had a waiting list and 'every day's delay meant pecuniary loss'.[136] The bungalow, described by Smyth as 'a sort of outdoor hut for patients', was built on foundations of wooden piles and contained a nurse's and four separate patients' bedrooms each twelve feet square and unheated. They were used both in summer and

[131] Battersby and Co. estate agents to Major Lambert John Dopping-Hepenstal, 4 Dec. 1900; Major Dopping-Hepenstal to Battersby and Co., 12 Dec. 1900 and 10 Jan. 1901 (NLI, Dopping-Hepenstal papers MS 35847(28)).
[132] Major Lambert John Dopping-Hepenstal to Battersby and Co., 12 Dec. 1900; Battersby and Co. to Major Dopping-Hepenstal, 11 Feb. 1901; Draft agreement amended for approval between Major Lambert John Dopping-Hepenstal and Joshua C. Smyth dated 14 Mar. 1901 (NLI, Dopping-Hepenstal papers MS 35847(28)).
[133] *Irish Times*, 18 May 1901. The demesne was set in 263 acres of land. *Daily Express*, 29 Mar. 1890 and 5 Feb. 1891.
[134] Receipt, 10 June 1902 (NLI, Dopping-Hepenstal papers MS 35847(31) (3)); Joshua C. Smyth to Bernard O'Grady, 1 June 1905 (NLI, Dopping-Hepenstal papers MS 35847(30)); *Irish Times*, 24 Dec. 1904.
[135] *Irish Times*, 10 Dec. 1904. Walters, *Sanatoria*, p. 390.
[136] Smyth to O'Grady, 6 Apr. 1905 (NLI, Dopping-Hepenstal papers MS 35847(30)).

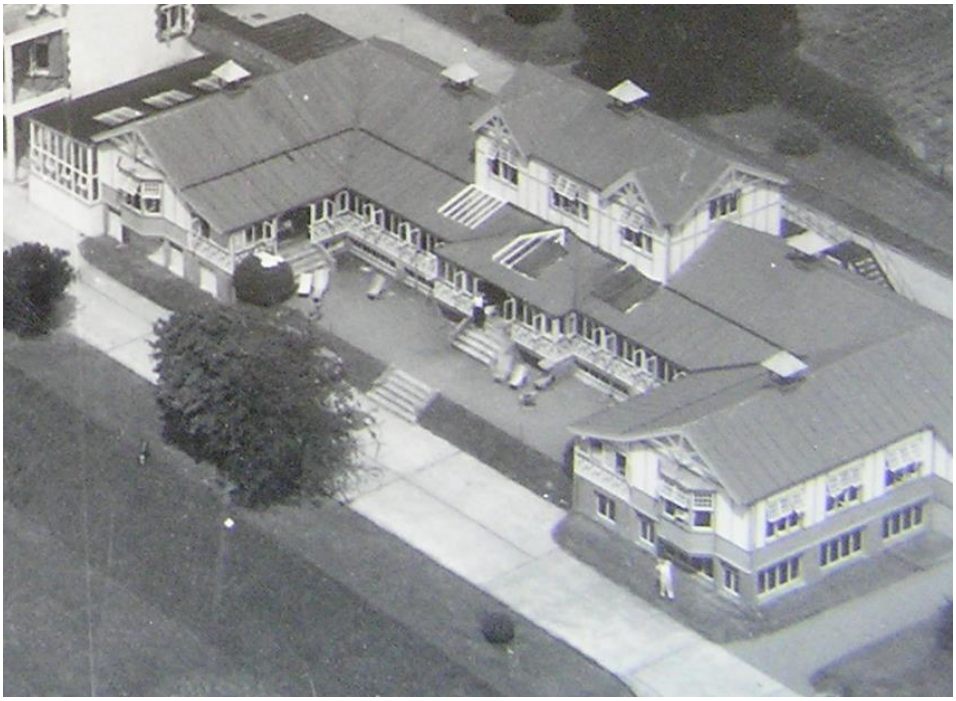

Plate 2.3 National Hospital for Consumption for Ireland, Newcastle, County Wicklow, thirty-three- bed female wooden block opened in 1905 (Newcastle Hospital Archive)

Plate 2.4 Altidore House, County Wicklow in 1902. The premises had been leased by Dr Joshua Smyth for use as a private tuberculosis sanatorium in 1901 (Charles A. Reinhardt, *A handbook of the open-air treatment and life in an open-air sanatorium* (London, 1902), p. 112)

winter. The total cost of providing this additional accommodation was £150 with an additional £100 being spent on outfitting the premises.[137] The structure was serviced by a dry earth closet, placed beside the bungalow.[138] In addition Smyth designed a double-roomed timber framed chalet, each room measuring twelve feet square exiting onto a four feet wide verandah. The chalet was constructed by the Dublin firm of Keenan and Sons Ltd, at an approximate cost of £85. The firm also built to Smyth's design a more up-market octagonal single person chalet measuring fourteen feet by ten feet. This structure cost £80 and 'met the desired requirements without the usual appearance of sanatoria buildings'.[139] Replicas of both these structures were displayed at the tuberculosis exhibition organised as part of the Irish International Exhibition, which ran on a sixty-five acre site at Herbert Park, Ballsbridge, Dublin from 4 May to 9 November 1907.[140] The construction of these extra facilities increased the capacity of Altidore to eighteen patients.[141]

Smyth, having established a reputation as an expert on consumptive sanatoria, was invited by Lady Aberdeen to deliver a lecture at the tuberculosis exhibition in Ballsbridge in 1907. In his paper *The climate of Ireland in relation to the open air treatment of consumption*, through the judicious use of statistics, he demonstrated that the equability of the temperate Irish climate being similar to England and superior to Nordrach favoured the treatment of the disease especially near the seaboard where the combined curative benefits of sea and mountain air might be found.[142] These attributes naturally applied to Altidore.

Indications of financial difficulties at the sanatorium began to emerge in July 1909 when

[137] *Poor Law Reform Commission (Ireland). Minutes of evidence taken before the Vice-Regal Commission on Poor Law Reform in Ireland. Volume III. Minutes of evidence and index*, 1 [Cd. 3204] H.C. 1906, lii, 1.
[138] Smyth to O'Grady, 20 July 1905 (NLI, Dopping-Hepenstal papers MS 35847(30)).
[139] Pamphlet, Keenan and Sons Ltd. prepared for the tuberculosis exhibition as part of the Irish exhibition 1907 (NLI, Dopping-Hepenstal papers MS 35847(34)).
[140] Pamphlet, Keenan and Sons Ltd., 1907; Brian Siggins, *The great white fair: the Herbert Park exhibition of 1907* (Dublin, 2007), pp 38, 100, 110.
[141] Walters, *Sanatoria*, p. 390; Isaac Burney Yeo, *The therapeutics of mineral springs and climates* (Chicago, 1904), p. 743.
[142] *Irish Times*, 1 Nov. 1907; J. C. Smyth, 'The climate of Ireland in relation to the open air treatment of consumption' in The Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis* (3 vols, Dublin, 1908), ii, pp 1-13.

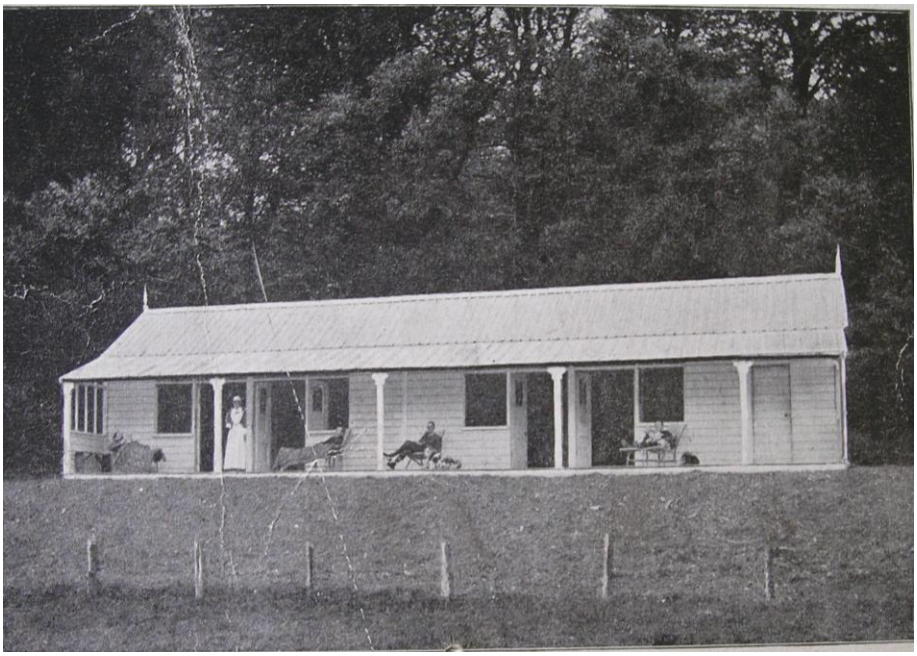

Plate 2.5 Unheated five room bungalow at Altidore private sanatorium, County Wicklow, *c.* 1907 (NLI, Dopping Hempenstal papers, MS35847)

Plate 2.6 Single occupancy chalet developed by Dr Leopold Hare for use at his private sanatorium at Larch Hill, County Dublin, *c.* 1907 (NLI, Dopping Hempenstal papers, MS35847)

Smyth proffered a cheque for £50 in lieu of the £100 due on the 25 March.[143] The balance was not paid until the 14 September when Smyth assured his landlord that matters would be all right as his luck though 'still poor enough' had changed for the better.[144] However by January he had not succeeded in raising the rent due on 29 September as 'patients are scarce and will be for another month or two'. He found the rent a financial handicap, being out of proportion to the then earning capacity of the business. He pleaded for a reduction to a level, which would 'enable him to live out of the earnings'. He also complained about the smoking chimneys, which had two patients threatening to quit and he feared the loss of all his patients if the matter was not attended to.[145] On 23 March 1910 he made a payment of £50 against the moiety due the previous September.[146]

However matters did not improve and Smyth's desperation may be gauged by the almost daily frequency with which he advertised the premises in the *Irish Independent* and the *Freeman's Journal,* during the months of August and September 1910, at the reduced charge of two guineas for certain accommodation. This strategy did not work. On 8 and 9 November, on Smyth's instructions, Joseph Keane a local auctioneer conducted a two day auction at Kilpedder at which he disposed of Smyth's goods including antique and modern furniture, glass, old china, paintings, carpets, rugs, a seventy-five guinea piano and farm implements.[147] By January 1911, with arrears of rent amounting to £311 in addition to an unpaid rates bill of £15, to avoid bankruptcy proceedings, Smyth entered into negotiations with his landlord to hand over the premises. Smyth had additional outstanding liabilities amounting to £559, owed to a variety of unsecured creditors. Smyth had assets of £505 only to set against these debts. When the secured debts due to the Dopping-Hepenstal estate were deducted from this amount it left a mere £179 to be distributed amongst his creditors.[148] At a meeting held in January 1911 the creditors agreed to accept 5/- in the pound in settlement.[149] At the beginning of March 1911 Smyth

[143] Joshua C. Smyth to Major Lambert John Hepenstal, 15 July 1909 (NLI, Dopping-Hepenstal papers MS 35847(36)).
[144] Same to same, 14 Sept. 1909.
[145] Same to same, 7 and 18 Jan. 1910.
[146] Same to same, 23 Mar. 1909.
[147] *Freeman's Journal*, 5 Nov. 1910.
[148] File note dated 27 Jan. 1911 (NLI, Dopping-Hepenstal papers MS 35847(38)).
[149] Cussen and Kieran solicitors to Bernard O'Grady, 26 Jan. 1911 (NLI, Dopping-Hepenstal papers MS 35847(38)).

handed over Altadore to the Dopping-Hepenstal estate.[150] His attempt to run a small private tuberculosis sanatorium had not proved financially viable.

In 1906 the Limerick born Dr Leopold Hare from Bullwell, Nottingham entered into a ninety-nine year lease on Larch Hill a house situated at Pine Forest, Tibradden, County Dublin at an annual rent of £157.[151] Hare's main experience had been as assistant medical officer at the London County Asylum and the Cornwall County Asylum.[152] However he had himself contracted tuberculosis, which required ten months treatment in a sanatorium. There his weight increased and he managed to walk without fatigue 10 miles a day, a task impossible in his former invalid state. Following recovery, he spent time at Nordrach studying Dr. Walther's methods.[153] These experiences provided him with sufficient knowledge to open a sanatorium for the open-air treatment of consumption at Larch Hill.

The house was situated at an elevation of 800 ft above sea level on a wooded site of eighty-seven acres on Kilmashogue Mountain.[154] To treat his patients, according to the Nordrach method, Dr Hare developed sheltered walks on the grounds.[155] He also provided chalets, constructed to his own design. The chalets, built by Keenan and Sons at a cost of £35 each, featured in the 1907 tuberculosis exhibition. Each consisted of a living space measuring 12 ft by 10 ft fronted by a 4 ft wide verandah. They were intended for single occupancy. In keeping with the principles of open-air treatment the centre front six-foot wide chalet doors were constructed in two parts. The lower hinged part could be opened or closed at will while the upper section was normally left open. However in severe weather, with winds blowing in the direction of the verandah, the open section could be secured with panel shutters removed from the rear of the chalet,

[150] Bernard O'Grady to Major L. J. Dopping-Hepenstal, 3 Mar. 1911 (NLI, Dopping-Hepenstal papers MS 35847(38)).
[151] I have assumed a ninety-nine year lease as when the premises were subsequently offered to the Joint Hospital Board in 1908 ninety-seven years of the lease remained. *Irish Independent* 25 May 1908; *The Medical Directory 1906* (London, 1906), p. 661; General Register Office; Census Returns 1901; Birth certificate Leopold Hare (RCPI, Kirkpatrick archive).
[152] *The Medical Directory 1906* (London, 1906), p. 661; *The Medical Directory 1907* (London, 1907), p. 1389.
[153] Leopold Hare 'Some popular objections to sanatoria answered' in The Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis* (3 vols, Dublin 1908), ii, pp 67-85.
[154] *Irish Independent*, 25 May 1908; *Irish Times*, 19 May 1908.
[155] *Weekly Irish Times*, 23 May 1908.

thereby creating the open air aspect on the reverse now sheltered side.[156] In pursuance of Walther's methods, Hare was present at all meals, personally serving his patients. Each patient's food was measured exactly and Dr Hare partook of his own meals with them so he could 'insist upon the last morsel being finished', thereby ensuring that each patient was taking his allocated nourishment.[157]

Dr Hare was also among the speakers at the Ballsbridge tuberculosis exhibition. That someone of such relatively limited experience was invited to deliver a lecture is an indication of the dearth of medical expertise on tuberculosis then available in Ireland. In his lecture *Some popular objections to sanatoriums answered* he attempted to address the fears of patients and their relatives regarding sanatorium treatment, namely, infection, exposure to weather, sanatorium food, strictness of rules, depression and the incurability of the disease. He maintained that sanatoria regimes 'practically prevented the possibility of the disease being infectious' while it was well established that open air conditions were successful in the treatment of tuberculosis. He argued that sanatoria diets arose from the necessity to 'feed the disease as well as the patient' and that adherence to strict rules resulted in quicker patient cure. In relation to the inevitable fatality of the disease he recited what could be considered a mantra for early-twentieth-century sanatoria physicians 'tuberculosis in its early stages is curable; later it can be arrested and later still its horrors can be relieved'. Commenting on the mental state of tuberculosis patients he stated that in general such patients were amongst the most hopeful to be found concluding with 'where there's life there's hope'.[158] His lecture was well received as he was asked to repeat it when the tuberculosis exhibition opened in Cork in January 1908 and in Waterford in April 1908.[159]

Hare responded to an advertisement from the Dublin Joint Hospital Board, seeking a sanatorium site, in early 1908, by offering to dispose of his interest in Larch Hill for £3,150.[160] This was an early indication that his health was declining and that his own sanatorium 'cure' had not been sustained. In June 1909 Hare announced his retirement

[156] Pamphlet, Keenan and Sons Ltd. 1907.
[157] Leopold Hare 'Some popular objections'.
[158] Leopold Hare 'Some popular objections'.
[159] *BMJ*, i, no. 2455 (1908), p. 171; *Daily Express*, 4 Apr. 1908.
[160] *Irish Independent*, 25 May 1908.

from practice.[161] He died in Tramore County Waterford on 18 December 1909.[162] Dr Robert Campbell Nicholl acquired his interest in the premises and continued to operate it as a private sanatorium for the open-air treatment and rest cure of consumption.[163] Nicholl attempted to widen the scope of the sanatorium in March 1911 by advertising it as a medical home 'eminently suited for those needing rest and change'. In May 1911 he was referring to it as a health resort in which 'no cases of an infectious nature are received'. By October 1911 he had reverted to calling the premises a sanatorium but for chest diseases.[164] In August 1913 he declined the terms offered by the Dublin Insurance Committee to treat their patients. These terms presumably equated to the £1 per patient per week paid by the committee to the Linden Convalescent Home or the one guinea per week paid to the Royal National Hospital for Consumption for Ireland.[165] None of his strategies appeared to have worked in attracting non-consumptive patients as in September 1913 he informed the insurance committee that he had relinquished his interest in the institution.[166] Once again attempts to establish a private tuberculosis sanatorium floundered on economic grounds.

The Larch Hill premises had been acquired by Lady Aberdeen, wife of the lord lieutenant, from her own personal funds.[167] She was familiar with the premises having visited them in an official capacity in October 1910.[168] Her intention was to use the premises as a home for the treatment of children suffering from non-infectious surgical tuberculosis.[169] However Colonel Charles D. Guinness, a resident of Tibradden, objecting to the 'arbitrary manner in which the scheme was conceived', raised a petition opposing the proposal signed by over 1,200 people from the surrounding areas. Their main grounds of objection related to the erroneous belief that persons suffering from surgical tuberculous were infective. Seeing no need to bring tuberculous persons from all over Ireland to their neighbourhood, they believed that recently established sanatoria at Crooksling and Peamount could adequately cater for local needs. They maintained that

[161] Ibid., 3 June 1909.
[162] *Weekly Irish Times*, 1 Jan. 1910.
[163] *Irish Times*, 19 Jun. and 18 Sept. 1909.
[164] Ibid., 22 Mar. 1911, 29 May 1911 and, 3 Oct. 1911.
[165] *Irish Independent*, 21 Aug. 1913; Royal National Hospital for Consumption for Ireland (RNHCI), *Report and statement of accounts with list of subscriptions for the year ended 31st December 1913*, p. 5 (NHA).
[166] *Irish Independent*, 11 Sept. 1913.
[167] *Weekly Irish Times*, 9 Dec. 1916.
[168] *Irish Times*, 13 Oct. 1910.
[169] *Irish Independent*, 3 Sept. 1913.

each county should cater for its own tuberculous patients, the vicinity of Dublin not being a suitable place 'for the assembly of all these diseased persons'. They questioned the wisdom of placing a hospital capable of containing three or four hundred patients 'in a locality to which the citizens of Dublin are in the habit of resorting to for fresh air and exercise'. They exhorted their political representatives, who would ultimately bear some responsibility for funding the project, to reject the proposals on which neither they nor the local residents had been consulted.[170] In December 1916 the premises was still lying idle 'owing to the war and other circumstances'.[171] It never re-opened as a sanatorium. By the mid 1920s it had reverted to use as a private residence.[172]

Conclusions

Wynne in common with many Anglican middle class women in the Victorian era considered it her religious and moral duty to perform charitable works for the benefit of the poorer classes. It was the observance of these duties that provided her with the motivation to develop her tuberculosis hospital concept. Her recruitment of Lady Zetland, probably intended to secure the endorsement of members of the nobility and thus raise the profile of the project, which in turn would facilitate fundraising, proved crucial. Lady Zetland used her social contacts to secure the site and establish a nationwide fund-raising network. She also performed an executive management role in overseeing the project and approving of the hospital plans, a role normally reserved to male board members.

The recruitment of key medical personnel provided legitimacy for the project and ensured the adoption of best medical practice in the development of the hospital. The recruitment of philanthropists provided ready access to funds and an inducement to like minded individuals to contribute. The political astuteness of certain of these board members made its development possible. The influence of religion played a key role in the sanatorium, initially in its impact on the development process and latterly in the continuous addressing by the board of matters of perceived religious importance.

[170] *Irish Times*, 3 Oct. 1913.
[171] *Weekly Irish Times*, 9 Dec. 1916.
[172] Damian O'Sullivan, 'A short history of Larch Hill' (www.larchhill.org) (11 Nov. 2011).

The hospital although modelled in almost all respects on the Royal National Hospital in Ventnor also borrowed the best design features from German sanatoria. Its subsequent development had regard to advances in design in British and continental sanatoria.

Attempts, in Leinster to replicate large, fee paying, continental sanatoria on a smaller scale floundered on economic grounds. With the available alternatives of travel to climates more amenable to sufferers, employment of nurses and doctors to provide for home treatment and competition for patients from larger British and more especially Swiss and German sanatoria, the small scale Irish institutions did not prove financially viable.

Chapter 3

The contribution of voluntary organisations to combating tuberculosis 1898-1916

In the decade 1871-1880 the average Irish national death rate attributed to tuberculosis was 2.6 per 1,000 of the population. It increased steadily thereafter to 2.7 deaths per 1,000 of the population in the decade 1881-1890 and 2.8 deaths per 1,000 of the population in the decade 1891-1900. It peaked at a rate of 2.9 deaths per 1,000 of the population in the years 1897, 1898, 1900 and 1904. In 1904, 12,696 deaths nationally were attributed to the disease accounting for 16 per cent of the total deaths from all causes that year. 3,774 of these deaths occurred in Leinster a rate of 3.3 deaths per 1,000. Dublin city accounted for 1,819 of the deaths a rate of 4.7 deaths per 1,000 of the population.[1] From 1904 to 1914 the national death rate from tuberculosis fell steadily declining to 2.07 deaths per 1,000 of the population (9,089 deaths) in the latter year. 2,849 of these deaths were recorded in Leinster (2.45 deaths per 1,000 of the population), with 1,103 (3.62 deaths per 1,000 of the population) of them occurring in Dublin city.[2]

In the late nineteenth and early twentieth centuries it was national voluntary organisations, which, through their organised campaigns, brought anti-tuberculosis measures into public focus thus placing them on political agendas. In Ireland the National Association for the Prevention of Tuberculosis and the Women's National Health Association fulfilled this function. Both organisations were to play a lead role in heightening awareness of the disease and the measures necessary to resist it.

National Association for the Prevention of Tuberculosis

The founding of the National Association for the Prevention of Tuberculosis can be traced to a series of meetings conducted by Sir William Broadbent, in 1898, to discuss

[1] *Forty-first detailed annual report of the registrar general for Ireland containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1904*, 1 [Cd 2673], H.C. 1905, xvii, 569.

[2] *Census of Ireland,1911. Area, houses, and population: also the ages, civil or conjugal condition, occupations, birthplaces, religion, and education of the people. Province of Leinster,* 1 [Cd 6049], H.C. 1912-13, cxiv, 1. *Fifty-first detailed annual report of the registrar general for Ireland containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1914*, 1 [Cd 7991], H.C. 1914-16, ix, 687.

the recent increase in knowledge about the means of spreading tuberculosis.[3] Present at the meetings was the dermatologist Malcolm Morris, editor of the medical journal *The Practitioner*. Morris had devoted the June 1898 edition to discussing new methods of dealing with tuberculosis, in particular the advancement in sanatorium treatment in Germany. For this edition he coined the phrase 'the crusade against consumption'.[4] Resulting from these meetings a conference of medical men was convened at which it was decided to form The National Association for the Prevention of Consumption (later retitled The National Association for the Prevention of Tuberculosis, the NAPT), with Broadbent as chairman and Morris as treasurer.[5]

The objectives of the association were to educate the public as to the means of preventing the disease, to extinguish tuberculosis in cattle and to promote the erection of sanatoria.[6] The fledgling organisation received a considerable boost, especially in terms of publicity, when on Broadbent's initiative a private meeting was held in London on 20 December 1898, at the invitation of and under the presidency of the Prince of Wales, to further the objectives of the association. At this meeting Broadbent set out the association's mission as the carrying 'into every dwelling in the land an elementary knowledge of the modes in which consumption is propagated and of the means by which its spread may be prevented'. He also expressed his belief that an educated public in self-defence would 'repress the filthy and unnecessary habit of expectoration in public vehicles and places of public resort'.[7] In France following Koch's discovery of the tuberculosis bacillus in 1882 doctors from leading medical schools had 'targeted spitting as the principle vehicle of tuberculosis and a fearsome treat to public health'. Resulting from this initiative government authorities 'covered walls in public places with placards and posters warning against spitting on the ground or floor'.[8] Prompted by its anti-tuberculosis crusading

[3] 'Obituary Sir William Henry Broadbent' in *BMJ*, ii, no. 2429 (1907), pp 177-81; M. E. Broadbent, *Life of Sir William Broadbent* (London, 1909), pp 268-9. Broadbent was physician extraordinary to Queen Victoria and consulting physician to St Mary's Hospital London.
[4] 'Obituary Sir Malcolm Morris' in *BMJ*, i, no. 3296 (1924), pp 407-9; Broadbent, *Sir William Broadbent*, pp 268-9.
[5] Broadbent, *Sir William Broadbent*, p. 269; Robert Philip, 'Malcolm Morris memorial lecture on the outlook on tuberculosis: changing orientation' in *BMJ*, i, no. 3653 (1931), pp 43-9.
[6] Broadbent, *Sir William Broadbent*, p. 270.
[7] 'The prevention of tuberculosis meeting at Marlborough House' in *BMJ*, ii, no. 1982 (1898), pp 1899-1903.
[8] David S. Barnes, *The making of a social disease: tuberculosis in nineteenth-century France* (Berkeley, 1995), pp 75, 88.

department of health director Dr Hermann Biggs, New York City had in 1896 passed an ordinance prohibiting public expectoration.[9]

The influence of the new organisation spread to Ireland when a special meeting of the board and medical staff of the National Hospital for Consumption for Ireland in Newcastle was convened on 1 February 1899 to further the objectives of the NAPT. The meeting, following an address by Thomas Grimshaw, passed a motion supporting the work of the association and called for the establishment of branches of the association in Ireland.[10] The first branch in Ireland was the Dublin branch formed following a conference on 30 June 1899, presided over by the lord lieutenant. The meeting appointed an executive committee with Grimshaw as president, a position he occupied until his death in January 1900, being succeed in the role by Lord Cardogan the lord lieutenant.[11] To fund its activities the committee set its annual membership at 5/- with life membership costing five guineas.[12]

Initially the branch had two core functions, raising public awareness of the disease through education and securing political support for initiatives to combat the disease. It commenced a public advertising campaign, in the process developing standardised methodologies. Part of the campaign involved approaching the Dublin Electric tram Company, requesting that they display transparency notices on all their vehicles banning spitting. The company acceded to this request, displaying advertisements designed by the association with the addendum 'conductors are requested to enforce this notice'. The committee designed posters and circulars listing precautions to be taken to prevent the spread of tuberculosis. In December it sought the consent of the Local Government Board (LGB) to have the posters placed in dispensaries and addressed a similar request to the various hospital authorities. It asked the National Board of Education to adopt its posters for use in national schools.[13]

[9] Jeanne E. Abrams, '"Spitting is dangerous, indecent and against the law!": legislating health behaviour during the American tuberculosis crusade' in *Journal of the History of Medicine and Allied Sciences*, lxviii, no. 3 (2013), pp 416-50.
[10] 'The prevention of tuberculosis' in *BMJ*, i, no. 1989 (1899), pp 367-9.
[11] 'The prevention of tuberculosis ' in *BMJ*, ii, no. 2010 (1899), pp 90-2; Minutes of inaugural meeting of Dublin branch of the NAPT, 3 July 1899; Minutes of meeting of executive committee of Dublin branch of NAPT, 20 Apr. 1900 (RCPI, NAPT/2).
[12] Minutes of meeting of executive committee of Dublin branch of NAPT, 17 July 1899 (RCPI, NAPT/2) (Henceforth Minutes Dublin Branch of NAPT)
[13] Minutes Dublin branch of NAPT, 12 Sept. 1899 and 15 Dec. 1899 (RCPI, NAPT/2).

In January 1900 the Dublin Corporation together with the urban district councils of Pembroke, Rathmines and Kilmainham and the Coombe Hospital adopted the posters and circulars for use in their facilities.[14] During the year the sanitary staff of Dublin Corporation distributed 20,000 of the circulars while the staff of Rathmines and Pembroke UDCs distributed 5,000 copies each.[15] The honorary secretary J Knox-Denham reported in June 1901 that the LGB had agreed to use its sanitary inspectors to distribute the committee's pamphlets throughout the country and to place in every dispensary and workhouse waiting room in Ireland large posters giving simple 'information to consumptive people and those who live with them' (See appendix 6). The task of distributing the posters nationwide was completed by mid-October.[16]

Also in June 1901, the president of the Commissioners of National Education in Ireland approved of the committee's scheme to deliver a series of lectures on tuberculosis and its prevention to the student teachers at the four national teacher training colleges in Dublin so that 'future teachers of the youth of Ireland can give intelligent practical instruction on this important subject'. Four doctors were appointed to deliver the programme during the autumn term.[17] Despite these initial successes, a proposed public meeting to elicit support for and promote the objectives of the association, agreed to at the inaugural meeting, was postponed indefinitely 'in view of the fact that concentration of public attention on the war in South Africa would in all probability interfere with the success of the meeting'.[18]

In pursuance of its function of securing political support to improve conditions and facilities for sufferers, in June 1900, the association called upon the Dublin sanitary authorities to provide small sanatoria for the treatment of consumptive poor in the early stages of the disease. It pointed out to Dublin Corporation the necessity of providing proper homes for advanced cases of the disease amongst the poorer classes as 'it is in the advanced stage that they are most infective to their families and most interfere with the earning capacity of those who have to nurse them'. The association drew the attention of the LGB to the necessity of isolating consumptive patients in union infirmaries

[14] Ibid., 1 Feb. 1900.
[15] *First annual report of the Dublin branch of the NAPT, 1901*.
[16] Minutes Dublin branch of NAPT, 22 Oct. 1900 (RCPI, NAPT/2).
[17] Minutes Dublin branch of NAPT, 19 June 1901 (RCPI, NAPT/3); *Freeman's Journal*, 22 June 1901.
[18] Minutes of inaugural meeting of Dublin branch of NAPT, 3 July 1899; Minutes Dublin branch of NAPT, 12 Sept. 1899 (RCPI, NAPT/2); *First annual report of the Dublin branch of the NAPT, 1901*.

throughout the country having regard 'to the infectious nature of consumption'.[19] At the 1902 annual meeting the committee pointed out that the treatment afforded by the Newcastle sanatorium was available only upon payment of a minimum weekly sum thus disbarring the very poor from the benefits of that institution. It therefore reiterated its call upon the Dublin sanitary authorities to provide sanatoria for the treatment of mild cases and isolation facilities for advanced cases. It also urged the authorities to adopt a scheme for the voluntary notification of tuberculosis and to provide for the thorough disinfection of all dwellings occupied by consumptives.[20] In April 1905 when city councillor Dr McWalter proposed a motion requiring the Public Health Committee of Dublin Corporation to investigate the feasibility of erecting a sanatorium for consumptives for Dublin the NAPT circulated all corporation members with information on the disease to elicit support for the motion. However its efforts were in vain as the motion was defeated on a vote of 21 to 17.[21] In November 1905 the NAPT passed a motion calling on Dublin Corporation to convene a meeting of all Dublin local authorities to consider the feasibility of erecting a tuberculosis sanatorium.[22]

While the Dublin authorities prevaricated the branch adopted the initiative. In March 1902 Sir Christopher Nixon became aware that the Sisters of Mercy had acquired a house and a 110 acre demesne at Beaumont, for the purpose of providing a convalescent home for the patients of the Mater Misericordiae Hospital.[23] He suggested to Sister Mary Ligouri Keenan, the sister superior of the hospital, that the site might be used for the establishment of a sanatorium for the treatment of destitute poor consumptives. The site appeared to be one that would obtain public support being ideally located in close proximity to the city yet being relatively isolated from neighbours, a potential source of objections to its use. Keenan placed the suggestion before her council, who, familiar with the ravages of the disease through their visitations to the sick and believing that skillful treatment administered in Beaumont would save many a young life, determined that 'no greater boon could be bestowed on those suffering from this painful and fatal disease than to have an institution in the country where they could be properly treated and in most cases cured'. However although willing to offer the site for the construction of a

[19] Minutes Dublin branch of NAPT, 1 Nov. 1900 (RCPI, NAPT/2).
[20] *Second annual report of the Dublin branch of the NAPT, 1902*; *Freeman's Journal*, 10 June 1902.
[21] Minutes Dublin branch of NAPT, 18 Apr. 1905 (RCPI, NAPT/3); *Freeman's Journal*, 20 Apr. 1905.
[22] Minutes Dublin branch of NAPT, 14 Nov. 1905 (RCPI, NAPT/3).
[23] Nixon was senior physician to the Mater Misericordiae Hospital and a member of the executive committee of the Dublin branch of the NAPT.

sanatorium and the services of the sisters to manage the institution and nurse the patients, as their resources had been drained in acquiring and equipping the premises for their own patients, they found it necessary to impose two conditions. Namely 'that the proposed sanatorium be built and fully furnished' at no cost to the congregation and 'that the expenses be defrayed for the maintenance of the patients and for the proper working of the institution'. Nixon discussed the matter with the Rev. W. Walsh the Catholic archbishop of Dublin, who gave the project his 'warmest commendation', coupled with an undertaking to aid the project in any way he could, based on his belief 'that the treatment of such cases in a general hospital such as the Mater Misericordiae would result in a spreading of the dreadful disease rather than in the checking of it'.[24]

In March 1902 the executive committee passed two motions fully supporting the Beaumont sanatorium project.[25] The Sisters of Mercy agreed that the proposed sanatorium would be a non-sectarian institution managed by the nuns, operating under a board of management representing all creeds in the community. At the AGM in June 1902 it was suggested that Dublin Corporation and the North and South Dublin Unions should in combination provide the sanatorium and jointly strike a rate sufficient to maintain the patients therein. However no action on the matter was taken. [26] In 1905 the attention of the public health committee of the corporation was again drawn to the offer of a free site made by the sisters but again the matter was left in abeyance.[27] The branch had created the ideal opportunity to develop a Dublin sanatorium, however unlike their Cork counterparts, their ability to influence the decision making of the fractious Dublin political status quo was ineffective (see Chapter 5).

While infrastructural projects were under discussion the educational remit of the association was not neglected. Between 1902 and 1903 work continued on distribution of posters and handbills with copies of the poster *Information for consumptive people and those who work with them* displayed in municipal libraries, Tara Street public baths, the offices of the city's public health department and the biscuit manufacturers W. R. Jacob

[24] Minutes Dublin branch of NAPT, 25 Mar. 1902, which include the text of letters on the subject, Sister Mary Ligouri Keenan to Sir Christopher Nixon 12 Mar. 1902 and William Walsh to Sir Christopher Nixon 12 Mar. 1902 (RCPI, NAPT/1).
[25] Minutes Dublin branch of NAPT, 25 Mar. 1902 (RCPI, NAPT/3); 'The prevention of consumption' in *BMJ*, i, no. 2153 (1902), p. 858.
[26] *Freeman's Journal*, 10 June 1902.
[27] Minutes Dublin branch of NAPT, 14 Nov. 1905 (RCPI, NAPT/3).

and Company.[28] Notices in relation to the prevention of consumption were also distributed by the postmaster general to post offices throughout Ireland and Great Britain.[29] Dublin Corporation had drawn up handbills similar to those drafted by the committee and staff of the public health department had distributed them in tenements throughout the city.[30] In January 1903 the committee distributed 10,000 copies of a pamphlet *Consumption and its prevention*, which had cost £8.[31] The pamphlet stressed the preventable nature of the disease and sought to dismiss all notions of it being hereditary, while emphasising the dangers of promiscuous spitting and the necessity for fresh air, proper diet and cleanliness. The pamphlet stressed the necessity of educating schoolchildren regarding tuberculosis. This theme was taken up by the Commissioners of National Education, who undertook to distribute an estimated 15,000 copies of the pamphlet to the managers of schools under their control.[32] Having regard to the demand for this pamphlet and the precarious financial position of the branch it was decided to charge persons or organisations seeking larger quantities of the pamphlet £1 per 1,000 copies.[33]

Edward P. Culverwell's landmark paper *Tuberculosis and consumption* was published in mid 1903.[34] In this paper he set out in terms readily understandable to the layman the modes of infection of tuberculosis and the precautions necessary to prevent its spread. From published examples he showed how in the absence of disinfection persons appeared to contract the disease from infected rooms and tenements. He argued for compulsory disinfection, pointing out that in 1902 the free service, offered by Dublin Corporation, to disinfect premises, occupied or recently vacated by consumptives, was refused in three quarters of cases. The reason advanced for this was the subsequent shunning by neighbours of persons who had had their premises disinfected. Such persons would 'attend wakes, sleep, dwell or visit in places teeming with infection, without a moment's misgiving, but as soon as ever the officer has been to disinfect a house or

[28] Ibid., 27 May 1902 and 7 Oct. 1902.
[29] Ibid., 18 Nov. 1902.
[30] Ibid., 27 May 1902.
[31] Ibid., 20 Jan. 1903.
[32] *Irish Times*, 4 May 1903.
[33] Income for 1902 together with cash on hands amounted to £24 5*s.* 7*d.* yet expenditure that year was £25 12*s.* 9*d.* leaving a debit balance of £1 7*s.* 2*d.* Minutes Dublin Branch of NAPT, 21 Apr. 1903 (RCPI, NAPT/3).
[34] *Irish Times*, 18 Apr. 1931. Culverwell was a fellow of Trinity College and an acknowledged expert on education and scientific training.

room, they shun it as if he has brought the plague instead of banishing it'. He considered it necessary to change the attitudes of the poorer classes so that they would demand the adoption of precautions by those afflicted with tuberculosis. He dispelled the myth of the hereditary nature of consumption demonstrating that in the absence of strict precautions the children and relations of consumptives are 'exposed to more frequent and more concentrated doses of infection than those whose near relatives are not consumptive' thus accounting for the apparent susceptibility of such families to the disease.[35] In October Culverwell offered to fund the publication of 500 copies of his paper, under the title *Consumption its history and how to prevent its spread*, if the committee adopted it as one of their publications. The offer was accepted.[36]

The Dublin branch developed new distribution methods to provide for greater dissemination of the educational material. In December 1903 it placed a price of 2d on Culverwell's 40-page pamphlet to encourage booksellers to stock copies of it, in the belief that purchasers would value it more than copies distributed free of charge.[37] That month agreement was reached with the Queen Victoria's Jubilee Nursing Institute to have the association's literature distributed to patients by Jubilee nurses, provided it had been approved by the local authorities.[38] In February 1904 it was necessary to print a further 10,000 copies of the pamphlet *Consumption and its prevention* at a cost of £7, to meet the demand thus created.[39] During 1904 literature was distributed through the technical instruction committees of the local authorities, the forerunners of the vocational education committees.[40] By December 1904 34,000 copies of the pamphlet *Consumption and its prevention* had been distributed nationwide.[41]

In 1905 agreement was reached with the Commissioners of National Education to produce a poster on consumption for display in national schools.[42] Demonstrating the

[35] Edward P. Culverwell, 'Tuberculosis and Consumption' in *The Dublin Journal of Medical Science*, cxvi, no. 380 third series (1903), pp 91-107.
[36] Minutes Dublin branch of NAPT, 20 Oct.1902 (RCPI, NAPT/3); *Fourth annual report of the Dublin branch of the NAPT, 1904* (NLI).
[37] Minutes Dublin branch of NAPT, 1 Dec. 1903 (RCPI, NAPT/3).
[38] Ibid, 15 Dec. 1903.
[39] Ibid., 2 Feb. 1904.
[40] Ibid., 13 Feb. 1904, 15 Mar. 1904, 18 Apr. 1905 and 30 May 1905. The committees had been established nationally under the Agriculture and Technical Instruction (Ireland) Act, 62 & 63 Vict., c.50 (9 Aug. 1899) to provide instructions in the principles of science and art applicable to industries .
[41] *Fourth annual report of the Dublin branch of the NAPT, 1904* (NLI).
[42] Minutes Dublin branch of NAPT, 18 Apr. and 14 Nov. 1905 (RCPI, NAPT/3).

branch's receptivity to the adoption of ideas tried elsewhere with success, the poster was based on a handbill, which had been distributed by Dr Birmingham the medical officer of health for Westport in his district since 1900. 10,000 copies of the new poster were provided to the educational authorities in 1906.[43] In order to promote this initiative, arrangements were made by the committee for Dr Kennedy the medical officer of health for Waterford to address the annual congress of the Irish National Teachers Organisation held in that city in 1906.[44]

The subject of spitting in railway carriages, considered by many medical experts at the time as one of the most obvious means of spreading the disease, yet largely ignored by the railway operators, was revisited by the Dublin branch in November 1902. It wrote to all railway companies with Dublin termini pointing out the dangers arising from the habit to both the public and company servants, especially carriage cleaners and advocating the necessity for notices and adequate disinfection procedures. The Dublin and Blessington Steam Tramway Company responded that instructions had been issued to staff to carry out the recommendations of the NAPT. The Dublin and Lucan Electric Railway Company replied that the cars of the company were sprinkled daily with a suitable disinfectant prior to cleaning. The directors of the Great Northern Railway Company sought advice on suitable wording for enamelled notices, which they undertook to erect in their third-class carriages.[45] However the company's general manager was of opinion that to enable the company to deal effectively with the matter it would be necessary to adopt by-laws making spitting an offence. A by-law to that effect had been sanctioned by the Board of Trade for adoption by the Liverpool Corporation Tramways providing for a fine of 40/-. That corporation had adopted a policy of requesting offenders to desist. Those who ignored the request were summoned. The stringent manner in which the courts had dealt with offenders had, it was reported, led to a marked diminution in the habit.[46]

Attempts by the Great Northern Railway Company to prohibit spitting were stymied by the Board of Trade, when in April 1903 it refused to sanction by-laws to that effect, on

[43] Ibid., 1 Dec. 1903, 27 Feb. and 20 Mar. 1906.
[44] Ibid., 20 Mar. 1906; *Fifth annual report of the Dublin branch of the NAPT, 1905*.
[45] Minutes Dublin branch of NAPT, 21 Oct. and 18 Nov. 1902 (RCPI, NAPT/3); *Freeman's Journal,* 21 Nov. 1902.
[46] Minutes Dublin branch of NAPT, 16 Dec. 1902 (RCPI, NAPT/3).

Plate 3.1 Sample of early 1900s notice regarding spitting displayed in third-class carriages by Irish railway companies. The first and second class carriages were decorated with scenic pictures of local attractions (D. G. Coakham, 'Passenger stock of the B. & C.D.R. in *Journal of the Irish Railway Record Society,* vii, 38 (1965), pp 176-190) (Irish Railway Records Society)

Plate 3.2 Standard sign regarding spitting erected by railway companies on platforms in Ireland in the early 1900s (Irish Railway Records Society)

Plate 3.3 Poster prohibiting spitting issued by the Dublin branch of the National Association for the Prevention of Tuberculosis, probably in the early 1900s (Royal College of Physicians of Ireland archives)

the grounds that railway companies were not unanimous on the matter. The company undertook to raise the subject at the conference of railway managers to see if concerted action was possible.[47] On 22 May 1903 the Board of Trade sanctioned new by-laws for the Dublin United Tramway company which contained a provision that 'no person shall […] spit in, on or against any carriage or wilfully interfere with the comfort of any person and any person so doing shall in addition to incurring the penalty provided (not exceeding forty shillings) forfeit his fare and be summarily removed by or under the direction of the conductor'.[48] However when in November 1903 a proposed by-law prohibiting spitting in 'any shed or covered platform of a station, or in any building of the company, or in any carriage or compartment of a carriage' was submitted by the Great Northern Railway Company to the Board of Trade, the proposal was again rejected as the board did not feel disposed to 'entertain the making of such a by-law as a separate matter' but would only consider same in conjunction with a general revision of by-laws.[49] Clearly, provision for the proper regulation of the railways was to take precedence over any attempt to prevent the spread of a contagious disease and protect the health of railway passengers. However the companies persisted and on 29 July 1904 the Great Southern and Western Railway Company passed a by-law prohibiting spitting in any building, platform or carriage of the company with offenders liable to be removed from the premises and subject to a fine of forty shillings for a first offence and five pounds for subsequent offences. The by-laws were sanctioned by the Board of Trade on 16 November 1904.[50] By 1911 the Great Southern and Western Railway Company was spending in excess of £100 per year on prosecutions, for spitting in railway carriages, 'instituted for the protection of public health'.[51]

When the Women's National Health Association (WNHA) was formed in 1907 the Dublin NAPT branch co-operated closely with it, contributing to the development of the organization, which was to assume its educational and political advocacy roles. In May 1907 Lady Aberdeen, wife of the viceroy, wrote to the branch enclosing her cheque for five guineas life membership and requesting assistance in the form of leaflets and lantern

[47] Ibid., 21 Apr. 1903.
[48] Ibid., 15 Nov. 1904.
[49] Ibid., 17 Nov. 1903.
[50] *By-laws and regulations made by the Great Southern and Western Railway Company, 29 July 1904* (Irish Railway Record Society Archives).
[51] *Irish Independent*, 6 Nov. 1911.

slides to inaugurate her newly-formed WNHA movement. The request was acceded to.[52] In August 1907 the branch secretary and the WNHA secretary acted as joint secretaries to the organizing committee for the forthcoming tuberculosis exhibition, at which several branch members delivered papers.[53] In November Edward Culverwell represented the branch on a deputation to the lord lieutenant organized by Lady Aberdeen to discuss the need for 'urgent action in dealing with tuberculosis in Ireland'.[54] Thereafter the role of the Dublin branch declined being largely superseded by the WNHA. When responsibility for dealing with the tuberculosis problem was handed over to state authorities following the enactment of the National Insurance Act 1911 the branch 'passed into a state of suspended animation'. However it continued to exist as a branch of the parent association ready to be called to action if the occasion arose. By the time of its demise it had distributed 50,000 copies of its consumption pamphlet and Culverwell's pamphlet had entered its third edition.[55] In January 1930 a decision was finally taken to dissolve the branch; its remaining assets amounting to £51 were distributed between Peamount and Newcastle sanatoria and Dr Steeven's and the Meath hospitals in Dublin.[56]

Foundation of the Women's National Health Association (WNHA)

The foundation of the Women's National Health Association owed much to the endeavours of Lady Aberdeen. The organisation superseded the NAPT in its educational role and political activities, employing innovative methods to deliver its messages to the public.

Lord Aberdeen arrived in Dublin to serve a second term as Irish viceroy in 1906. He was accompanied by his forty-nine year old wife Ishbel.[57] Her duties as viceroy's wife

[52] Minutes Dublin branch of NAPT, 21 May 1907 (RCPI, NAPT/3).
[53] *Freeman's Journal*, 15 Aug. 1907.
[54] 'Ireland' in *BMJ*, ii, no. 2450 (1907), pp 1742-5.
[55] Alfred E. Boyd honorary secretary NAPT Dublin branch to T. W. Lyster National Library of Ireland, 25 Sept. 1918 (NLI). Letter attached to the *fifth annual report of the Dublin branch of the NAPT 1905*, the last such report to issue.
[56] Alfred E. Boyd hon. secretary NAPT Dublin branch to the secretary Peamount sanatorium, 14 Feb. 1930 (NAI, Priv/1212/wnha/3/45). The sanatoria received £16 each and the hospitals £10 each.
[57] At this stage in her career Lady Aberdeen had developed many skills, which she was subsequently to employ for the benefit of the Irish populace. She was an accomplished organiser and administrator having, in 1881, established and directed a locally based Haddo House Young Women's Improvement Association in Scotland 'to work for the elevation of women materially mentally, morally and spiritually', which under her guidance, through the formation of a network of local branches, grew into the nationwide Onward and Upward Association. During the late 1880s and early 1890s her political skills were honed as a leading member and president of the 80,000 strong Women's Liberal Federation and as president of the International Council of Women. While based in Canada from 1893 to 1898 she was instrumental in

involved frequent visits to Dublin hospitals and attending the annual meetings of hospital boards. In the performance of these duties she became aware that many lives were lost through childhood diseases and tuberculosis and large classes of the population suffered permanent ill health through malnutrition.[58] She determined to take action to improve the health of the population. Her previous experiences had shown her that women had a significant role to play in shaping society and that 'if you would influence any class of people you must get at the women'.[59] Accordingly together with an acquaintance Alice Rushton she decided to form the Women's National Health Association.[60]

The inaugural meeting of the Women's National Health Association was held on 15 March 1907 when a provisional committee was appointed with Lady Aberdeen as president and honorary treasurer and Rushton as organizing secretary. The meeting adopted the objectives of the organization as drafted by Lady Aberdeen and Rushton as:-

> To arouse public opinion, and especially that of the women of Ireland, to a sense of responsibility regarding the public health. To spread the knowledge of what may be done in every home and by every householder to guard against disease and to eradicate it when it appears. To promote the upbringing of a healthy and vigorous race.

The initial focus of the association was on seeking 'the active co-operation of women of all classes' to 'stamp out' consumption, determining how to combat the causes of infant mortality and protecting the health of the population through proper supervision and regulation of the supply and distribution of milk.[61] The latter point was brought to public attention in January 1907, by the second report of the Royal Commission on Human and

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founding the National Council of Women of Canada and as president developing it into a national organisation and played a major role in the founding of the Victorian Order of Nurses for Canada. *Every woman's encyclopaedia* (8 vols, London *c*. 1910-*c.* 1912) vii, p. 4640. *Aberdeen Weekly Journal*, 11 Aug. 1891. *The Times*, 31 May 1893; W. T. Stead, 'Lord and Lady Aberdeen: a character sketch' in *Review of Reviews*, ix (1894), pp 41-60. National Council of Women of Canada 'History' (www.ncwc.ca) (20 Aug. 2012); *Inaugural meeting of the local council of women of Halifax. Address of her excellency the Countess of Aberdeen, August 24th 1894* (Halifax, 1894), pp 8-9. Keane, *Ishbel, Lady Aberdeen in Ireland* (Dublin, 1999), p.18; Aberdeen and Aberdeen ,*We twa, reminiscences of Lord and Lady Aberdeen* (2 vols, London, 1925), ii, pp 114-8; Victorian Order of Nurses, 'History- A century of caring'(www.von.ca) (21 Aug. 2012); Countess of Aberdeen, *What is the use of the Victorian order of nurses for Canada?* (Ottawa, 1900), pp 2-9.

[58] Majorie Pentland, *A bonnie fechter the life of Ishbel Majoribanks Marchioness of Aberdeen* (London, 1952), p. 158. Aberdeen and Aberdeen, *We twa*, ii, pp 276-7.

[59] *Aberdeen Weekly Journal*, 14 Apr. 1882.

[60] Report of the AGM of the WNHA, 13 Apr. 1915 (NAI, Priv/1212/wnha/3/13). Rushton's husband had died from consumption and her primary interest was in founding an organization 'to fight tuberculosis'.

[61] 'Ireland' in *BMJ*, i, no. 2420 (1907), pp 1211-2.

Bovine Tuberculosis[62], which found that certain cases of tuberculosis, especially in children, was caused by the ingestion of the bovine tuberculosis bacillus, introduced in the majority of cases through cow's milk. Its findings pointed to the necessity of stringent measures to prevent the sale of tuberculosis-infected milk.[63] Lady Aberdeen due to an attack of acute rheumatic fever was unable to attend the inaugral meeting. She engaged the services of the physician William Thompson to treat her and promptly recruited him to replace her as honorary treasurer of the association.[64] Two junior versions of the association were also instituted in the form of the Boy's National Health Battalion and the Girl's Guild of Good Health to inculcate the youth from an early age in the health measures necessary to avoid disease.[65]

To provide the newly-formed association with a proper island-wide reach it was necessary to form local branches through which its messages could be delivered and work performed. Following the formula she had devised for the Haddo House Association in Scotland, Lady Aberdeen drew up instructions detailing how to establish local branches. Preliminary meetings were to be held to which 'representative ladies […] in touch with all classes of the people' were to be invited. Gentlemen were to be invited to ascertain 'if the general public opinion of the district is in favour of the formation of such a society'. The instructions stressed the need to have available local expert speakers on the needs of the area and the role women could play in helping provide for them. Plans were to be in place for enrolling as wide a selection of women as possible. Once formed branches were expected to organize and provide facilities for lectures on various health matters, distribute literature produced by the association, liaise with the local district nurse or seek the appointment of one where absent and arrange for the regular inspection of school children by her. They were also to consider the adequacy of the milk supply chain and the inspections thereof, interest the local press in health matters and consider the creation of local dispensaries which might 'form a centre of information and

[62] The commission had been established in August 1901, to investigate the links between bovine and human tuberculosis, following the controversial declaration at the 1901 British Congress on Tuberculosis by Robert Koch, the discoverer of the tuberculosis bacillus, that bovine tuberculosis was incapable of development in man. (Address by Robert Koch to the second general meeting in *Transactions of the British Congress 1901*, i (London, 1902), pp 23-35).
[63] *Royal Commission on Tuberculosis (human and bovine). Royal Commission appointed to inquire into the relations of human and animal tuberculosis. Part I. Report,* 1, [Cd 3322], H.C. 1907, xxxviii, 1. (Henceforth *Second interim report of the Royal Commission on Tuberculosis).*
[64] Pentland, *A bonnie fechter*, p. 159.
[65] *Irish Times*, 9 Nov. 1908.

propaganda regarding the methods of fighting the ravages of consumption'. The services of Alice Rushton were offered to facilitate this process in return for half her travelling expenses together with the provision of hospitality for her.[66]

The expansion of the WNHA's educational role began in July 1907, when Lady Aberdeen received from friends in Boston pamphlets relating to a tuberculosis exhibition held in that city in 1906, which subsequently toured the area 'with very valuable educational results to the public'. She set about organizing a similar exhibition for Ireland, to be held in conjunction with the Irish Exhibition at Herbert Park, with the intention of touring it to various parts of Ireland, where branches of the association had been established. [67] The exhibition was opened by the lord lieutenant on 12 October 1907 and ran until 7 November in two of the exhibition halls. The exhibit was divided into four parts; statistical, literary, pathological and appliances and featured demonstrations on invalid cookery and the sterilisation and pasteurisation of milk. The statistics section, prepared by the registrar-general, showed in graphic form the extent of tuberculosis in Ireland, where it was responsible for 11,756 deaths in 1906. Of every 100 deaths in the country, 16 were attributable to the disease making Ireland the fourth worst 'with regard to the disease among the British possessions and foreign countries'.[68] The illustrations demonstrated that the worst affected areas were the unions of Cork and the North and South Dublin unions. Shock tactics to bring home the impact of the disease to the audience were employed by the display of pictures of the bacillus and dissected diseased lungs preserved in jars of formaldehyde. As part of its educational remit the appliances section incorporated two models, one a hygienic and the other an unhygienic room. Examples of isolation shelters, which could be purchased and used for the home treatment of consumptives, were displayed.[69] The exhibition was accompanied by a series of evening lectures on various aspects of the disease delivered by leading authorities in the field, with the opening lecture titled 'What the public can do in the fight against tuberculosis' given by William Ostler the regius professor of medicine at

[66] WNHA, *Suggestions for forming a local branch of the WNHA and indications of the means whereby the aims of the society can be advanced'* (undated) (NAI, Priv/1212/wnha/4/57).
[67] Ishbel Aberdeen to Dr Boyd, NAPT, 23 July 1907 (RCPI, NAPT/4).
[68] *Irish Times*, 12 Oct. 1907.
[69] *Irish Times*, 12 Oct. 1907; Brian Siggins, *The great white fair: the Herbert Park exhibition of 1907* (Dublin, 2007), pp.100-6; Frances Carruthers, 'The organisational work of Lady Ishbel Aberdeen, Marchioness of Aberdeen and Tenmair (1857-1939)' (PhD thesis in history, National University of Ireland, Maynooth, 2001), pp.133-7.

Oxford.[70] The popularity of the venture may be gauged by the fact that on numerous evenings many prospective members of the audience failed to gain admission.[71]

On the closing of the Dublin exhibition nationwide demand was such that it was found necessary to duplicate it providing for a northern and a southern circuit.[72] Detailed guidance notes were prepared setting out how preliminary public meetings should be arranged with local clergymen of all denominations, doctors, politicians, teachers, philanthropists, merchants, magistrates and especially ladies invited to attend for the purpose of forming an organising committee. The arrangements were facilitated by the distribution of explanatory literature on the nature and purpose of the exhibition which were provided free of charge from the viceregal lodge. Once a committee had been formed it was necessary to make formal application to Lady Aberdeen to procure a visit of the exhibition. Advance publicity for the exhibition was to be organized by obtaining the consent of bishops and clergy of all denominations to the distribution of handbills on the two Sundays preceding the exhibition and by distributing the handbills to schoolchildren, factory-workers and to every house in the district. Local committees found themselves incurring considerable costs in mounting the exhibition. Amongst the items to be paid for were the printing of publicity handbills and posters, the costs of conveying the exhibition from its last venue, the accommodation and travelling expenses of lecturers, the board and lodgings for the exhibition's custodian and the cost of labour in assembling and dismounting the exhibition. In keeping with Lady Aberdeen's non-denominational philosophy, it was necessary to procure a non-denominational hall in the town for the delivery of lectures, in addition to a display area of a least 2,400 square feet in which to mount the exhibition.[73]

If space permitted, two 'contrast bedrooms' were to be laid out as in the Dublin exhibition. One, demonstrating the ideal both for the avoidance and treatment of consumption, was to consist of a plain iron bed with sprung mattress and clean linen, oilcloth flooring, newly-papered walls, new painted or varnished chair, press and

[70] William Ostler, 'What the public can do in the fight against tuberculosis' in The Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis* (3 vols, Dublin, 1908), i, pp 17-28.
[71] Ishbel Aberdeen, 'Preface' in The Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis* (3 vols, Dublin, 1908), i, pp 1-4.
[72] Ishbel Aberdeen, 'Preface'.
[73] WNHA, *Notes for the guidance of committees preparing for a visit of the WNHA health exhibition* (undated) (NAI, Priv/1212/wnha/4/61).

washstand and a white painted window open either at top or bottom. In an early example of placed advertising, it was considered that a local trader at a total cost of *c*. £5 would sponsor this. The other unhealthy bedroom was to be furnished with a very old wooden bed complete with dirty linen and old dirty tick bolster, a broken chair, dirty washstand with cracked basin and ewer, a dirty torn carpet, a broken bottle with a candle with plenty of grease streaming down its sides and an old sealed four-paned window with broken panes stuffed with brown paper and rags. The dark paper walls were to be washed down in mud and ink and to complete the image empty cement bags were to be shaken over it to simulate dust and cobwebs added.[74] The expenses of mounting the exhibition did not prove a deterrent as by the end of August it had visited 67 venues on both circuits, which together with the Herbert Park exposition had catered for in excess of 550,000 visitors, who had listened to over 300 illustrated lectures delivered by prominent practitioners. As with the Dublin venue, due to lack of accommodation hundreds were 'crowded out and sent away' from many of the rural displays. Such was the pressure of numbers that on certain occasions it was reported necessary to engage the services of the local police to maintain control.[75]

With the National Council of Women of Canada, Lady Aberdeen had availed of the opportunities presented by local visits to deliver self-penned addresses, urging women to form local branches of the organization and encouraging continued participation in existing branches.[76] She employed a similar strategy in Ireland to stimulate local interest in the WNHA. Frequently such visits formed part of the local launch of the tuberculosis exhibition although some were solely to launch local branches of the fledgling organization. Often leaving the vice regal lodge in the Phoenix Park in Dublin in the early hours of the morning and returning late at night, Lady Aberdeen toured the country and during the first two years of the organization's existence she personally oversaw the establishment of branches in such diverse locations as Cork,[77] Portadown,[78] Kilkenny,[79]

[74] WNHA, *Notes for the guidance of committees*.
[75] *Irish Times*, 28 Aug. 1908.
[76] *Inaugural meeting of the local council of women of Halifax. Address of her excellency the Countess of Aberdeen, August 24th 1894* (Halifax, 1894); *Ottawa Citizen,* 27 Jan. 1931; National Council of Women of Canada, *Meeting to inaugurate the local council of Victoria and Vancouver Island on Thursday, November 8, 1894* (Victoria, 1894).
[77] *Irish Times*, 1 Jan. 1908.
[78] Ibid., 9 Jan. 1908.
[79] Ibid., 11 Mar. 1908; *Irish Independent,* 10 Mar. 1908

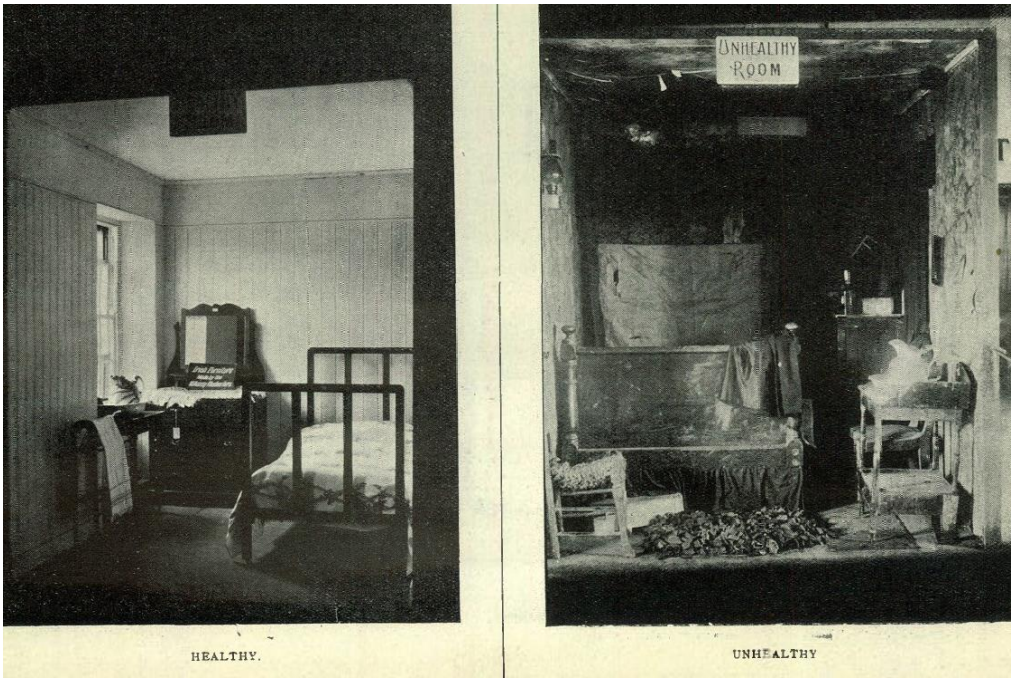

Plate 3.4 Models of two ‘contrast bedrooms’ which toured Ireland under the aegis of the Women’s National Health Association following the Dublin tuberculosis exhibition in 1907 (*Good Health,* August 1908)

Plate 3.5 The travelling caravan of the Women’s National Health Association, titled *Eire* touring Ireland with its anti-tuberculosis exhibition in 1908 (NAI, Priv1212/wnha/7/3)

Killarney,[80] Monaghan,[81] Clonmel[82], Kingstown,[83] Tipperary,[84] Bray,[85] Sligo,[86] Tullamore,[87] Wicklow,[88] Ennis,[89] Athy,[90] Donegal,[91] Terenure[92] and Tanderagee[93]. In the same period as part of her strategy she also visited existing branches exhorting them to continue in their endeavours at Banbridge,[94] Navan,[95] Nenagh,[96] Tralee,[97] Listowel,[98] Belfast,[99] Ballinasloe,[100] Derry,[101] Rathgar[102] and Bray[103]. When she found herself unable to attend such meetings, she tendered her apologies and arranged suitable replacements thus her husband oversaw the inauguration of the Bray[104] and Ennis[105] branches and Lady Mayo the institution of the Naas[106] branch. Alice Rushton continued to play a key role in the organization, touring the country, organizing visits to the exhibition, delivering lectures to interested parties on the role of the association and assisting in the formation of new branches. She helped establish the Belfast branch in October 1907 and oversaw the inauguration of branches in Wexford, Carlow, Trim, New Ross and Enniscorthy in early 1908. She reported that everywhere 'extraordinary interest' was taken in the exhibition, which became 'a meeting ground for those interested in public health and philanthropic matters'. She found that there was a general acknowledgement that there was a need for information on the matters addressed by the exhibition and that the formation of new branches of the association was everywhere welcomed.[107] The

[80] *Irish Times*, 24 Apr. 1908.
[81] Ibid., 16 May 1908.
[82] Ibid., 10 Feb. 1908.
[83] Ibid., 13 May 1908
[84] Ibid., 27 May 1908.
[85] Ibid., 30 May 1908
[86] Ibid., 11 June 1908.
[87] Ibid., 12 June 1908.
[88] *Ibid.*, 24 June 1908.
[89] Ibid., 3 July 1908.
[90] Ibid., 25 July 1908.
[91] Ibid., 28 Nov. 1908.
[92] Ibid., 12 Feb. 1909.
[93] Ibid., 25 Mar. 1909.
[94] Ibid., 10 Feb. 1908.
[95] Ibid., 9 May 1908.
[96] Ibid., 6 July 1908.
[97] Ibid., 23 July 1908.
[98] Ibid., 23 July 1908.
[99] Ibid., 22 Oct. 1908
[100] Ibid., 21 Nov 1908.
[101] Ibid., 18 Dec. 1908
[102] Ibid., 12 Mar. 1909.
[103] *Weekly Irish Times*, 27 Mar. 1909.
[104] *Irish Times*, 30 May 1908.
[105] Ibid., 3 July 1908.
[106] Ibid., 26 Mar. 1908.
[107] Reports of Alice Rushton to Lady Aberdeen 5 Oct. 1907 and 28 Feb. 1908 (NAI, Priv/1212/wnha/3/2); *Proceedings of the first annual meeting of the WNHA*, 14 Apr. 1908 (NAI, Priv/1212/wnha/1/2).

success of the strategy employed may be adjudged by the number of branches formed nationwide rising from 41 in April 1908 at the end of the association's first year of existence to 172 in April 1909 at the end of the second year.[108]

Lady Aberdeen was quick to realize the limitations of the traveling exhibition. Because of its size and cumbersome nature it could be mounted only in those larger centres of population where facilities were available. To remedy this situation and provide for greater dissemination of information she conceived the idea of a smaller exhibition capable of being transported by mobile caravan. With the aid of a grant of £500 from the trustees of the estate of Lady Pembroke, the WNHA obtained and equipped a horse drawn caravan titled '*Eire*'. Taking the theme of the 'war on consumption' the van advertised its weapons as 'pure air, pure food, pure milk and cleanliness' and declared its enemies to be 'bad air, bad food, bad drink and dirt'. To reach both English and Irish speaking populations this simple message was painted on one side of the van in English and on the other in Irish. It was fully equipped with diagrams, charts, pictures, pathological exhibits, a limelight lantern with slides to illustrate lectures and literature to be delivered free of charge at the venues visited. A gramophone was supplied to provide 'musical selections to enliven the proceedings', which was occasionally supplemented with performances by local musicians. Staff consisted of a bi-lingual doctor capable of delivering lectures in both Irish and English, a cookery teacher and demonstrator who also delivered special lectures to children, an exhibition custodian and a driver. Margaret Molloy who had been in charge of the tuberculosis exhibition's southern tour was engaged as advance agent. In this role she organized preliminary public meetings to which all local dignitaries including the local bishops were invited. At the meetings she explained the 'benefits to be derived from a visit of the van' and made arrangements for the formation of local committees who would fund the visit, which could last for up to four days. [109]

The new caravan left Dublin on the morning of 6 November 1908 en route for Rathcoole, County Wicklow, where three days later it was formally launched by Lady Aberdeen in

[108] *Irish Times*, 22 Apr. 1909.
[109] 'The travels of the tuberculosis exhibition caravans' in The Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis* (3 vols, Dublin, 1908), iii, pp 121-6; *Connaught Tribune*, 25 Sept. 1909.

the presence of the local parish priest and members of the local branch of the WNHA.[110] The following day the caravan proceeded to Newtownmountkennedy where again Lady Aberdeen was in attendance together with members of the local Catholic and Church of Ireland clergy and local dignitaries.[111] Following a short visit to Newcastle village the van was returned to Dublin to remedy certain shortcomings, which were discovered on this trial run. From there it was transported by rail to Killeshandra, County Cavan and from there by road to Trillick, County Tyrone, where Lady Aberdeen gave 'a formal send off' to the caravan on its tour of the north-west.[112] Lady Aberdeen had herself played a key role in this process personally overseeing the selection of the exhibits and mapping out the dates and the route to be taken by the caravan. Having being regularly informed by telegram of the traveling exhibition's progress four weeks into the tour she declared in her diary the project a success.[113]

On route from Strabane to Lifford in mid March 1909 the accidental overturning of the stove resulted in the total destruction of the caravan and its contents.[114] At 103 locations over 70,000 people had visited the caravan since its inception and in order not to lose momentum arrangements were made to deliver lime light lectures with the lecturers traveling by car to the arranged venues.[115] An immediate public appeal for funds to provide a replacement caravan was launched.[116] Within days the trustees of Lady Pembroke's estate provided a sum of £300, which enabled the appeal organizers to announce that no further subscriptions were required and that surplus funds would be returned to the subscribers or at their behest applied to the 'general purposes of the anti-tuberculosis campaign'.[117] A new caravan named 'Phoenix' was procured and outfitted however its pressing into service was delayed when it was accidentally damaged on coming into contact with an overhead bridge while being conveyed by rail from Dublin. The Great Northen Railway Company admitted liability for the accident and bore the costs of the repairs.[118] By early April the fully restored caravan's tour was resumed with

[110] *Irish Times*, 7 and 9 Nov. 1908.
[111] Ibid., 11 Nov. 1908.
[112] 'The travels of the tuberculosis exhibition caravans'; *Irish Times*, 27 Nov. 1908.
[113] Pentland, *A bonnie fechter*, p. 160.
[114] *Irish Times*, 16 Mar. 1909.
[115] Ibid., 16 Mar. 1909; 'The travels of the tuberculosis exhibition caravans'; 'Ireland' in *BMJ*, i, no. 2522 (1909), pp 1088-9.
[116] *Weekly Irish Times*, 20 Mar. 1909.
[117] *Irish Times*, 18 Mar. 1909; *Freeman's Journal*, 18 Mar. 1909.
[118] *Freeman's Journal*, 2 Apr. 1909.

total attendance climbing to 105,500 by the end of May, at which stage 357 lectures had been delivered.[119]

However the touring caravan was not universally welcomed. Henry Robinson, the vice president of the LGB and a critic of Lady Aberdeen, maintained that the lectures on the cure and prevention of tuberculosis 'rather frightened the people' and that the people objected to the importation of pathological samples into their districts convinced that 'some of them microbes might escape…attacking quiet people when it was too dark to see them and get out of their way'.[120] In Athenry following an address by Margaret Molloy to a preliminary meeting under the chairmanship of the local parish priest it appeared that the majority of those present did not favour a visit. Although a show of hands voted eleven to ten to permit the visit, it was not arranged as 'the proceedings would not be very popular.[121] The closeness of the vote may have been influenced by the presence of three clergymen whose parishioners did not want to be seen to oppose their wishes. Support for the tour came from Dr John Healy, Roman Catholic archbishop of Tuam, who warned 'against paying any attention to the nonsensical scare got up by some people about the visit of the van'.[122]

In 1909, certain political bodies began to raise objections to the WNHA campaign. The South Dublin Union Guardians called on Lady Aberdeen to discontinue the tuberculosis crusade because of the deleterious effect it was having on the commercial interests of the country and on tourist traffic. They cited in support of their call allegations that persons had been dismissed from employment because of 'the faintest tint of consumption', that an outcome of the campaign was that Irish persons could no longer get employment in England and that fear of visiting certain parts of the country was resulting in falling tourist numbers.[123] They were joined in the call by the members of Rathdown Rural District Council who blamed the fall off in the tourist trade on 'the alarmist speeches made at meetings and published in newspapers and the promiscuous dissemination of literature representing Ireland as a hotbed of consumption'.[124] Castlebar Urban District Council also objected to the campaign fearing it was ruining Ireland having destroyed the

[119] 'The travels of the tuberculosis exhibition caravans'.
[120] Henry Robinson, *Memories wise and otherwise* (London, 1923), pp 225-6.
[121] *Connaught Tribune*, 16 Oct. 1909.
[122] Ibid., 25 Sept. 1909.
[123] *Irish Times*, 16 Sept. 1909.
[124] Ibid., 23 Sept. 1909.

lace-making industry and stating that 'Americans and other foreigners were now afraid to come to Ireland to mix with the people as they thought the country was full of consumption'.[125]

The WNHA position was strongly defended by Lady Aberdeen who pointed out that it was 'not in the power of any individual to stop the campaign' which was being carried out not only in Ireland but in 'every enlightened country' resulting in such a level of public awareness that 'they would only avoid those countries where no preventative or curative measures were being taken'.[126] Her stance was supported by the chairman of the Killarney branch of the WNHA who obtained a statement from Cook and Son the leading travel agency that the campaign had no effect whatsoever on the tourist industry with neither their agents in Dublin nor London being able to cite a single instance of the campaign dissuading a potential visitor. Rather, poor weather was responsible for the drop in tourist numbers in the early party of the year, which numbers had since recovered. Regarding the lace industry she had obtained evidence from the leading manufacturers and exporters that 'business was brisk' and the 'difficulty was in getting work done fast enough'. They were 'unaware of any scare about tuberculosis in the lace trade'. She completed her demolition of her opponents' arguments by obtaining evidence from prominent English employers that they had never thought of refusing employment to Irish persons because of the fear of consumption or on any other grounds.[127] The allegation of persons being dismissed from employment was refuted by the company in question, Messrs. Jacob, as groundless and withdrawn by its assertor.[128]

In 1890 Lady Aberdeen launched a monthly magazine titled *Onward and Upward,* in order to keep in contact with the ever-expanding membership of that organisation. She personally edited the magazine in addition to penning many of its articles.[129] Having observed the usefulness of this magazine as an effective means of communication between members of an organization and having honed both her writing and editorial skills, Lady Aberdeen decided to establish a similar magazine for the members of the

[125] *Freeman's Journal*, 29 Sept. 1909.
[126] *Irish Times*, 30 Sept. 1909.
[127] Ibid., 11 Oct. 1909.
[128] Ibid., 30 Sept. 1909.
[129] *Birmingham Daily Post*, 27 Aug. 1890; *Aberdeen Weekly Journal*, 3 Dec 1890.

WNHA.[130] The necessity for the magazine arose from the geographical spread of the association's almost 100 branches which had resulted in their isolation from each other and their consequential exclusion from 'the stimulus and practical help that could be theirs if they knew what was being done elsewhere'.[131] The magazine edited by Lady Aberdeen and titled *Sláinte* was launched in January 1909 as a monthly publication at a price of 1*d.*. In its first year the magazine had a paid circulation of 1,176 copies however an additional 7,000 copies were distributed free of charge by the organization's central office.[132] In addition to reports on the activities of both the national association and its branches, together with notifications and detailed descriptions of lectures and exhibitions of interest, the magazine also furnished articles by prominent practitioners and details of developments abroad on a wide range of health issues with particular emphasis on tuberculosis. The magazine continued in a monthly format until late 1914 when difficulties occasioned by the first-world-war began to interrupt its publication schedule. It was reconstituted, as a quarterly bulletin in August 1915 but was unable to continue following the publication of its January 1916 issue. During its short life it had become one of the chief methods of dissemination of information on tuberculosis to the public in Ireland, its articles being extensively referenced and quoted in newspapers and many being published in leaflet format.

Appointment of Nurses

The concept of district nursing for the poor had been introduced into Ireland thirty years prior to the establishment of the WNHA and operated under the control and direction of the Queen's Jubilee Institute. Each newly-formed branch of the WNHA had as one of its 'foremost objects […] obtaining the services of a district nurse in places where there were none available'.[133] With little local experience in the engagement of suitable individuals to fill such positions, it fell to the central association to develop a scheme to fill the posts.

[130] In 1893 her book *Through Canada with a Kodak,* sketches of two tours of Canada many of which had appeared as articles in *Onward and Upward* was published. While in Canada she personally scripted her speeches many of which were subsequently published in leaflet form such as her addresses to the local inaugural meetings of the National Council of Women of Canada at Halifax, Port Arthur and Victoria, her annual speeches as president of that organization and her explanatory pamphlet on the role of the organization. She edited the seven-volume report on the London International Congress of Women in 1899. Following the 1907 Dublin tuberculosis exhibition she personally edited the three-volume account of the proceedings.
[131] *Sláinte*, i, 1 (1909), p. 1.
[132] WNHA, *Report for 1910*, p.2 (NAI, Priv/1212/whna/6/1).
[133] WNHA, *Employment of district nurses* (Dublin, undated) (NAI, Priv/1212/wnha/4/64).

In the early 1870s Lady Plunket, wife of the Protestant archbishop of Dublin, while on house visits as part of the St Patrick's cathedral mission, came into frequent contact with the extent of sickness that existed amongst the Dublin poor. She formed the idea of adding district nursing to the charity and in 1876 founded the St Patrick's Nursing Home to train district nurses to minister to the needs of the poor. To ensure that members of all creeds could benefit from the services she enforced a rule that nurses should not interfere with the religion of the patients.[134] In 1887 to celebrate the occasion of Queen Victoria's jubilee a women's fund was established to which over three million women contributed. Having disbursed the fund on various pet projects Queen Victoria decided that the balance of the fund amounting to almost £70,000 should 'be devoted to the benefit of nurses or nursing establishments'.[135] She appointed trustees of the fund, assigning them the task of deciding how it could best be applied. They recommended that an institution be founded 'for the education and maintenance of nurses for tending the sick poor in their own homes'.[136] Thus the Queen's Jubilee Institute was founded being incorporated by royal charter in 1889.[137] In 1890 St Patrick's Nursing Home was affiliated to the institute and became responsible for the training of the institutes nursing candidates in Ireland.[138]

As the majority of the poor in Dublin were Roman Catholics, the Catholic authorities 'in order to give effect to the beneficent purposes of the jubilee fund', while at the same time ensuring that poor members of their religion would not fall under the influence of the Protestant St Patrick's nurses decided to start a Catholic nurses' home. St Laurence's Catholic Home was established in 1891 being affiliated to the Queen's Jubilee Institute from its inception. Although operated under similar non-sectarian rules to its Protestant counterpart, its purpose was to ensure that sick Catholics would, 'in good time, receive the consolations of their religion' by providing a pool of personnel upon which their co-

[134] Falkiner, Ninian M., 'The nurse and the state' in *Journal of the Statistical and Social Inquiry Society of Ireland*, xiv, no. 1 (1919/20), pp 29-60; 'District nursing in Ireland' in *The British Journal of Nursing*, l, no. 1313 (1913), pp 437-8; Lavinia L. Dock, *History of nursing* (4 Vols, London, 1912), iii, pp 108-9.
[135] 'The Queen's nursing fund' in *BMJ*, ii, no. 1391 (1887), pp 475-6.
[136] William Rathbone, *Sketch of the history and progress of district nursing from its commencement in the year1859 to the present date including the foundation by the queen of the Queen Victoria Jubilee Institute for nursing the poor in their own homes* (London, 1890), p. 81. The trustees were the Duke of Westminster, Sir James Paget, the queen's physician and the former diplomat Sir Rutherford Alcock.
[137] Amy Hughes, 'The origin, growth and present status of district nursing in England' in *The American Journal of Nursing*, ii, no. 5 (1902), pp 337-345.
[138] 'District nursing in Ireland' in *The British Journal of Nursing*, l, no. 1313 (1913), pp 437-8.

religionist priests, doctors and charitable visitors could call upon in emergencies to administer to the Catholic sick.[139]

Initially all institute nurses were required to undergo one to two years' training in a general hospital followed by three months' training in a maternity hospital after which they would receive six months' training in district nursing under the supervision of a trained district nursing superintendent.[140] However by 1908 the period of general hospital training in keeping with the general professionalisation of nursing services was extended to a compulsory three years.[141]

In pursuance of their objective in early 1908 the central committee of the WNHA entered into an agreement with the Queen's Jubilee Institute for the provision of nurses as required. Each nurse would cost the employing branch approximately £100 per annum. However for those branches unable to raise the means to employ such a nurse, a special scheme was developed in co-operation with the Queen's Institute for the employment of trained health workers, who could be employed at a lower cost of between £55 and £75 a year in addition to a uniform allowance and the provision of a bicycle where required. These health workers were required to have a minimum of one year's hospital nursing training following which they would receive two months' district training, 'including special instruction in dealing with the home treatment of tuberculosis', in one of the two homes affiliated to the institute.[142] In order to differentiate the health workers from the fully-qualified nurses the WNHA designed a separate uniform which could not be mistaken for the nurses' distinctive blue one. The engagement of the nurses and health workers was the sole responsibility of the employing branch. However, in order to ensure a continuing good relationship with the medical profession, the sanction of local doctors was required before any appointment was made.[143] Both nurses and health workers were subject to supervision by the institute, which produced periodic reports on their performance.[144]

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[139] M. J. Martin, 'St Laurence's Catholic Home' in *The Irish Monthly*, xxi, 235 (1893), pp 14-8.
[140] Mrs. Dacre Craven, *A guide to district nurses* (London, 1889), p. vii.
[141] 'District nursing' in *BMJ*, i, no. 2465 (1908), pp 771-2.
[142] WNHA, *Employment of district nurses* (Dublin, undated) (NAI, Priv/1212/wnha/4/64).
[143] WNHA, *Memorandum of conditions under which the WNHA may employ queen's nurses and health workers under the supervision of the Queen Victoria's Jubilee institute for nurses* (Dublin, 1908). (NAI, Priv/1212/wnha/4/87).
[144] WNHA, *Memorandum;* Letter Miss A. Martin Leake, Queen Victoria's Jubilee Institute for Nurses to Sir William Thompson, Hon. Sec. WNHA, 19 June 1909 and letters Miss A. C. Lowe Queen Victoria's

The agreement between the WNHA and the Queen's Institute bore early fruit. By the close of 1910 thirty jubilee nurses and four jubilee health workers were employed nationwide by branches. In five instances branches unable to acquire the services of a jubilee nurse had employed trained hospital nurses although two of these individuals were employed solely to run baby clubs. In addition forty-three jubilee nurses and sixteen trained non-jubilee nurses were employed in areas covered by other WNHA branches. Although the local branches did not directly employ these nurses, many individual members of the branches contributed to their employment and four branches had entered formal arrangements to contribute to the engagement of these nurses. In Leinster eighteen jubilee nurses, one jubilee health worker and four non-jubilee nurses were employed directly by the WNHA's constituent branches, while a further seventeen jubilee nurses and five non-jubilee nurses were employed by a variety of local committees, resulting in a reasonable geographic spread of district nurses throughout the province (see appendix 7).[145]

Conclusion

The publicity campaigns conducted by both the National Association for the Prevention of Tuberculosis and the Women's National Health Association, through its posters, pamphlets, leafleting, lectures, travelling exhibitions and magazines brought tuberculosis, its causes and methods of prevention to the forefront of public notice. They succeeded in grasping the attention of all sectors of society and keeping them focused on tuberculosis, enlisting the aid of public authorities, transport companies and clergy of all denominations to do so. It was pressure from the NAPT that lead to the introduction of anti-spitting bye-laws. Through the employment of nurses the WNHA became involved in the direct provision of medical services to the poor on a scale not seen before, delivering health care to the poorest and most neglected sectors of the population.

Jubilee Institute for Nurses to Sir William Thompson Hon. Sec. WNHA, 22 Dec. 1909, 9 June 1910 and 16 Feb. 1911 in minutes of meetings of Hospitals Tuberculosis Committee1907-1911 (NAI, Priv/1212/wnha/1/15).

[145] WNHA, *Report for 1910*.

Chapter 4

Laying the foundations for tuberculosis treatment—Legislative change 1908-1911

Although by 1905, throughout the United Kingdom, the number of deaths from all forms of tuberculosis was decreasing, high levels of mortality were still attributed to the disease. Tuberculosis had accounted for 10.7% of all recorded deaths in England and Wales, in 1905. In total 57,759 had died from the disease, a rate of 1.63 deaths per 1,000.[1] In Scotland, in 1905, there were 9,619 tuberculosis deaths amounting to 13% of all Scottish deaths, a rate of 2.07 deaths per 1,000.[2] The Irish records for 1905 showed 11,882 tuberculosis deaths, being 16% of the total number of deaths, a rate of 2.71 deaths per 1,000.[3]

In order to counteract these high mortality rates, in the early years of the twentieth century new legislation was enacted in the United Kingdom that at last provided a statutory basis for tackling tuberculosis. It mirrored foreign legislative developments directed towards this aim. Of primary concern was the introduction of compulsory notification to authorities of persons found to be suffering from tuberculosis and the provision of facilities for their treatment and isolation. Although the primary focus of Irish politicians in Westminster was on the question of home rule for Ireland, they nevertheless brought pressure to bear to ensure that enacted provisions specifically addressed Irish circumstances.

Notification of tuberculosis

Following Koch's discovery of the tuberculosis bacillus in 1882, which provided proof of the infective nature of the disease, many prominent physicians turned their attention to identifying the steps necessary to counteract the disease. One such step was the voluntary or compulsory notification of the disease. Such notification would provide authorities

[1] *Sixty-eighth annual report of the Registrar-General of Births, Deaths, and Marriages in England and Wales,* 1 [Cd 3279], H.C. 1906, xx, 1.
[2] *Fifty-first detailed annual report of the Registrar-General of Births, Deaths, and Marriages in Scotland,* 1 [Cd 3650], H.C. 1907, xvi, 233.
[3] *Forty-second detailed annual report of the Registrar General for Ireland, containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1905,* 1 [Cd 3123], H.C. 1906, xx, 617.

with data to determine what actions to put in place. It would enable them to educate the members of consumptive households on how to avoid the spread of the disease, both through the distribution of information leaflets and through visits by properly-trained personnel. By providing for continuous supervision of tuberculosis cases it could ensure that patients applied precautionary measures to protect themselves and others. It would facilitate the putting in place of disinfection regimes covering premises vacated by tuberculous persons. With such information the authorities could identify where sanatoria for incipient cases or isolation hospitals for advanced cases were required. As in the case of smallpox and cholera this new data could lead to the compulsory hospitalisation of dangerous non-compliant infectious cases.[4]

Resulting from pressure applied by Hermann Biggs, the director of laboratories in New York City's Department of Health, a scheme of voluntary notification was introduced there in February 1894. Under this scheme all data supplied was kept strictly private. The only premises visited by department inspectors for the purpose of dissemination of information were tenement houses, boarding houses and hotels. If notifying physicians undertook to provide the necessary information by either personal visits or leaflet drops department inspectors were not engaged. When vacated, premises formerly occupied by consumptives, were visited by inspectors, who directed 'the removal of infected articles such as carpets rugs bedding etc., for disinfection', a service provide free of charge. The inspectors also made recommendations as to 'the cleansing and renovation of the apartment as may be required'. These recommendations were embodied in an order served on the owner with compliance enforced. No persons except existing residents were allowed to occupy the premises pending compliance with the order.[5]

The New York scheme was moderately successful with 4,166 cases reported in its first year of operation rising to 8,334 by 1896. However the lack of in-patient treatment facilities proved a serious drawback. In addition many sufferers either through ignorance or impoverished living-conditions were unable to follow anti-infection instructions. This resulted in a decision of the board of health in January 1897 to immediately secure the

[4] Alderman McDougal, 'On the notification of phthisis as carried out in the city of Manchester' in *Transactions of the British Congress 1901*, ii (London, 1902), pp 14-24.
[5] Hermann M. Biggs, 'The notification of tuberculosis in New York City and its results' in *Transactions of the British Congress 1901*, ii (London, 1902), pp 5-14. The paper was read by Professor Janeway on behalf of Biggs who was unable to attend due to family illness.

provision of hospital accommodation for poor pulmonary tuberculosis sufferers who were active sources of danger to the community. The board also decided to make the disease compulsory notifiable in respect of those cases 'which are likely to be communicable and therefore dangerous' to public health. Later that year a sum of $60,000 was appropriated to compensate private institutions at the rate of one dollar a day for the care of such patients. As it would have been 'undemocratic and probably illegal' to apply the regulations to tenements and not to private houses the ordnance was of general application. However it was not strictly enforced in private practice cases with attending physicians been written to and asked to explain failure of notification only in cases of reported deaths from the disease, it being assumed that such private patients had been instructed by their physicians in precautionary measures.[6]

In May 1900 Norway seeking to emulate the objectives of the New York scheme introduced compulsory notification. In the Norwegian scheme compliance with instructions as to the implementation of preventative measures was obligatory. If patients or their connections failed to concur with issued orders the state was empowered to remove them to hospital. In the event of a husband and wife expressing a wish to remain together they could not be separated, resulting presumably in both being institutionalised.[7] Boston was to follow suit introducing compulsory notification and compulsory removal of patients in May 1900 when it had in place the organisational structure to enable it 'to carry out the steps which logically must arise from such an action'. These steps included the appropriation of funds to provide a municipal hospital for advanced cases. Between May 1900 and July 1901 fourteen cases were forcibly removed for treatment to a pauper hospital.[8]

In Britain in 1893 James Niven, Oldham's medical officer of health, presented a scheme for the notification of phthisis to the Oldham Medical Society however due to opposition it did not proceed.[9] In 1894 Cheshire County Council had suggested to its constituent borough, urban and district councils that phthisis should be made a compulsory notifiable

[6] Biggs, 'The notification of tuberculosis'.
[7] M. Holmboe, 'On the notification of tuberculous diseases in Norway' in *Transactions of the British Congress 1901*, ii (London, 1902), pp 26-7.
[8] A.K. Stone, 'The notification of tuberculosis in Boston, U.S.A.' in *Transactions of the British Congress 1901*, ii (London, 1902), pp 40-4.
[9] Arthur Newsholme, 'The voluntary notification of phthisis in Brighton' in *JRSI*, xxviii, no. 1 (1907), pp 26-35.

disease. Although many authorities passed resolutions to similar effect, upon making application to the LGB seeking sanction to their proposals in every instance the board declined to give the necessary approval.[10]

The 'much vexed question of compulsory notification'[11] was the subject matter of several papers delivered to the sixty-fourth meeting of the British Medical Association in 1896 and featured largely in the debates thereon. The Dublin-based John William Moore[12] in his keynote address expressed the opinion that compulsory notification of tuberculosis was impracticable having regard to the many manifestations and chronic nature of the disease, which would lead to notifications being received concerning the same individual continually at intervals of months or years, following periods of remission. He stated that it would be of little practical use 'as regards disinfection while the invalid was occupying his room or dwelling'. However he favoured voluntary notification and compulsory notification in the case of death from tuberculous to facilitate the disinfection of the dwelling-place and the effects of the deceased.[13]

Thomas Wrigley Grimshaw, the Registrar General for Ireland, supported Moore's contentions. He stated that the impracticability of compulsory notification was 'calculated by its failure to throw doubt on the value of notification generally in the eyes of the public and thus throw discredit on the notification of infective fevers'. He felt that complete or compulsory isolation of notified patients was impracticable, and strongly condemned attempts to deal with such patients in general hospitals. He recommended 'the establishment of special hospitals for the treatment of the disease in its early stages and hospitals for incurables for the reception of advanced and incurable cases'. Grimshaw succeeded in having a proposal passed, which called inter alia for the provision by all sanitary authorities at public expense of bacteriological laboratories for the diagnosis of the disease from sputum samples.[14]

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[10] Dr Francis Vacher medical officer of health for Cheshire during the discussion on a paper on 'Notification of tuberculosis' by John Robertson at the 1904 Glasgow conference of medical officers of health in *JRSI*, xxv, no. 3 (1904), pp 763-4.
[11] 'British Medical Association sixty-fourth annual meeting brief summary of proceedings section of medicine' in *BMJ*, ii, no. 1858 (1896), p.347.
[12] Moore was senior physician to the Meath Hospital and Professor of the Practice of Medicine at the Royal College of Surgeons in Ireland.
[13] 'Discussion of tuberculosis its prevention and cure' in *BMJ*, ii, no. 1867 (1896), pp 1008-13.
[14] Ibid.

James Niven, the Manchester medical officer of health, in his paper delivered to the 1896 meeting considered that tuberculosis with discharge should be made a notifiable disease, as this would facilitate the gathering of clinical information regarding the various conditions under which persons contracted tuberculosis. He did point out however that assembling such information would require additions to the sanitary staff, probably a qualified medical assistant. However such a person would also be in a position to remedy domestic insanitary conditions thus enhancing the patient's chances of recovery and diminishing the risk of infection to other household members. In addition he could distribute information on preventative measures and secure the disinfection of premises. He also maintained that such notifications could 'bring about an understanding with medical practitioners as to their giving systematic personal instruction to the patients' and their attendants a matter which he obviously felt was being neglected. Sir Charles Cameron, the Dublin medical officer of health, while dismissing compulsory notification, felt that the disease might be voluntary notifiable provided the inducement of payment for notification was provided. Niven succeeded in having his proposal adopted: 'that cases of tuberculous disease in man attended with discharge be included among the diseases to be notified under the general or local acts as the case may be'.[15]

At the Sanitary Institute Congress held at Newcastle-upon-Tyne in 1896 Harold Scurfield, the medical officer of health for Sunderland, set out his proposals for an anti-tuberculosis programme. He recognised the chief source of danger as being persons with a tuberculous discharge, especially those in overcrowded conditions where 'the chances of others becoming infected will be in direct proportion to the amount of overcrowding'. He suggested a system of notification for such individuals. Upon notification the appropriate health department would issue instructions to the patient's family pointing out specifically how to deal with sputum and other discharges, the importance of ventilation, keeping the patient's room dust free and the importance of sunlight as a disinfecting agent. The premises occupied by consumptives would be disinfected at such times in the course of the illness 'as might appear necessary'. If poverty made it impossible to take adequate precautions such as supplying the consumptive with a separate bed or ' a suitable amount of cubic space', 'homes for consumptives' would have to be considered. He felt it would be no great departure to provide such homes in a

[15] James Niven, 'The public health aspects of tuberculous diseases' in *BMJ*, ii, no. 1858 (1896), pp 321-2.

similar fashion to existing fever hospitals. He dismissed fears that 'notification and precautions would brand the consumptive as a social outcast'. The congress adopted his proposal 'that some system of notification of human tuberculosis at any rate when accompanied by a discharge is desirable'.[16]

In January 1899, under the direction of its medical officer of health Arthur Newsholme, the Brighton sanitary authority introduced a scheme of voluntary notification of tuberculosis. In the first two years of operation 111 and 105 cases were notified. This increased to 153 in 1901 and 224 in 1902, exceeding 300 per annum in the following four years. Newsholme attributed the relative success of the scheme to the provision that had been made for the sanatorium treatment of notified cases. Initially four beds were reserved at a sanatorium outside Brighton. However in July 1902 four beds were opened for phthisis at the borough isolation hospital. This number was increased to ten in December 1902 and to twenty-five in April 1903 by the conversion of the former enteric fever pavilion at the hospital into a sanatorium. Provision was also made in the workhouse infirmary for thirty-five beds for advanced consumptives. [17]

Newsome had come to regard the 'educational aspect of sanatorium treatment as….more important in the public interest than its curative aspect'. He had formulated this belief from his experiences in visiting phthistical patients in their homes when he found that precautionary measures recommended by their physicians were not being carried out. Even when he himself gave 'definite precautionary instructions', he found on subsequent visits they were 'not being effectually carried out'. He found that after one month's practical training 'in the simple precautions required to prevent him from becoming a danger to others' his patients left the sanatorium 'ardent advocates for the fresh air *regime'* and taking great care as regard to coughing and expectoration.[18]

One month was chosen as the appropriate period as that was the maximum period that most of his patients who were from the poorer classes could afford to be absent from work. When initially presenting themselves for examination by a physician the majority

[16] H. *Scurfield*, 'An anti-tuberculous programme' in *JSI*, xvii, no. 4 (1897), pp 426-32.
[17] Newsholme 'The voluntary notification of phthisis in Brighton'.
[18] Arthur Newsholme, ' Four and a half years experience of the voluntary notification of pulmonary tuberculosis' in *JSI*, xxiv, no. 3 (1903), pp 253-60; Arthur Newsholme 'Public health authorities in relation to the struggle against tuberculosis in England' in *Journal of Hygiene*, iii, no. 4 (1903), pp 446-67.

were found to be in the second or third stage of the disease exhibiting extensive lung damage, a condition that would require prolonged sanatorium treatment for many months to effect any significant improvement. Therefore Newsome adopted the principle of 'training the patients in personal hygiene and in the general management of their illness rather than attempt at cure'. This one-month limit also enabled him to have a greater throughput of patients. After discharge his patients were visited quarterly to ensure continued application of the precautions. In addition they were supplied with Japanese handkerchiefs and spit-bottles to manage their sputum.[19] The scheme also provided for instructing patients and families, on disinfecting premises and personal effects and remedying sanitary defects in buildings. Newsome found that the 'presence of consumption in a house greatly increases the leverage in securing sanitary improvements'.[20] Newsholme succeeded in having the international British Congress on Tuberculosis held in London in 1901 adopt his proposal that 'notification should be encouraged in all districts in which efficient sanitary administration renders it practical to adopt the consequential measures'.[21]

In 1899 Manchester introduced a scheme of paid voluntary notification, to be implemented along similar lines to Brighton. However, with only one doctor appointed to oversee the scheme, notifications were confined to public institutions. In February 1900, following the appointment of an assistant, notifications were invited from general practitioners.[22] Reliance was placed on the voluntary Manchester and Salford Ladies' Health Society to visit notified patients. Two houses in the precincts of the smallpox hospital were adopted to accommodate sixteen tuberculosis cases.[23] Other patients were accommodated in the voluntary sanatorium St Anne's Hospital, Bowden and in a hospice for terminal advanced cases. Local politicians in Manchester accepted that municipal hospital accommodation was required for tuberculosis patients as evidenced by Alderman McDougal's statement that 'notification of phthisis is a necessary concomitant or antecedent to the municipal provision of hospitals for consumptives so that cases requiring to be removed to hospital may be selected on rational grounds'. His rational grounds referred to weighing the benefits of removal of consumptive patients against 'the

[19] Newsholme 'The voluntary notification of phthisis in Brighton'.
[20] Newsholme, ' Four and a half years experience of … pulmonary tuberculosis'.
[21] *Transactions of the British Congress 1901*, ii (London, 1902), pp 37-40.
[22] McDougall, 'On the notification of phthisis as carried out in the city of Manchester'.
[23] James Niven, 'On the notification of phthisis in Manchester' in *JSI*, xxiv, no. 3 (1903) pp 266-70.

harm which they would effect by staying at home'. [24] In conjunction with the scheme the Manchester authorities arranged for the placement of notices regarding the dangers of spitting in lodging houses and public houses.[25]

The example set by Brighton and Manchester was followed successfully in Northampton (1900) Leeds (1900) Leicester (1903) and Newport (1903). [26] The success of the scheme in Eastbourne (*c*.1903) was attributed to the prior discussions which had taken place with the members of the local medical society resulting in their agreement to the scheme before its launch.[27] The success of the Liverpool (1899) scheme was facilitated when the three poor law districts in the city combined to erect a sanatorium for paupers.[28] Other schemes such as that operated by Borough of Stoke Newington (1901) in London were only partly successful although Henry Kenwood its medical officer of health maintained that it had served the useful purpose of 'educating public opinion so as to prepare it for a measure of compulsory notification'.[29]

Elsewhere attempts to introduce schemes were less successful. In Glasgow (1900), where free testing of sputum had been introduced, a sanatorium for paupers provided and a site for a working men's sanatorium acquired, notification extended only to those cases notified by the public dispensaries.[30] In Gateshead (1901) despite arrangements being in place to provide sanatorium accommodation the numbers notified decreased each year.[31]

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[24] Alderman McDougall, 'On the notification of phthisis as carried out in the city of Manchester'.
[25] Niven, 'On the notification of phthisis in Manchester'.
[26] J. D. McCrindle, 'Some difficulties in administrative methods in connection with the treatment of early cases of phthisis' in *JRSI*, xxix, no. 8 (1908) pp 377-80; J. Howard Jones, 'The municipal training of consumptives' in *JRSI*, xxix, no. 8 (1908) pp.374-6; Dr Charles Killick Millard medical officer of health for Leicester and Dr James Spottiswoode Cameron during the discussion on McCrindle and Jones papers at the 1908 Cardiff conference of medical officers of health in *JRSI*, xxix, no. 8 (1908), pp 380-2.
[27] Dr William George Willoughby medical officer of health for Eastbourne during the discussion on a paper on 'notification of tuberculosis' by John Robertson at the 1904 Glasgow conference of medical officers of health in *JRSI*, xxv, no. 3 (1904), p. 766.
[28] Newsholme 'Public health authorities in relation to the struggle against tuberculosis in England'; Dr Edward William Hope medical officer of health for Liverpool during the discussion on papers by Arthur Newsholme and Harold Scurfield on 'Notification of consumption: its pros and cons' at the 1899 Southampton conference of medical officers of health in *JSI*, xxi, no. 1 (1900), pp 58-9.
[29] Henry R. Kenwood and Gerard C. Taylor, 'Two years experience of the voluntary notification of phthisis in the metropolis –and its lessons' in *JSI*, xxiv, no. 3 (1903), pp 261-5.
[30] Bailie W. F. Anderson Glasgow during the discussion on a papers delivered by Arthur Newsholme, Henry Kenwood and Gerard Taylor at the 1903 Bradford conference of medical officers of health in *JSI*, xxiv, no. 3 (1903), pp 283-4.
[31] Dr Thomas Morrison Clayton medical officer of health for Gateshead during the discussion on a paper on 'The municipal training of consumptives' by J. Howard Jones , in *JRSI*, xxix, no. 8 (1908), p. 381.

In Carmarthen when a scheme was introduced no cases were notified.[32] Notification difficulties were experienced in Newcastle due to the fear of sufferers being boycotted by fellow workmen.[33] In the Borough of Kensington, London less than 25% of cases were reported and a large proportion of those only by means of death certificates. For living patients, reports almost exclusively emanated from poor law medical officers relating to members of the pauper classes usually in the latter stages of the disease. The refusal of the LGB to sanction the use of vacant premises in the possession of the Asylums Board as sanatoria for the use of those above the pauper class 'because of the heavy outlay it would entail' was advanced as a contributory reason for the scheme's lack of success.[34]
Some areas made no attempt to introduce any form of notification. In Birmingham only information leaflets had been distributed. An attempt there to provide a sanatorium had failed as 'expense […] stood in the way' a matter that also made the provision of sanatorium accommodation in other places 'utterly impossible'.[35] Thus the reluctance of certain areas to introduce notification could be attributed to attempts to shield the ratepayers from the financial consequences of notification. In Edinburgh the population consisted 'almost entirely of medical men and hotel and lodging house keepers' who were totally opposed to notification.[36] The failure to introduce a scheme there could be seen as protecting the hotel/lodging house industry from possible adverse publicity. Other areas opposed voluntary notification on the ground that the provision of confidential patient information by doctors unless imposed by a statutory duty would lead them open to a charge of breach of professional secrecy.[37] This reason was also

[32] Dr Lloyd M. Bowen-Jones Carmarthen during the discussion on a paper on 'The municipal training of consumptives' by J. Howard Jones , in *JRSI*, xxix, no. 8 (1908), p. 381.
[33] Alderman Flowers during the discussion on a paper on 'The municipal training of consumptives' by J. Howard Jones, in *JRSI*, xxix, no. 8 (1908), p. 382.
[34] Dr Thomas Orme Dudfield medical officer of health for the Royal Borough of Kensington during the discussion on 'The consumptive at home' at a sessional meeting of the Royal Sanitary Institute at London 17 April 1906 in *JRSI*, xxvii, no. 6 (1908), pp 283-5.
[35] Dr Alfred Hill medical officer of health for Birmingham during the discussion on papers delivered by Arthur Newsholme, Henry Kenwood and Gerard Taylor at the 1903 Bradford conference of medical officers of health in *JSI*, xxiv, no. 3 (1903), p. 280.
[36] Sir Henry Littlejohn medical officer of health for Edinburgh during the discussion on papers by Arthur Newsholme and Harold Scurfield on 'Notification of consumption: its pros and cons' at the 1899 Southampton conference of medical officers of health in *JSI*, xxi, no. 1 (1900), p. 61.
[37] Newsholme 'Public health authorities in relation to the struggle against tuberculosis in England'; Referred to by Dr W. Butler medical officer of health for Willesden during the discussion on a paper on 'Notification of tuberculosis' by John Robertson at the 1904 Glasgow conference of medical officers of health in *JRSI*, xxv, no. 3 (1904), p. 769.

advanced for the failure of a proposed voluntary notification scheme in Cheshire despite the payment of 2*s.* 6*d.* per notification.[38]

Evidence of the growing support for notification was provided at the Bradford conference of medical officers of health in 1903 when a resolution was passed in favour of the 'systematic notification of consumption' calling on the Council of the Sanitary Institute to take action to put the terms of the motion into effect.[39] The council formally adopted the resolution as policy forwarding a copy to the LGB for action.[40]

In Sheffield voluntary notification commenced in 1899.[41] Political support enabled the notification to be made compulsory through the enactment of local legislation. In early 1903 a private omnibus bill pertaining to many different aspects of local government in Sheffield was promoted in the British parliament. One clause provided for the compulsory notification by registered medical practitioners of any person of whom they became aware was suffering from tuberculosis of the lung. The notification was to provide details of the name, sex, age, abode and place of employment of the sufferer. Payment of 2*s.* 6*d.* was to be made for notifications from private practice and 1*s.* from institutional practices with defaulters facing a fine of 40*s.*. Provision was made for the disinfection of premises and belongings 'at the cost of the corporation' with payment of full compensation being made to the owners of any property or goods damaged in the process. The operation of the scheme was to be funded from the general district rate. The act was signed into law on 14 August 1903 becoming operative on 1 November.[42]

Following the passing of the Sheffield Act, in November 1903, two inspectors were engaged to carry out home inspections, issue instructions and identify where disinfection was required. [43] They also visited consumptives' places of employment to identify sanitary defects or dangers posed by consumptives to fellow workers, passing on their

[38] Dr Francis Vacher medical officer of health for Cheshire during the discussion on a paper on 'Notification of tuberculosis' by John Robertson at the 1904 Glasgow conference of medical officers of health in *JRSI*, xxv, no. 3 (1904), pp 763-4.
[39] Discussion on a papers delivered by Arthur Newsholme, Henry Kenwood and Gerard Taylor at the 1903 Bradford conference of medical officers of health in *JSI*, xxiv, no. 3 (1903), p. 287.
[40] *JSI*, xxiv, no. 4 (1903), p. 855.
[41] H. Scurfield, 'Notification of tuberculosis of the lung in Sheffield and the incidence of tuberculosis on males, females and children in various towns' in *BMJ*, ii, no. 2538 (1909), pp 462-9.
[42] Sheffield Corporation Act, 1903 (3 Edward VII, c. 255) (14 August 1903).
[43] H. Scurfield, 'A municipal scheme for consumption' in *JRSI*, xxvii, no. 10 (1906), pp 587-91.

findings to the factory inspectorate for remedial action. Arrangements were made with the Bacteriological department of Sheffield University to carry out free sputum examination of samples, the cost being borne by the corporation. [44] Although the corporation had decided to establish a tuberculosis sanatorium in 1901 and secured LGB consent to the raising of the necessary finance, following the passing of the act this proposal was abandoned.[45] Patients were referred to adapted infectious diseases wards operated by the city's two boards of guardians for sanatorium treatment, with special wards being used for advanced cases.[46] The primary use of the adapted facilities was for the education of patients with secondary uses being providing respite for relatives, facilitating disinfection of vacated premises and identifying patients suitable for sanatorium treatment. In June 1908 the corporation opened a sanatorium for the treatment of twenty male patients set in 1½ acres of grounds where the patients were employed at gardening for as many hours a day as their strength permitted. Referrals to the sanatorium were restricted to those patients capable of so working. In May 1909 a converted smallpox hospital was opened as a female sanatorium along similar lines. [47] Despite the penalty provisions of the legislation not all cases were notified and 'as regards the very well-to-do people, if those cases remained unnotified it did not really matter very much, because under those circumstances precautions were taken and instructions carried out'.[48]

In October 1900 the public health committee of Dublin Corporation, on the advice of Sir Charles Cameron, the city's superintendent officer of health, sought to add pulmonary tuberculosis to the schedule of notifiable diseases, quoting the example of the recently-passed Norwegian Act.[49] Consideration of the report having been deferred for six months its recommendation was rejected at the July 1901 meeting of the corporation on a vote of

[44] Scurfield, 'Notification of tuberculosis of the lung in Sheffield …'.
[45] Newsholme 'Public health authorities in relation to the struggle against tuberculosis in England'; Dr Harold Scurfield medical officer of health for Sheffield during the discussion on a paper on 'Notification of tuberculosis' by John Robertson at the 1904 Glasgow conference of medical officers of health in *JRSI*, xxv, no. 3 (1904), pp 771-2.
[46] Scurfield, 'A municipal scheme for consumption'; Scurfield, 'Notification of tuberculosis of the lung in Sheffield …'.
[47] Scurfield, 'Notification of tuberculosis of the lung in Sheffield …'.
[48] Dr Harold Scurfield medical officer of health for Sheffield during the discussion on a paper on 'Notification of tuberculosis' by John Robertson at the 1904 Glasgow conference of medical officers of health in *JRSI*, xxv, no. 3 (1904), pp 771-2.
[49] *Report of the public health committee re notification of tuberculosis*, report no. 165, Dublin Corporation reports 1900, pp 421-2 (DCCA).

thirty-nine to nineteen.[50] However by September 1901 the corporation had instituted a scheme of voluntary notification of tuberculosis.[51] In January 1908 Cameron entreated medical men in Dublin to aid Lady Aberdeen's campaign against tuberculosis by engaging in the voluntary notification of pulmonary consumption. Only 80 cases had been voluntarily notified in 1907, a small number when compared with the 973 deaths from lung tuberculosis recorded in the city that year. He explained that although the corporation was willing to pay for such notifications it was constrained by legal difficulties from doing so. He also informed the profession that it was intended to promote a bill in the next session of parliament, which would make notification compulsory in Dublin.[52]

In January 1908 Dublin Corporation published the text of a bill providing for the granting of various powers to the corporation, along similar lines to those granted to Sheffield Corporation in 1903. A compulsory notification clause in the bill was identical in terms to the Sheffield Act. A further provision sought to ban spitting in any place of public resort, public waiting room, place of public entertainment, place where public business was transacted, public carriage, pavement or road.[53] As bacillus contained in dried sputum was believed to be the main means of transmission, a spitting ban had long been sought by anti-tuberculosis campaigners in particular the National Association for the Prevention of Tuberculosis. Glamorgan County Council had introduced by-laws, banning spitting in public places, on 13 March 1902, despite vigorous opposition to the measure in the council chamber.[54] Another anti-tuberculosis measure provided for in the bill was the establishment and equipping of a bacteriological laboratory which had been urged by public health officials for many years.[55] Regulations were proposed to test and certify meat sold in the city, to protect against infective diseases and tuberculosis. Butchers were to be compensated for the destruction of tuberculous meat. A 40s penalty was to be applied to any person selling, offering or keeping for sale anything intended for human food 'which has been or may be reasonably supposed to be or to have become infected with tuberculosis or any disease communicable to man'. The bill made elaborate

[50] *Minutes of meeting of municipal council, 1 July 1901*, minute no. 411, pp 362-3. (DCCA).
[51] *Report of the public health committee- breviate for the quarter ended 30 September1902*, report no. 177, Dublin Corporation reports 1902, pp 205-33 (DCCA).
[52] *Irish Times*, 4 Jan. 1908; *Irish Independent*, 4 Jan. 1908.
[53] Dublin Corporation (Various Powers) Bill, 1908; *Irish Independent*, 2 Jan. 1908.
[54] They were the first sanitary authority in Britain to do so. 'The spitting nuisance abroad and at home' in *BMJ*, i, no. 2151 (1902), pp 730-1.
[55] *Irish Independent*, 3 Jan.1908.

provisions for the regulation, inspection and supervision of milk depots and dairy yards. However compensation was to be given to dairymen if their milk supply was stopped on the 'probability that the consumption of such milk may cause tuberculosis to persons residing within the city'.[56] The inclusion of the milk provision was no doubt influenced by the findings of the Royal Commission on Tuberculous which had reported in 1907 that 'a very considerable amount of disease and loss of life, especially among the young, must be attributed to the consumption of cows' milk containing tubercle bacilli'.[57]

The 1908 bill contained widespread provisions governing building by-laws, sanitary by-laws, infectious diseases, compensation for criminal injuries, the sale and transportation of fruit, vegetables, comestibles, shell fish and ice cream, electricity supply, library services, public recreation and advertising. It sought powers to obtain returns from insurance companies and to inspect their books for the purpose of checking property valuations for rating purposes and for levying the companies for fire brigade services. It sought greater representation on the Port and Docks Board, effectively placing the corporation members in a majority on that board. Although opposition could have been anticipated from victuallers and dairymen to the licensing provisions of the bill, the editor of the *Irish Independent* found the bill overloaded and singling 'out for drastic treatment such a multiplicity of interests as to provoke inevitably a campaign of opposition which may jeopardise the passage of those parts of the measure that are admittedly sound and reasonable'.[58] In addition the full implementation of the proposals would have had the effect of considerably increasing the rate in the pound thus alienating a body of ratepayers/electors. The editor of the *Irish Independent* found the provisions of the bill dealing with consumption as measures 'designed for the purpose of combating that deadly and decimating disease' and as such 'ought to be considered dispassionately and on their merits', nevertheless those particular provisions would involve the corporation in much labour and heavy expense. He also maintained that the provisions could only be effectively implemented if accompanied by the isolation of persons at some stages of the diseases a matter constrained by the want of sanatoria. [59]

[56] Ibid., 2 Jan. 1908.
[57] *Second interim report of the Royal Commission on Tuberculosis*.
[58] *Irish Independent*, 2 Jan. 1908.
[59] Ibid., 3 Jan. 1908.

Attempting to satisfy objections from the many interests in the city injuriously affected by the bill, on 24 January 1908, officials in consultation with the lord mayor proposed removing from the bill the sections dealing with compulsory notification of tuberculosis, the provision of a bacteriological laboratory, the licensing of butchers and dairies, the destruction of tuberculous meat, the reporting of tuberculous cattle, the making of building by-laws, electricity supply, the contribution of insurance companies to fire services and advertising.[60] This proposal was agreed on 3 February 1908. The corporation decided to proceed with the balance of the bill.[61] The editor of the *Irish Times* regarded this as a 'cynical performance' on behalf of the promoters of the bill to win over the powerful interests opposed to it by sacrificing 'the health of the citizens'.[62] The Dublin Sanitary association disapproved of the bill as a result of this 'sacrifice (of) several of the most valuable sanitary provisions' while also stressing that a sanitary bill should be introduced without 'overloading it with provisions which are not cognate to sanitation'.[63]

On 5 March 1908 a meeting of ratepayers was held in the round room of the Mansion House to discuss the omnibus bill and an equally contentious private housing bill being promoted by the corporation. Such was the inflamed nature of the packed meeting that the attendance of thirty policemen was required to keep order.[64] The meeting determined to conduct a ballot of city electors under the provisions of the Borough Funds (Ireland) Act to either approve or disapprove of the two bills.[65] Over 46,000 ballot papers were issued and over 25.000 returned resulting in a vote of 14,606 against the various powers bill while 10,514 votes were cast in its favour.[66] The bill was withdrawn in the House of Commons on 26 March 1908.[67]

Tuberculosis Prevention (Ireland) Act 1908

Following the failure to introduce local anti-tuberculosis legislative provisions the WNHA and medical interest groups succeeded in having national legislation introduced.

[60] Ibid., 31 Jan. 1908; *Irish Times*, 31 Jan. 1908, 4 Feb. 1908 and 5 Mar. 1908.
[61] *Irish Times*, 4 Feb. 1908.
[62] Ibid., 5 Mar. 1908.
[63] Ibid., 3 Mar. 1908.
[64] Ibid., 6 Mar. 1908.
[65] Ibid., 7 Mar. 1908.
[66] Ibid., 16 Mar. 1908.
[67] *Hansard 4*, clxxxvi, c.1538 (London, 1908).

On 29 November 1907 a deputation led by the Countess of Aberdeen representing the WNHA and consisting of representatives of the Royal College of Physicians, the Royal College of Surgeons, the Irish Medical Association, the National Association for the Prevention of Tuberculosis, the Dublin Sanitary Association, the Veterinary Association and various medical societies met the lord lieutenant and Augustus Birrell the Chief Secretary for Ireland. The deputation sought the introduction of legislation to assist in combating tuberculosis. Specifically they requested that the disease be made compulsorily notifiable, that more stringent and uniform measures be introduced to regulate milk and food supplies, that power be given to county councils 'to erect and maintain such hospitals, sanatoriums and dispensaries for the treatment of tuberculosis as they thought fit' and that a system of medical inspection of schools and schoolchildren be introduced. Birrell undertook 'to give as early effect as possible' to the recommendations of the deputation.[68]

The Tuberculosis Prevention (Ireland) Bill was published on 3 June 1908. The bill provided for the compulsory notification to the sanitary authority by any medical practitioner who became aware of a person suffering from tuberculosis 'of any form or at any stage and in any circumstances' prescribed by the LGB. A penalty of 40*s.*for non-notification was laid down with fees of 1*s.* and 2*s.* 6*d.* being paid respectively for institutional and private notifications. The provisions of the Public Health and Infectious Diseases (Prevention) Acts regarding disinfection of premises and goods were to be extended to tuberculosis. County councils were to be given discretionary powers to provide staff and manage hospitals or dispensaries for the treatment of tuberculosis or to enter into arrangements with other bodies for the provision of such facilities. The expenses incurred in establishing hospitals were to be levied against the poor rate as a county-at-large charge but limited to the sum produced by a rate of one penny in the pound, although with the consent of the LGB this amount could be doubled. Expenses pertaining to tuberculosis dispensaries were to be levied against the area benefiting from the dispensary. Only paupers were to be treated free of charge; all other patients were liable for fees although proceedings for the recovery of sums due could not be instituted for a period of six months following a patient's discharge. If however the patient died in hospital immediate proceedings could be taken against his successors. Sanitary

[68] 'The tuberculosis war in Ireland' in *BMJ*, ii, no. 2450 (1907), pp 1743-4.

authorities were to be empowered to raise public awareness of tuberculosis through organising lectures, leaflet drops or providing notices. Bacteriologists were to be appointed to examine sputum or samples of milk or milk products being offered for sale. Subject to the payment of compensation not exceeding £10 the sanitary authority could order the destruction of any milch cow certified by a veterinary officer to be suffering from tuberculosis of the udder. Existing powers in relation to the inspection of dairies were to be extended to include those located outside the administrative area of a sanitary authority, which were supplying milk for sale within the boundaries of that authority.[69]

While approving generally the terms of the bill the Royal College of Physicians felt that a committee appointed jointly by it and the Royal College of Surgeons should be constituted to advise the LGB as to what forms of tuberculosis should be notifiable.[70] The Royal Academy of Medicine in Ireland also supported this stance but was of opinion that the task of notification should fall on a responsible person, either a relation or attendant of the affected person, with the medical practitioner only acting where such persons defaulted.[71] The Irish Medical Association agreed on an advisory committee and considered that a medical practitioner upon informing a responsible person of their notification duties should be discharged from all responsibilities. However in it's opinion compulsory notification should apply only to those cases that 'occur under conditions of defective hygiene or where segregation of patients is difficult and there is a probability of infection'.[72] All four bodies agreed that it should be mandatory on county councils to provide hospital accommodation for the isolation of advanced cases. The members of the Apothecaries Hall expressed the view that only pulmonary consumption should be notifiable and then only under specific circumstances including where segregation was impossible or defective hygienic surroundings existed. They also called for the provision of sanatoria by county councils to be made obligatory.[73] The national executive of the WNHA expressed 'their unabated and warm support' for the bill 'believing it to be necessary for the successful prosecution of the anti-tuberculosis campaign in Ireland'.[74]

[69] *Tuberculosis prevention (Ireland). A bill to prevent the spread and provide for the treatment of tuberculosis;and for other purposes connected therewith*, p. 1, H.C. 1908 (259), v, 723.
[70] *Irish Times*, 11 July 1908.
[71] Ibid., 13 July 1908.
[72] Ibid., 16 July 1908.
[73] *Irish Independent*, 1 Aug. 1908; *Irish Times*, 1 Aug. 1908.
[74] *Irish Independent*, 29 Oct. 1908

When the second reading of the bill was proposed in parliament on 15 July 1908 the Dublin MP Joseph Nannetti informed 'the House that there was a good deal of opposition to its provisions in Ireland'. Firstly there was the matter of cost arising from the payment of 2*s.* 6*d.* for every notification and the even more expensive provision of sanatoria, 'which must cost a great deal of money'. Secondly the singling out of a working man as an 'affected person' could cause hardship to him 'as it might be the cause of him being unable to find employment' with others objecting to working alongside a person liable to spread infection. Charles Craig the MP for South Antrim agreed with Nannetti but fundamentally objected to the bill as having identified persons as 'comparatively dangerous members of the community' no obligation was placed on authorities to take steps towards curing them of tuberculosis or of 'segregating them if they were in a state that was past curing'. Lord Balcarres the MP for Chorley, Lanchashire did not think that the average county council in Ireland would or could afford to spend money on adequately equipping a hospital to deal with the disease. He was also of opinion that the recoupment provisions 'were illusory, because in nine cases out of ten it would be impossible for the persons who were treated to repay the local authority the cost of their…extremely expensive… treatment'. All three speakers recommended that the bill be referred to committee.[75]

Birrell in replying to the debate set out the functions of the facilities to be provided. Hospitals even if small would be used for advanced cases and demonstrate to the public how these cases should be dealt with. Sanatoria were to be used 'for those who can be treated curatively, and in the hope of restoring them to society'. Birrell explained that, in accordance with the then widely-held belief, these were to be provided from inexpensive materials 'the more inexpensive the better, because after a time they become so infected that they are better destroyed'. Dispensaries were to provide for the skilful medical home treatment of persons 'so that the chance of the disease spreading by contagion to other members of the family may be reduced'.[76] On 21 July 1908 Birrell informed the House of Commons of his intention to refer the bill to committee during the autumn parliamentary session.[77]

[75] *Hansard 4*, cxcii, cc 983-92 (London, 1908).
[76] Ibid.
[77] *Hansard 4*, cxcii, c.1734 (London, 1908).

Several Irish medical practitioners were unhappy at the notification provisions of the bill. They maintained that they should be severely restricted and applied only to cases of tuberculosis of the lung. They approached two Liberal medical members of parliament, the surgeon Sir William Collins member for St Pancreas West and Dr George Cooper the member for Southwark Bermondsey, who undertook to put down amendments to reduce the impact of the proposed legislation.[78] At the committee stage proposed amendments by Dr Cooper, making local authorities and not the LGB responsible for determining the circumstances under which tuberculosis should be notifiable and by Sir William Collins, giving doctors discretion in deciding upon notification were both defeated.[79] However it was agreed to include a provision that the LGB should consult with an advisory council consisting of the 'leading medical practitioners throughout Ireland' prior to deciding on the forms of the disease to be notifiable.[80] This was subsequently determined to be the Irish branch of the General Council of Medical Education and Registration of the United Kingdom.[81]

An attempt by Joseph Nannetti to have notification apply to only those cases, which had been identified as tubercular following bacteriological examination of their sputum, was defeated.[82] A proposal by John Joseph Mooney the nationalist MP for Newry that the disease should only be notifiable in areas where the local authorities had already provided the necessary dispensary and hospital facilities was not accepted by Birrell; although he did agree that in the longer term the provision of facilities by county councils should be mandatory, the time for such was not opportune. To placate this growing opposition to the bill, Birrell proposed an amendment to the effect that 'no forms of tuberculosis should be notifiable save such as by reason of infective discharges were liable to communicate the disease to other persons'. This amendment was agreed.[83]

Following additional amendments mainly of a minor and administrative nature the amended bill was referred back to the house.[84] However even this amended bill did not

[78] *Irish Independent*, 24 July 1908.
[79] Ibid., 22 Oct. 1908; *Irish Times*, 22 Oct. 1908.
[80] *Irish Independent*, 29 Oct. 1908.
[81] *Tuberculosis prevention (Ireland). A bill [as amended by Standing Committee A] to prevent the spread and provide for the treatment of tuberculosis; and for other purposes connected therewith*, p. 1, H.C. 1908 (366), v, 737.
[82] *Irish Independent*, 29 Oct. 1908; *Irish Times*, 29 Oct. 1908.
[83] *Irish Independent*,3 Nov. 1908; *Irish Times*,3 Nov. 1908.
[84] *Irish Independent*,5 Nov. 1908.

satisfy J. P. Farrell the MP for North Longford. He considered it would brand Ireland 'as the most tubercularly diseased part of the earth' while giving unfettered rights to dispensary doctors over the lives of sufferers, which would see the doctors forcing their way into their homes, dragging them off and 'branding [their] family for ever after with the tuberculosis taint'.[85] Finding that the ratepayers, who would have to bear the financial brunt of the legislation had been left 'in the dark as to the evils, which will come upon them as a result of this ill-considered legislation' he asked 'the nationalist bodies of Ireland to wake up and cry out in strong protest against this coercion act that Lady Aberdeen and her friends want to impose on a confiding Irish public'.[86]

On the 20 November 1908 the unionist Charles Craig gave notice of his intention to propose a new clause leaving the adoption of the notification measures optional with county and county borough authorities.[87] With opposition to compulsory notification mounting and to prevent the unionists from becoming the leading proponents in the matter, the Irish Party at a meeting on 25 November 1908 agreed that, at the next stage of the bill, John Mooney would move an amendment 'that no part or section of this act shall come into operation' until the appropriate authority 'have decided by resolution to adopt this Act'.[88] Having being informed of this Birrell pre-empted the issue by announcing that he proposed amending part 1 of the act by making it inoperative until adopted by resolution by the relevant authority. [89] Sir Charles Cameron informed the annual meeting of the Women's National Health Association that 'the backbone of the tuberculosis bill [...] was compulsory notification and if that backbone was broken the bill would be worth very little'.[90]

When the bill came before the House of Commons on 16 December 1908 Birrell's amendments to make the act adoptive by each sanitary authority were accepted. Lord Balcarres felt that the act would strengthen and assist propaganda to such an extent that it was only a matter of time before public opinion was brought 'to such a pitch that the measure would be made compulsory'. Birrell's amendment to substitute as advisors to the LGB the presidents of the royal colleges of physicians and surgeons was agreed. A

[85] Ibid.,2 Nov. 1908; *Irish Times*,2 Nov. 1908.
[86] *Irish Independent*,7 Nov. 1908.
[87] *Irish Times*,21 Nov. 1908.
[88] *Irish Independent*,26 Nov. 1908.
[89] Ibid.,5 Dec. 1908.
[90] Ibid.,12 Dec. 1908.

further amendment suggested by John Mooney to make compulsory the inspection of all meat killed outside and town and brought therein for sale was accepted.[91] However when this particular measure was considered by the House of Lords on 18 December Lord Killanin succeeded in having it removed from the bill on the grounds that the clause would be used by urban authorities to the benefit of urban butchers by rendering 'it impossible […] for people who carried on the meat trade outside a town to continue their business at all'.[92] The bill was returned to the House of Commons where the Lords' amendments were agreed to without discussion. As only two sitting days, both with full agenda remained before the Christmas recess 'it was understood that if this course had not being followed the entire matter would have been sacrificed'.[93] The act received royal assent on 21 December 1908, becoming operative from 1 July 1909.[94]

The editor of the *Irish Times* expressed the worry that since the act now fell short of expectations it would have a detrimental effect on the anti-tuberculosis campaign. He felt that, resulting from the 'permissive character' of the Act, the desirable objective of raising the level of the public health would not be obtained, especially if a consumptive could move from a district where compulsory notification was obligatory into an adjoining district where 'the sanitary authority is less regardful of its duties'. He expressed the view that 'it rarely happens in matters affecting the public health that the permissive clause serves any useful purpose'.[95] The LGB expressed the pious hope that Local Authorities would 'generally make use of […] the valuable provisions of the act for preventing and arresting the spread of tuberculosis'.[96]

Progress of compulsory notification

The enactment of enabling legislation did not provide an immediate solution to notification problems. Central authorities were slow to define the scope of notification. Local authorities delayed in adopting the act and following adoption were not diligent in its application.

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[91] *Hansard 4*,cxcviii, cc 1950-72 (London, 1908).
[92] Ibid., cc 2181-90.
[93] *Irish Times*,9 Dec. 1908.
[94] Ibid.,22 Dec. 1908; Tuberculosis Prevention (Ireland) Act, 1908, 8 Edw. VII, c.56 (21 Dec. 1908).
[95] *Irish Times*,19 Dec. 1908.
[96] *Annual report of the Local Government Board for Ireland for the year ended 31st March, 1909, being the thirty-seventh report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd. 4810], H.C. 1909, xxx, 1. (Henceforth *Thirty-seventh annual report of the LGB*).

Following the passage of the 1908 act the LGB having consulted with the presidents of the royal colleges of physicians and surgeons decided on 3 June 1909 to confine notification to those cases only, which in the absence of precautionary measures, were likely to become conveyors of the disease, either through their housing or working conditions.[97] Although to an outside observer the act had been strictly complied with, it was an 'open secret' that the presidents were not consulted in the ordinary sense of the word, being merely asked to confirm their approval to what had already been predetermined in terms of notification by the LGB.[98]

The LGB's order applied to those infective consumptives, who habitually slept or worked in rooms occupied by non-sufferers or were engaged in the handling or preparation of food for human consumption. Effectively this confined notification only to members of the poorer classes and accorded with the stated desires of the legislature, 'to safeguard sufferers from unnecessary intervention to the greatest extent compatible with the public interest'. The identity of sufferers was to be protected, with authorities prohibited from divulging any particulars which would reveal the name of individuals. Any disregard of 'the obligation of secrecy' by officials would be treated as a serious breach of discipline.[99] John William Moore alleged that this restriction on the type of cases notified was a contributory factor in the failure of notification in Ireland. He maintained that the information supplied was useless for statistical purposes and did not provide sanitary authorities with 'information relative to the prevalence of pulmonary tuberculosis, which would enable them to cope successfully with that affection'.[100]

Dublin Corporation called a special meeting on 9 August 1909 to consider adopting the notification provisions of the Act. The proposal was opposed by Alderman McWalter M.D., because of the effect the provisions would have on the poor, especially if employers became aware of their condition and also because of the lack of treatment

[97] *Annual report of the Local Government Board for Ireland for the year ended 31st March, 1910, being the thirty-eighth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 5319], H.C. 1910, xl, 1. (Henceforth *Thirty-eighth annual report of the LGB*).
[98] John Moore, 'Notification of Tuberculosis in Ireland: its failure and the reasons therefor' in *The Dublin Journal of Medical Science*,cxxxvii, no. 507, third series (1914), pp 331-40. Moore had been President of the Royal College of Physicians from 1898 to 1900 and was their representative on the General Medical Council from 1903-1933.
[99] *Thirty-eighth annual report of the LGB.*
[100] Moore, 'Notification of Tuberculosis in Ireland…'.

facilities. However, following discussion a motion adopting compulsory notification was carried on a vote of twenty to ten.[101] Dublin Corporation was joined by Athlone No. 1 Rural District Council in becoming the first authorities to adopt the notification provisions of the act making them effective from 1 Oct 1909. By 31 March 1910, thirty-six authorities nationwide had adopted compulsory notification including an additional twelve Leinster authorities[102]. This progress in adopting notification was regarded by the LGB as not unsatisfactory. In the first six months of operation 588 cases were notified in Dublin city.[103]

In the year ending 31 March 1911 only the Leinster urban district councils of Dalkey and Drogheda adopted compulsory notification. That year 852 cases were notified in Dublin city.[104] Although the following year three further authorities adopted notification, none of these were in Leinster. 541 notifications were made that year in Dublin city. The LGB was of opinion that this fall off in the number of notifications could not be ascribed to a decrease in the prevalence of the disease but could be attributed to 'the incomplete working of the system of notification'. However it's medical inspector Thomas Browne felt that the larger numbers recorded in the previous two periods could be accounted for by the number of long standing cases notified upon coming into operation of the Act, whereas only cases of recent origin were now being notified. However he did acknowledge that in the other Leinster districts where notification was in force 'it is doubtful whether all cases subject to notification are duly notified'.[105]

No other authorities adopted notification in the year ending 31 March 1913. That year 528 notifications were made in Dublin city. As the registrar general had recorded 1,104 deaths occurring in the city from all forms of tuberculosis in 1912 including 758 from pulmonary tuberculosis and since the number of deaths recorded should be a fraction of the number of sufferers, the LGB considered this shortfall in the number of notifications

[101] *BMJ*,ii, no. 2537 (1909), p. 415.
[102] The Leinster authorities were the urban district councils of Kingstown, Naas, Navan, New Ross, Pembroke and the rural district councils of Balrothery, Celbridge No. 2, Dublin North, Dublin South, Mullingar, Navan and Trim.
[103] *Thirty-eighth annual report of the LGB.*
[104] *Annual report of the Local Government Board for Ireland for the year ended 31st March, 1911, being the thirty-ninth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*,1 [Cd 5847], H.C. 1911, xxxiii, 1.
[105] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1912, being the fortieth report under 'the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 6339], H.C. 1912-13, xxxvii, 1.

from recorded deaths as evidence that the number of notifications could not be regarded 'as affording a complete index of the incidence of the disease'. However as notification applied only in strictly limited circumstances the validity of their contention is open to question. Notifications in the remaining Leinster districts to which notification applied remained comparatively few.[106]

In the year ending 31 March 1914 a further fourteen authorities adopted compulsory notification.[107] That year 1,020 notifications were made in Dublin city. This significant increase was attributed mainly to the number of notifications emanating from the Charles Street tuberculosis dispensary, which had come under corporation control during that year.[108]

The following year ending 31 March 1915 an additional fourteen authorities adopted notification.[109] This brought the total number of sanitary districts to which notification applied to sixty-nine covering approximately one third of the population of Ireland. That year the numbers recorded in Dublin city increased to 1,445. The increase was due to the number of notifications received from Charles Street, which had been under corporation control for the entire year. However Thomas Browne found that despite adopting the relevant provisions of the act very few notifications were received from the other Leinster authorities 'although many deaths due to pulmonary tuberculosis are registered in the districts'. He also found that in these areas authorities were lax in disinfecting

[106] *Forty-ninth detailed annual report of the Registrar General for Ireland containing a general abstract of the numbers of marriages, births and deaths registered in Ireland during the year 1912. Transmitted pursuant to the provisions of the 7 & 8 Vic., cap. 81, S. 56; 26 Vic., cap. 11, and 26 & 27 Vic., cap. 90. General summary. Population. Marriages, their number and their relation to population, religious denominations, ages, and civil condition. Births, their number and their relation to population. Deaths, their number and their relation to population, ages, and causes. Emigration; weather*, 1 [Cd 6917], H.C. 1913, xvi, 575; *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1913, being the forty-first report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 6978], H.C. 1913, xxxii, 457. (Henceforth *Forty-first annual report of the LGB*).

[107] This included the Leinster rural district councils of Celbridge No. 1, Edenderry No.2, Naas No.1 and Rathdown No.1.

[108] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1914, being the forty-second report under 'the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 7561], H.C. 1914, xxxix, 595. (Henceforth *Forty-second annual report of the LGB).*

[109] This included the Leinster urban district council of Blackrock and the Leinster rural district council of Ardee No.1.

houses, formerly occupied by tubercular patients, leading to new tenants contracting the disease.[110]

Ten new authorities adopted notification in the year ending 31 March 1916.[111] Dublin city recorded 1,007 notifications, the decrease being due to a levelling off of the numbers recorded from Charles Street.[112] Only the Leinster based urban district councils of Kells and Wexford and the rural district council of Enniscorthy, adopted notification in the year ended 31 March 1917. The LGB found that the misapprehensions regarding notification of the disease, which were prevalent when the statute was passed, were now gradually disappearing. However it did note that the delay of notification, until the disease had reached its latter stages, was still the norm.[113]

In the year ending 31 March 1918 five new authorities adopted notification.[114] In Dublin city 892 cases were notified. Included in this figure were an increasing number of notifications of children in the 5-15 years age group. This was not believed to be as a result of an increase of the incidence of the disease in this group, but rather as a result of the operation of the 1912 city tuberculosis scheme, which brought such patients to the attention of the medical officer. This proved of considerable benefit to this cohort of patients enabling treatment to be administered to them at a much earlier period than in former times.[115] No addition was made to the number of authorities adopting notification in the year ending 31 March 1919. That year the Dublin city recorded 746 notifications.[116]

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[110] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1915, being the forty-third report under 'the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 8016], H.C. 1914-16, xxv, 341. (Henceforth *Forty-third annual report of the LGB*).

[111] This included the Leinster urban district councils of Athlone and Enniscorthy.

[112] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1916, being the forty-fourth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 8365], H.C. 1916, xiii, 199. (Henceforth *Forty-fourth annual report of the LGB).*

[113] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1917, being the forty-fifth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 8765], H.C. 1917, xvi, 257. (Henceforth *Forty-fifth annual report of the LGB).*

[114] This included Dundalk urban district council and Dundalk rural district council in Leinster.

[115] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1918, being the forty-sixth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., s. 69*, 1 [Cmd 65], H.C. 1919, xxv, 1.

[116] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1919, being the forty-seventh report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cmd 578], H.C. 1920, xxi, 1.

On 24 February 1919, having consulted the presidents of the royal colleges of surgeons and physicians, the LGB decided to widen the application of compulsory notification, by extending it to apply to sufferers of any form of tuberculosis at any stage whose sputum or other infective discharge in the opinion of an attending medical physician would render them liable to communicate the disease to other persons. The notification requirement was not to extend to patients undergoing institutional tuberculosis treatment or persons being treated under an approved tuberculosis scheme. If an attending practitioner was doubtful regarding the existence of the disease, where bacteriologists had been appointed, he could forward a specimen of the sputum or discharge, for free analysis, to assist his diagnosis.[117]

Following the promulgation of this provision in the year ending 31 March 1920 another twelve authorities adopted compulsory notification.[118] This highlighted the problem of adoptive legislation; almost twelve years after the passing of the legislation only 39 out of 96 urban authorities and 62 out of 215 rural authorities had embraced the relevant statutory provisions. Notifications for the Dublin city that year were 772. The LGB was again to complain that 'notified cases in many rural districts fall short of the actual facts'.[119]

National Insurance Act 1911

Following the example of Germany, where late-nineteenth-century social legislation provided benefits for workers and enabled the provision of tuberculosis treatment facilities, similar legislation was enacted in Britain in the early twentieth century.

On 17 November 1881 the chancellor Otto Von Bismarck announced to the German Reichstag that, in the cause of 'furthering the welfare of the working people', he intended to introduce a bill providing for insurance of workmen against industrial accidents with supplementary measures providing for 'Industrial Sick Relief Assurance'.[120] This was followed by a series of Acts, passed between 1883 and 1911, which provided for the

[117] The Local Government Board for Ireland, The Tuberculosis (Notification) Order, 1919. No. 4018/1919 (24 Feb. 1919) (NAI, Health D112/4).
[118] None were in Leinster.
[119] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1920, being the forty-eighth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cmd 1432], H.C. 1921, xiv, 781. (Henceforth *Forty-eighth annual report of the LGB*).
[120] F. Parkes Weber, 'Remarks on the medical aspect of a system of compulsory insurance of the working classes' in *BMJ*, i, no. 1885 (1897), pp 388-9.

compulsory insurance of all workmen in specified occupations, with earnings under certain limits. The benefits accruing to the workmen included medical care at home or in hospital, payment for industrial injuries, sick pay, invalidity payments and old age pensions. The system was funded by contributions from workers and employers. Contributions were registered by affixing stamps to individual workmen's cards and forwarding completed cards to special offices for recording. To administer the system a framework of associations, friendly societies and communal funds was established, under the control of a central Imperial Insurance Bureau and thirty-one regionally based government insurance offices.[121] To combat consumption the acts allowed these regional offices to expend funds on the provision of hospitals, sanatoria and convalescent homes. In the period 1884 –1909 they spent £2,822,000 on the provision of such facilities in addition to lending considerable sums to public authorities and societies for building such facilities. The offices also funded curative treatment in institutions for all illnesses. In 1909 their net annual expenditure in this regard was £957,300, about two-thirds of which was incurred in the treatment of consumptives.[122]

In the United Kingdom following on the German example legislation was passed in 1906 providing for workmen's compensation for industrial injuries[123] and in 1908 providing for old age pensions[124]. On 4 May 1911 Lloyd George the Chancellor of the Exchequer introduced a national insurance bill into parliament. The bill proposed benefits for workers earning under £160 per annum. The benefits included medical relief whereby an insured person could command the services of a competent doctor and the doctor could provide the services in the knowledge that he would be paid for them. Lloyd George believed that this benefit would 'make a very great difference in the doctoring of these people'. A sick allowance of 10*s.* per week for three months reducing to 5*s.* per week for a further three months for male workers (the corresponding rates for women were 7*s.* 6*d.* and 5*s.*) was intended to maintain the families of sick insured persons. If at the end of the six month period the person was 'broken down altogether' a disablement allowance of 5*s.* per week was payable. As in Germany these allowances were to be 'conditional in every case on the patient obeying the doctor's orders'. A maternity benefit of 30*s.* was to

[121] Annie Ashley, *The Social Policy of Bismarck* (London, 1912), pp 59-70.
[122] *The National Insurance Bill. Copy of memorandum on sickness and invalidity insurance in Germany*, 2 [Cd 5678], H.C. 1911, lxxxiii, 213.
[123] Workmen's Compensation Act, 6 Ewd. VII, c. 58 (21 Dec. 1906).
[124] Old Age Pensions Act, 8 Ewd. VII, c. 40 (1 Aug. 1908).

be paid to cover the cost of doctors and nurses but was conditional on the women workers not returning to work for four weeks. Unemployment benefit was to be made available through the labour exchanges to that one-sixth of the workforce engaged in 'precarious trades', which were liable to considerable fluctuations in employment opportunities.[125]

The benefits were to be funded by a wage deduction of 4*d*. a week for men and 3*d*. a week for women, 'about the price of two pints of the cheapest beer per week, or the price of an ounce of tobacco'. Employers were to provide 3*d*. per week per worker, which would be supplemented by a state contribution of 2*d*. Regarding the very low paid, reduced rates were payable of 3d, 2d and 1d for those earning under 2*s*. 6*d*., 2*s*. and 1*s*. 6*d*. per day respectively, with the shortfall being made up by an increased levy on employers. Those benefiting from unemployment benefit would be required to make an additional weekly payment of 2½*d*., with employers contributing the same amount. Deductions and contributions were to be recorded by the stamping of a card similar to the German system, which would be forwarded to the Post Office for onward transmission.[126]

To 'deal with the terrible scourge of consumption', noting the 'amazing results' that had been achieved from the chain of sanatoria established all over the country by the German authorities, Lloyd George proposed setting aside a capital sum of £1,500,000 to assist local authorities and voluntary bodies build sanatoria. To fund the treatment of insured persons in sanatoria he proposed deducting from the insurance sums collected 1*s*. per person to which the government would add a further 4*d*. He estimated that this would provide a sanatorium fund of over £1,000,000 per year. It was envisaged that benefits would be administered by larger friendly societies with memberships larger than 10,000 with a body called Post Office Contributors being established to cater for non-society members. However, sanatorium benefit was to be administered by newly-established county health committees. The membership of such committees would be drawn equally from the county councils, the friendly societies and the Post Office insurers.[127]

[125] *Hansard 5 (Commons)*, xxv, cc 609-644 (London, 1911).
[126] Ibid.
[127] Ibid.

John Redmond, leader of the Irish Parliamentary Party, responding to the chancellor's introduction of the bill, pointed out that because the needs, social circumstances and national resources of Ireland were different to the rest of the United Kingdom, although it might appear that the country might to a 'special degree' benefit from the proposed measures, it would only do so if they were 'constructed and adapted as to suit the peculiar circumstances and conditions of Ireland'. To determine if the proposals were suitable to the different needs of Ireland would require a 'careful consideration' of the details and the machinery proposed for their implementation.[128]

The published bill contained a specific clause 59 dealing with Ireland. This clause reduced the required membership of friendly societies in Ireland to 5,000 and included provision for county councils to establish, subject to the sanction of insurance commissioners, county societies, if warranted by circumstances. No requirements as to minimum number of members were to be placed on these societies.[129] These provisions were necessary, as only two large friendly societies existed in Ireland, the Irish National Foresters with a membership of *c.* 130,000 and the exclusively Catholic Ancient Order of Hibernians with a membership of *c.* 65,000.[130] At least three-quarters of the members of Irish local health committees were to be appointed by the county councils with the balance being the nominees of the insurance commissioners. These local health committees were to avail of the services of the medical officer of health for each dispensary district in administering medical benefits to insured residents. The committee was to prescribe fees to compensate the medical officers for these additional duties and to compensate the boards of guardians for the provision of medicines and drugs. [131] This provision was in recognition of the different medical care systems that applied in Ireland and England. In England general practitioners administered to the poor whereas in Ireland the services were supplied through the nationwide system of dispensaries provided under the Medical Charities Acts.

The Irish General Council of County Councils was concerned with the financial implications of the bill, especially in view of impending national self-government. It

[128] *Hansard 5 (Commons)*, xxv, cc 651-654 (London, 1911).
[129] *National insurance. A bill to provide for insurance against loss of health and for the prevention and cure of sickness and for insurance against unemployment, and for purposes incidental thereto*, p. 1, H.C. 1911 (198), iv, 1. (Henceforth *National insurance bill* (198)).
[130] *Irish Times*, 3 May 1911.
[131] *National insurance bill* (198).

estimated that the bill would cost employers £2,000,000 and the state £650,000 per annum. It queried the need for this expenditure, especially as Ireland possessed 'a medical service in relation to her industrial population far ahead of similar services in Great Britain and therefore stands far less in need of expenditure for its improvement'. It felt that the bill would impose an unfair burden on poorer Irish farmers, by bringing members of their families, employed on their holdings, within the ambit of the bill. It feared that implementation of such a far-reaching scheme would detract attention, at a time when it needed to be focused on an examination of the details of home rule proposals and accordingly called on the Irish Parliamentary Party to seek the exclusion of Ireland from the scope of the bill.[132] Redmond in taking on board some of their concerns requested the chancellor to produce an equitable scheme allowing for the distinctions between Ireland and England by permitting amendments to clause 59 and any other provisions that affected Ireland specifically. Lloyd George agreed to this request, undertaking to consider all proposals relating to Ireland when clause 59 fell due for consideration.[133]

To ensure that the concerns of constituents were considered the Irish Parliamentary Party formed a committee to draw up amendments to customize the bill to Irish circumstances. The chancellor undertook to furnish this committee with all the facts and figures at the disposal of the government to facilitate their work.[134] The committee invited any concerned persons to submit their views and information to it for consideration and proceeded to hold a series of meetings with deputations from various bodies representing concerns with an interest in Ireland.[135] J. J. Clancy, the nationalist MP for North County Dublin, suggested dropping from the bill, insofar as Ireland was concerned, the provision of medical benefit, as the equivalent of this benefit was already available under the existing medical service. In his view the elimination of this benefit would enable the contributions of both the employer and employee to be greatly reduced.[136]

The Irish Parliamentary Party Committee reported in mid July 1911. The principle amendments it sought to the bill were, the establishment of separate Irish insurance

[132] *Irish Times*, 18 and 24 May 1911.
[133] *Hansard 5 (Commons)*, xxvi, cc 1061-2 (London, 1911).
[134] Ibid., cc 1234-5.
[135] *Irish Times*, 12 June and 13 July 1911.
[136] Ibid., 12 and 14 June 1911.

commissioners and a separate Irish insurance fund, the exclusion of medical benefit from Ireland except for those insured members of friendly societies, a reduction in contributions, the exclusion of working family members not in receipt of wages from the provisions of the bill and the reconstitution of the county health committees to give greater representation to insured persons.[137] All of these proposals were agreed to by the government, introduced by way of chancellor's amendments and passed. The membership of the local health committee (re-titled insurance committee in the act) was fixed at twenty-four, twelve of whom were insured persons, four nominees of the insurance commissioners and eight nominated by the local authority of whom two must be female.[138] The contribution rate for Ireland was reduced to 3*d*. per week for men and 2*d.* per week for women with employers contributing 2½*d*.; as in the rest of the United Kingdom the parliamentary contribution was removed. In respect of the lower paid, contributions were fixed for those earning between 2*s.* and 2*s.* 6*d.* a day at 2*d.* with the employer paying 3½*d.* for men and 2½*d.* for women, for those earning between 1*s.* 6¼*d.* and 2*s.* a day at ½*d.* with the employer paying 4*d.* for men and 3*d.*for women, for those earning 1*s.* 6*d.* a day or less the employer paid 4½*d.* for men and 3½*d.* for women. In the later two cases the shortfall was made up by a parliamentary contribution of 1*d.*.[139] In respect of these lower paid people the political justification for the higher employers' contribution was that they were enjoying the benefits of cheaper labour.

In accordance with the agreement entered into between the government and the Irish nationalists, the bill passed all stages by mid December 1911 so as to clear the way for discussion of the home rule bill upon the resumption of parliament in 1912.[140] It received royal assent on 16 December becoming operative from 15 July 1912. The act allowed insurance committees, with the consent of the insurance commissioners, to enter into agreements with institutions for the provision of treatment to persons recommended by the committee. In addition to payments covering the actual cost of providing treatment for patients, the committees could make annual payments to institutions towards the costs incurred in maintaining facilities. However prior to any such payments being made, the approval of the LGB was required to both the institution, whether local authority managed or otherwise, and its proposed methods of treatment. Facilities provided by

[137] Ibid., 13 July 1911.
[138] *Hansard 5 (Commons)*, xxxi, cc 208-331 and cc 389-448 (London, 1911).
[139] National Insurance Act, 1 & 2 Geo. V, c.55 (16 Dec. 1911).
[140] *Irish Times*, 12 Dec. 1911.

poor law authorities were excluded from the provisions of the act. The act also determined that the capital sum of £1,500,000 and any further such sums that might be allocated for the construction of sanatoria should be apportioned between Ireland, England, Scotland and Wales in proportion to their respective populations as revealed by the 1911 census of population.[141] This resulted in an initial share of £145,623 accruing to Ireland.[142]

Conclusions

Although notification of tuberculosis cases had been implemented with moderate success in New York, Boston and Norway, as a first step in dealing with tuberculosis and had been introduced in parts of Britain, sectional interests initially prevented its introduction in Ireland. It was pressure from the WNHA and the medical profession's controlling bodies that facilitated the introduction of enabling legislation, although political expediency resulted in the notification provisions being adoptive rather than prescriptive, effectively allowing local authorities to opt out. The Tuberculosis Prevention (Ireland) Act highlighted the weakness of adoptive legislation. The take up of the notification provisions of the Act was not successful as, twelve years after its introduction, only 40 per cent of urban authorities and less than 30 per cent of rural authorities had implemented them. In addition where the provisions were adopted no mechanisms were put in place to ensure that their enforcement was adequately policed. This resulted in large underreporting of the prevalence of the disease, thereby defeating the purposes of notification. Jones has shown that the unwillingness of patients to make themselves available for treatment had a negative impact upon notification schemes.[143] However where implemented it demonstrated the benefits that could accrue from notification and thus paved the way for subsequent legislative reform making the notification of tuberculosis compulsory. Mirroring German social legislation the National Insurance Act 1911 provided medical and sickness benefits for workers and established a fund which could be drawn on to provide treatment facilities.

The statutory measures provided for in the Tuberculosis Prevention (Ireland) Act 1908 and the National Insurance Act 1911 laid the foundations for a comprehensive approach

[141] National Insurance Act, 1 & 2 Geo. V, c.55 (16 Dec. 1911).
[142] Forty-first annual report of the LGB.
[143] Jones, *Captain of all these men of death*, p. 115, pp 139-40.

to tackling the scourge of tuberculosis in Ireland. Many subsequent legislative enactments and actions implemented by authorities incorporated the main provisions of these enactments.

Chapter 5

The development of sanatoria and complementary facilities for the treatment of tuberculosis 1904-1918

In the early years of the twentieth century, outside of poor law premises, only one major voluntary sanatorium and a scattering of small private facilities existed in Leinster, for the treatment of pulmonary tuberculosis. It fell initially to the local authorities to augment this provision. However the decision of the WNHA to become directly involved in the provision of facilities and services provided a considerable impetus to the enhancement of treatment options.

Local authority facilities

The British Congress on Tuberculosis, held in London in July 1901, adopted a resolution 'that the provision of sanatoria is an indispensable part of the means necessary for the diminution of tuberculosis'. In September 1901 the Irish LGB in support of the resolution, issued a circular requesting authorities to refer curable patients to sanatoria and 'where unions are populous and sufficiently wealthy to make special provision themselves for the curative treatment of such cases'.[1]

Cork a model for the development of local authority sanatoria

Under pressure from the LGB and the NAPT, the Cork local authorities paved the way for subsequent developments by Irish local authorities by providing a public sanatorium. The process they engaged in highlighted the difficulties of site selection, which was to prove an ongoing problem in locating tuberculosis treatment facilities.

In January 1904 the Cork District Council circulated a resolution it had adopted, at the behest of the Cork Branch of the NAPT, requesting Cork local authorities to form a united body, to provide a public sanatorium in Cork, to be financed by levying a rate of one penny in the pound.[2] It followed this up by circulating a draft motion for adoption by the authorities, calling on the LGB to make a provisional order, pursuant to the Public

[1] LGB circular no. 127 M-miscellaneous tuberculosis 16 Sept 1901 in *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1902, being the thirtieth report under the Local Government Board Ireland Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 1606], H.C. 1903, xxv, 531. (Henceforth *Thirtieth annual report of the LGB*).

[2] *Southern Star*, 9 Jan. 1904; Minutes of meeting of executive committee of Dublin branch of NAPT 3 Mar. 1903 (RCPI, NAPT/3).

Health (Ireland) Act 1879, to form a united district of Cork Borough, the eight urban districts and the eighteen rural districts, which comprised the county.[3] The members of the Cork branch of the NAPT visited the various authorities 'laying before them the advisability of establishing the proposed sanatorium and urging upon them the necessity of levying a rate for the upkeep of the institution'.[4] Having received the necessary motions the LGB initiated the process, resulting in the passing of legislation, which constituted the authorities as a joint hospital district and provided them with the necessary powers to levy rates, to establish the sanatorium.[5]

In February 1905 the Cork Joint Hospital Board advertised for a sanatorium site of 80 to 100 acres of sandy soil, with a sheltered southerly aspect, situated 500 to 1500 feet above sea level, which had an ample water supply and was convenient to a railway station.[6] Sixteen sites were offered in response to this advertisement. To assist the selection process, Dr Charles Smith of Altidore was engaged. Smith with the advice of James McMullen[7] rejected the sites and proceeded to investigate other locations in the county. He found only three sites 'good enough for a sanatorium', expressing a preference for a site at Coolkellure, Dunmanway, which he considered 'by far the most suitable'.[8] However, when the site was considered by the board, it was reported the owner refused to sell the site. This together with the excessive rainfall to which the site was subject, were advanced as reasons for its rejection. Another site suggested by Smith at Mount Massey, Macroom was objected to on the basis 'that the disease might be propagated from the sanatorium to the people of the town', even though, through the introduction of regulations, patients could be prevented from going into the town. The third site at Rahan was considered by the board members to be 'not practicable' although no reasons for this were advanced. Having rejected the three sites the board decided to again advertise.[9] This resulted in twenty-nine sites being offered.[10] At its September meeting having narrowed the site selection process down to three sites the board determined to proceed with the Mount Massey site. However because of complex ownership issues regarding charges on

[3] *Southern Star*, 23 Jan. 1904.
[4] 'Ireland' in *BMJ*, i, no. 2250 (1904), pp 392-3.
[5] *Southern Star*, 23 Apr. and 14 May 1904; Local Government Board (Ireland) Provisional Orders Confirmation (No. 2) Act 1904, 4 Edw. VII, c. 124 (22 July 1904).
[6] *Southern Star*, 19 Feb. 1905.
[7] McMullen was an engineer representing the Cork branch of the NAPT.
[8] *Southern Star*, 8 Apr. 1905.
[9] Ibid., 13 May 1905.
[10] Ibid., 27 May 1905.

the site it was necessary to proceed with the acquisition by way of compulsory purchase order.[11]

As required by legislation the LGB in February 1906 held an inquiry into the acquisition of the site. Dr C. Theodore Williams, consulting physician to the Brompton Hospital for Consumption, gave evidence opposing the site on the grounds of its unsheltered nature, its bad sanitation and its closeness to Macroom, where patients from the labouring classes would have ready access to public houses. In these objections he was supported by the Cork branch of the NAPT, who regarded the proposal as a 'medical folly'.[12] The inquiry also dealt with an application for a loan of £14,600 to fund the sanatorium. The editor of the *Southern Star* disputing William's evidence commented that 'the doctors who have lived in the vicinity of Macroom all their lives characterise it as a salubrious, sunny and bracing place and their evidence ought to carry more weight than that of the stranger, specialist though he be'.[13] The board's justification for acquiring the site was weakened, when its legal counsel admitted that 'the joint board are not entirely satisfied as to its suitability, but they have adopted it as being the best which they have been able to secure'. Other evidence adduced showed that local objections to the proposal might prove greater than anticipated and that it might prove impossible to adopt the existing buildings on the site for use as a sanatorium. However in rejecting the proposal the LGB considered the 'fatal objection' to the site to be the impossibility of providing proper shelter to the unprotected northern, north-eastern and north-western sides.[14]

A site at Meeshal, offered to the NAPT in April 1903, for the construction of a voluntary sanatorium, was considered by the board in August 1906.[15] Following extensive investigations into its suitability, in January 1907 the board applied to the LGB to compulsorily acquire it and sought a loan of £17,750 to finance its development.[16] However following an inquiry, when local objections were heard and evidence given by Professor Moore of Queen's College, regarding the possibility of effluent from the site contaminating the Cork City water supply, the proposal was rejected.[17] Although the LGB accepted that evidence had disproved Professor Moore's contention, it nevertheless could not approve the application as 'it was apparent that a great feeling of uneasiness

[11] Ibid., 9 Sept. 1905.
[12] *BMJ*, i, no. 2356 (1906), pp 467-8.
[13] *Southern Star*, 17 Feb. 1906.
[14] Ibid., 14 Apr. 1906.
[15] Ibid., 11 Aug. 1906.
[16] Ibid., 8 Sept. 1906 and 5 Jan. 1907.
[17] Ibid., 2 Feb. 1907.

might be caused to the inhabitants of the city if we permitted the sanatorium to be erected on the site'.[18] When informed of this rejection a board member gifted a site at Streamhill, Ballyhoura two miles outside Duneraile which was unanimously accepted. LGB approval was granted following a site examination by its inspectors.[19] To overcome local objections covenants in the conveyance required the board to prohibit the patients 'to wander over the neighbouring lands or to approach the intake of the Buttevant waterworks'.[20]

The LGB sanctioned a loan of £12,000 for the project.[21] However as considerable funds were on hands from the rates levied by the constituent authorities only £5000 of this sum was drawn down. It was to be repaid over twenty-five years, the estimated life span of the proposed structure.[22] The sanatorium was built of wood supported by iron uprights on cement and steel foundations. The crescent-shaped building contained a central administration block flanked by male and female wings.[23] The wings were fronted by verandahs, onto which patients' beds could be rolled through French doors from the wards.[24] Lady Aberdeen laid the foundation stone on 13 April 1909 and on 4 Aug 1910 performed the official opening ceremony for the seventy-seven-bed, first county sanatorium in Ireland. It had cost *c*. £11,000.[25]

Crooksling Dublin

The Dublin local authorities attempted to follow the Cork example. However the financial implications of supporting a sanatorium proved a barrier to participation in a joint venture for several smaller authorities.

In early 1905, concerned at the lack of facilities for poor consumptives, Charles Cameron, the Dublin city medical officer of health, circulated the Dublin general hospitals suggesting they reserve in each hospital a small ward for consumptives, who would be retained until the termination of their disease by recovery or death. The Mater

[18] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1907, being the thirty-fifth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 3682], H.C. 1907, xxviii, 1. (Henceforth *Thirty-fifth annual report of the LGB*).
[19] *Southern Star*, 11 May and 1 June 1907;*BMJ*, i, no. 2521 (1909), p. 1030.
[20] *BMJ*, ii, no. 2482 (1908), p. 224.
[21] *Southern Star*, 14 Aug. 1909.
[22] Ibid., 14 Aug. 1909; *Irish Independent*, 5 Aug. 1910.
[23] *Southern Star*, 14 Aug. 1909; *Irish Independent*, 5 Aug. 1910; *Irish Times*, 5 Aug. 1910; *BMJ*, ii, no. 2590 (1910), p. 487.
[24] *Irish Times*, 5 Aug. 1910.
[25] *Southern Star*, 17 Apr. and 13 Nov. 1909; *Irish Times*, 5 Aug. 1910.

Misericordiae Hospital replied that they were making arrangements to have two wards devoted exclusively to the treatment of consumptive cases. Mercer's Hospital stated that it admitted early and acute cases of tuberculosis for diagnosis or special treatment, prior to sending them to the country or to a sanatorium. Phthisical patients were admitted to the Adelaide Hospital and when considered advisable kept until their demise. St Vincent's Hospital due to lack of space was unable to dedicate a ward to such purposes. Jervis Street hospital did not have sufficient accommodation to enable the admission of any consumptives.[26]

Politicians began to look to the provision of sanatoria facilities. In April 1905 a proposal to have the public health committee of Dublin Corporation report on the erection of a sanatorium for consumptives, was defeated by a vote of twenty-one to seventeen.[27] In November requests from the boards of guardians of the North and South Dublin Unions, inviting the co-operation of the corporation in establishing a sanatorium for the treatment of consumptives for the city and county of Dublin, was referred to the public health committee for consideration.[28] In January 1906 following a request from Cameron, it was agreed to give the public health committee permission to convene a meeting of the Dublin urban and rural district councils, to consider establishing a sanatorium to treat consumptives.[29]

The meeting took place on 13 February 1906, attended by representatives of the Corporation of Dublin, the urban district councils (UDCs) of Killiney and Ballybrack, Blackrock, Kingstown, Rathmines and the rural district councils (RDCs) of Balrothery, North Dublin, South Dublin and Rathdown. The meeting was addressed by Cameron and by Dr Edgar Flinn, the LGB medical inspector for the Dublin area. The consensus of the meeting favoured erecting a sanatorium. Cameron was requested to obtain financial details of public sanatoria in the United Kingdom for consideration at a meeting on 27 February.[30] At that meeting Cameron produced costings, which showed that the chalet system, 'whilst at least equal to any other, was the cheapest'. Beds provided on this system could be maintained at an annual cost of £60- £70. A rate of one penny in the pound on the valuation of all the authorities in Dublin city and county would produce

[26] *Report of the public health committee for quarter ending 30 June 1905*, report no. 158, Dublin Corporation reports 1905, vol. 2, pp 639-57 (DCCA).
[27] *Minutes of meeting of municipal council 19 Apr. 1905*, minute no. 229, pp 224-5 (DCCA).
[28] *Minutes of meeting of municipal council 13 Nov. 1905*, minute no. 567 p. 549 and minute no. 577 p. 565 (DCCA).
[29] *Minutes of meeting of municipal council 22 Jan 1906*, minute no. 51, pp 23-4 (DCCA).
[30] *Irish Times*, 14 Feb. 1906.

c. £6,500 sufficient to maintain 100 beds. These beds could be allotted to contributing authorities in a ratio proportional to their respective valuations. The conference concluded by recommending that the Dublin sanitary authorities should combine to erect a sanatorium, on the chalet system, for consumptives from the poorer classes. [31]

On 12 March 1906 Kingstown UDC adopted the conference recommendations and on 16 July 1906 committed the council to levying a rate of one penny in the pound.[32] However its members considered that erecting a sanatorium out of the first year's revenue as had been proposed was unsustainable and suggested that borrowing powers be obtained and the project financed by way of a capital loan.[33] South Dublin RDC on 18 July 1906, having being addressed by Edgar Flinn, who drew on the example of how the Cork authorities were proceeding, passed a motion calling on the Dublin authorities to form a deputation to the Chief Secretary seeking government aid to finance the proposed sanatorium.[34] Implicit in this decision was an acceptance of the conference recommendations. On 24 August, Alderman Daniel Bergin recommended that Dublin Corporation adopt similar proposals to Kingston. He pointed out that the proceeds from the first year's collection of the proposed rate of one penny in the pound would be more than adequate to fund the capital cost of acquiring a site and erecting chalets to accommodate forty patients. Opponents of the proposal objected on financial grounds, believing that the proposed rate was 'the thin end of the wedge' and that 'before they were done with this transaction it would be as much as 6d. in the pound'. Bergin's recommendation was passed on a twenty-two to six vote.[35]

Blackrock UDC considered the conference report on 19 September 1906. The chairman Lady Dockrell stated that she was in favour of any scheme to reduce tuberculosis provided the Imperial Exchequer funded it. With the burden of rates already too high, she did not see why the middle classes, who through the rates were providing for the education and housing of the poorer classes and who could not afford to send their consumptive children to Davos Platz for treatment, should be asked to fund sanatoria for

[31] *Report upon the state of public health and sanitary work performed in Dublin during the year 1906*. Appended to volume 2 of the Dublin Corporation reports 1907 as a separate report (DCCA); *Irish Times*, 13 Mar. 1906.
[32] *Irish Times*, 13 Mar. and 17 July 1906.
[33] *Urban District Council of Kingstown, reports of committees and officers, June 1906, report of number 1 committee, 26 June 1906* (DLRCC local studies section).
[34] *Irish Times*, 19 July 1906.
[35] *Minutes of special meeting of municipal council 24 Aug. 1906*, minute no. 490, pp 377-8 (DCCA); *Irish Times*, 25 Aug. 1906.

the children of the labourer and the artisan. By consenting to such a scheme she maintained that 'the drain on the rates will be limitless'. Under her urging the council called on Parliament to provide state aid for the erection and maintenance of a sanatorium for Dublin 'as the matter could not be adequately dealt with by the local authorities, whose burdens are already too heavy to admit of their grappling with a subject of such gigantic proportions'.[36] On 3 October North Dublin RDC, having been addressed by Edgar Flinn at its July meeting on the subject, agreed to levy a rate of 1d. in the pound to fund the proposals.[37] A meeting was convened on 9 Oct 1906 in an attempt to persuade the remaining Dublin authorities to join in the formation of a joint board. The meeting was informed that letters had been received from the Balrothery RDC and Celbridge no.2 RDC agreeing to the proposal.[38]

The authorities that had decided to join the scheme met on 5 December 1906 and requested the LGB to initiate the procedures to form a Dublin united district with powers to erect the sanatorium.[39] To pressurize the non-participating authorities, Cameron wrote to the *Irish Times* showing that deaths from lung consumption had increased in the Dublin metropolitan registration area to 32.9 per 10,000 population in the decade ending in 1904 from 29 per 10,000 population in the decade ending in 1880. He pointed out that additional means were therefore necessary to combat the disease, the most important of which was the provision of sanatoria. Quoting the example of Cork, he detailed the action carried out in Dublin, pointing out that Rathdown RDC and the UDCs of Rathmines, Pembroke, Blackrock, Killiney and Dalkey, which together represented a population of 86,937, had not joined the scheme. He hoped that a public show of interest in the scheme would stimulate the excluded authorities to join.[40] At the Dublin Corporation meeting on 28 December Alderman Bergin stated that 'it was […] very selfish of people living in the residential quarters of Pembroke and Rathmines to disassociate themselves from the poorer people of a city in which they made their living'. He believed that 'they would eventually be brought to think of their duty towards the poorer class of citizen'.[41]

[36] *Irish Times*, 20 Sept. 1906.
[37] Ibid., 12 July and 4 Oct. 1906.
[38] Ibid., 12 Oct. 1906.
[39] Ibid., 6 Dec. 1906.
[40] Ibid., 13 Dec. 1906.
[41] Ibid., 29 Dec. 1906.

On 7 February, Kingstown UDC, instructed its delegates to inform the LGB enquiry that Kingstown UDC was 'not disposed to join in the proposed scheme for the erection of a sanatorium unless all the sanitary authorities in the county of Dublin are included in the proposed united district'.[42] It was concerned at the additional financial burdens that would be placed on subscribing authorities to make up for the anticipated shortfall if all the Dublin authorities did not join the scheme. At the enquiry all the excluded authorities, with the exception of Dalkey, through their legal representatives, objected to their inclusion in the scheme.

Joseph Keogh the chairman of Dalkey UDC attended the enquiry, in order to ascertain what the burden would be on the township, if they joined the scheme. He was informed that the liability would not exceed a rate of 1d. in the pound.[43] On 20 March the council decided to write to the LGB urging it to provide for 'the safeguarding of the interests of minorities on any board of control of the joint sanitary authorities that might be established'.[44] This request together with their lack of objection at the enquiry probably influenced the LGB decision to include Dalkey, together with the subscribing authorities, in the provisional order forming a united district.[45] Kingstown, which had reaffirmed its decision to participate only if all authorities were included and subject to the proviso that it approved of the terms of the provisional order, when finally drafted, was excluded from the order.[46]

The order confirmed by legislation on 26 July 1907 established a Dublin joint hospital board to provide a sanatorium, with beds allocated in a ratio proportionate to the respective rateable valuations of the subscribing authorities. The amount to be subscribed by each authority was limited to the product of a rate of 1d. in the pound. The membership of the board reflected the relative size of the subscribing authorities with the corporation being allocated eighteen places on the board, Balrothery RDC four places, North and South Dublin RDCs three places each, Celbridge no.2 RDC two places and Dalkey UDC one place. The board was to appoint from within its membership a

[42] *Urban District Council of Kingstown, minutes of the monthly meeting of the council, 7 Feb. 1907* (DLRCC local studies section).
[43] *Irish Times*, 8 Feb. 1906.
[44] Ibid., 21 Mar. 1907.
[45] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1908, being the thirty-sixth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69*, 1 [Cd 4243], H.C. 1908, xxxi, 1. (Henceforth *Thirty-sixth annual report of the LGB*).
[46] *Urban District Council of Kingstown, minutes of the monthly meeting of the council, 15 Mar. 1907* (DLRCC local studies section); *Thirty-sixth annual report of the LGB.*

management committee, which would appoint staff and subject to LGB sanction determine admission procedures.[47]

The Dublin Joint Hospital Board placed advertisements, in December 1907, seeking suitable sites.[48] Four of the sites offered, two at Brittas, one at Saggart and one at Larch Hill Rathfarnham, were chosen for inspection by one of its members Dr E. McWeeney. Having inspected the sites, accompanied by Dr Cameron, McWeeney recommended Larch Hill, then occupied by Dr O'Hare's sanatorium. In arriving at his decision he was influenced by the fact that a sanatorium, to which doctors referred patients, was established on the site, thus implying that medical opinion considered the site suitable. The seventy-eight acre site was offered on a ninety-seven year lease, in respect of which a yearly rent of £157 was payable, for a capital sum of £3,150. McWeeney also considered a 300 acre site at Verschoyle's Hill, Brittas, which enjoyed an abundant and convenient water supply, suitable. This site was on offer for a sum of £4,000. The remaining two sites he dismissed as unsuitable.[49] The board met to consider his report on 26 June 1908. Considering the greater acreage available, its freehold tenure and statements made by Dr McWeeney to the effect that the aspect, configuration and accessibility of the site together with its remoteness from villages and public houses made it eminently suitable, the Brittas site was chosen. The decision was influenced by the lack of buildings on the site, which necessitated the construction of new facilities, as McWeeney had advised that 'the cost of adapting old structures is often considerable and the results not always satisfactory'.[50] In Alderman Bergin's view an additional benefit was that 'the ratepayers who had purchased the site would not be troubled with having the sanatorium in the vicinity of their own homes'.[51]

The new sanatorium, with accommodation for fifty patients, was officially opened by the Dublin lord mayor on 8 June 1911. It had been provided at a cost of just over £14,000. The building was constructed of wood, metal and plaster and roofed with corrugated iron. It consisted of a two-storey central administrative block containing the doctor's and matron's quarters, nurses' and servants' sitting and dining rooms and at first floor level nurses' bedrooms. This was flanked on both sides by 150 feet long wings, each

[47] Local Government Board (Ireland) Provisional Orders Confirmation (No. 2) Act, 1907. 7 Ewd.7, c. 53 (26 July 1907).
[48] *Irish Independent*, 21 Dec 1907.
[49] *Irish Times*, 19 May 1908.
[50] *Freeman's Journal*, 27 June 1908.
[51] *Irish Times*, 9 June 1911.

containing three male and female dormitories fronted by sloping verandahs onto which beds could be readily wheeled. Walkways provided access from these to the male and female dining rooms located to the rear. These were separated by a sliding screen, which could be opened to provide a large recreation hall. Attached to this hall were a large kitchen and a two-storey block of servants' bedrooms. The laundry block was located some 400 feet away so as not to inconvenience the patients with the large volumes of smoke emanating from its tall chimneystack. The most up to date sewerage disposal system was installed, whereby the effluent was conveyed by pipes a distance of half a mile, where collection tanks and filtration beds made it suitable for land irrigation. As the hospital was to deal with patients who 'were possibly curable', prospective patients required a certificate from their doctor, stating that they 'had a reasonable chance of recovery'.[52]

By 1913 the full complement of 114 beds was available. 105 of these were occupied by Dublin city patients. Because of the urgent demand for accommodation, with over fifty patients on the waiting list, a contract was placed to construct a new male wing to the hospital to provide for 130-150 patients. The new facility was ready for occupation from January 1914.[53]

Unlike the unanimity displayed by their Cork counterparts, the fractious agreement entered into by the Dublin authorities disintegrated resulting in the LGB, following an inquiry into the question of control and management of the institution, making an order on 25 March 1915 vesting Crooksling in Dublin Corporation.[54]

The Dublin Tuberculosis Dispensary

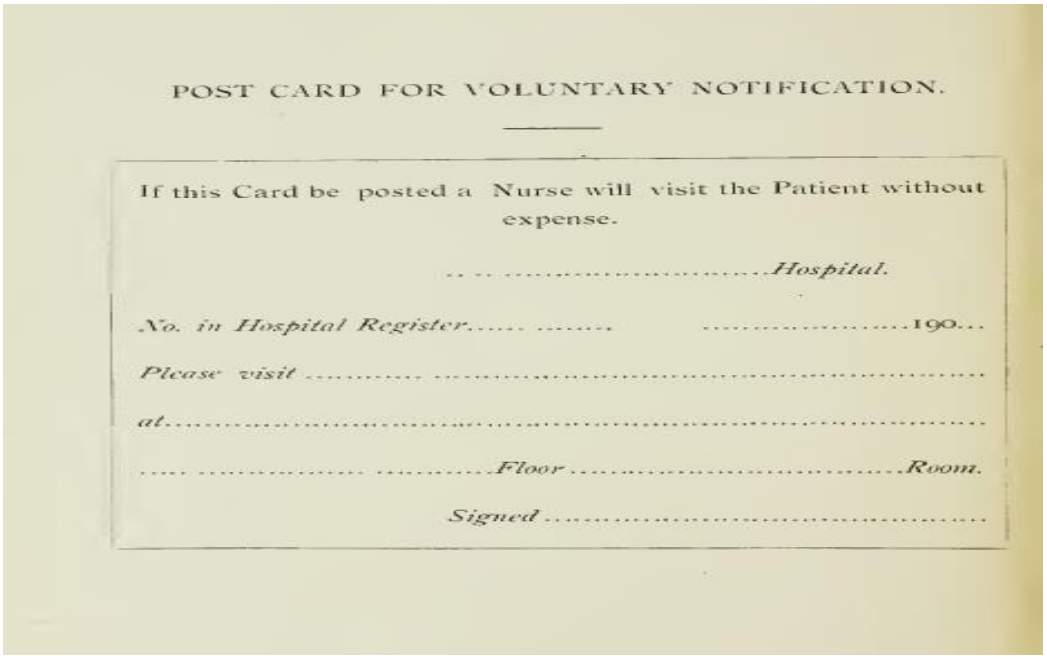
On 26 November 1907 Lady Aberdeen called a meeting to consider establishing special dispensaries for the treatment of tuberculosis patients, to which she had invited the leading medical representative from each of Dublin's ten clinical hospitals. The attendees formed themselves into the Hospitals Tuberculosis Committee (see appendix 8). The

[52] Ibid., 9 June 1911; *Freeman's Journal*, 9 June 1911; *Weekly Irish Times*, 10 June 1911.
[53] *Minutes of adjourned meeting of the municipal council, 16 June 1913*, minute no. 482 pp 331-3; *Report of the tuberculosis committee of management in re application of the balance of the County Borough share of Sanatorium Grant towards expenses of extension of Crooksling Sanatorium*, Dublin Corporation reports 1913, vol. 3, no. 267, pp 417-9 (DCCA); *Forty-third annual report of the LGB.*
[54] *Forty-third annual report of the LGB; Minutes of monthly meeting of the municipal council*, 2 Nov. 1914, minute no. 823, pp 466-7; *Report of the tuberculosis committee in re the working of the institutions under the Tuberculosis Acts*, Dublin Corporation reports 1915, vol. 2, no. 138, pp 195-204 (DCCA); *Irish Times*, 13 Nov. 1913.

meeting was informed that St Vincent's, the Mater and Jervis Street hospitals had decided to hold weekly chest clinics while Dr Steeven's, Mercer's and Sir Patrick Dun's were prepared to experiment along similar lines. However it was explained that the Adelaide, the City of Dublin and the Richmond hospitals would have difficulties in providing such facilities. It was decided to keep a special register of tubercular patients in each hospital and to avail of the offer of the WNHA to engage two nurses who would visit these patients in their own homes and in addition to ordinary nursing would 'try and teach the patients and their friends some of the elementary principles about tuberculosis'.[55] To overcome Sir Arthur Chance's objections to providing patients' details to the nurses without express consent, forms were designed and distributed to the hospitals for subsequent transmission by the patients to the WNHA, to arrange for nurses' visits (plate 5.1). An inquiry form was also designed, to facilitate the nurses in providing details of the family circumstances and living conditions of the patients, for the purposes of providing statistical feedback to the committee (plate 5.2).[56]

The WNHA engaged the services of two jubilee nurses who, from mid February 1908, spent a number of weeks in Edinburgh, receiving tuition in home nursing of tuberculosis patients at Dr Philip's dispensary.[57] In their first three months of duty the nurses visited 106 patients, seventy-three of whom had been notified through the hospitals, the balance being self referrals or referred by friends, who became aware of the nurses' work in their neighbourhoods. Most of the cases, when first seen by the nurse, displayed evidence of advanced disease and in almost all cases at least one other family member was found to be suffering from early tuberculosis and brought under medical care. In most instances, the families were found to be living in 'extreme poverty', in dirty accommodation lacking ventilation, with virtually no precautions taken against the disease. The nurses arranged to have thirty-eight premises disinfected and distributed forty-six sputum flasks.[58] In addition to providing verbal advice to the families, the nurses distributed a cardboard mounted list of instructions prepared by the hospitals committee. The instructions related to spitting and the proper disposal of phlegm, using separate eating

[55] Minutes of meeting of special conference of representatives of the Dublin clinical hospitals, 26 Nov. 1907 (NAI, Priv/1212/wnha/1/15). All of the invitees attended except Sir John Moore representing the Meath Hospital who tendered his apologies indicating that his hospital was in favour of some such scheme and offering his co-operation.
[56] Minutes of special conference, 26 Nov. 1907; William J. Thompson, 'Home treatment and nursing of pulmonary tuberculosis in Dublin' in The Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis* (3 vols, Dublin, 1908), ii, pp 173-7; Minutes of meeting of Hospitals Tuberculosis Committee, 10 Dec 1907 (NAI, Priv/1212/wnha/1/15) (Henceforth Minutes HTC).
[57] *First annual report of the WNHA, April 1908* (NAI, Priv/1212/wnha/1/2).
[58] Thompson, 'Home treatment'.



POST CARD FOR VOLUNTARY NOTIFICATION.

If this Card be posted a Nurse will visit the Patient without expense.

.....*Hospital.*

No. in Hospital Register..... ....190...

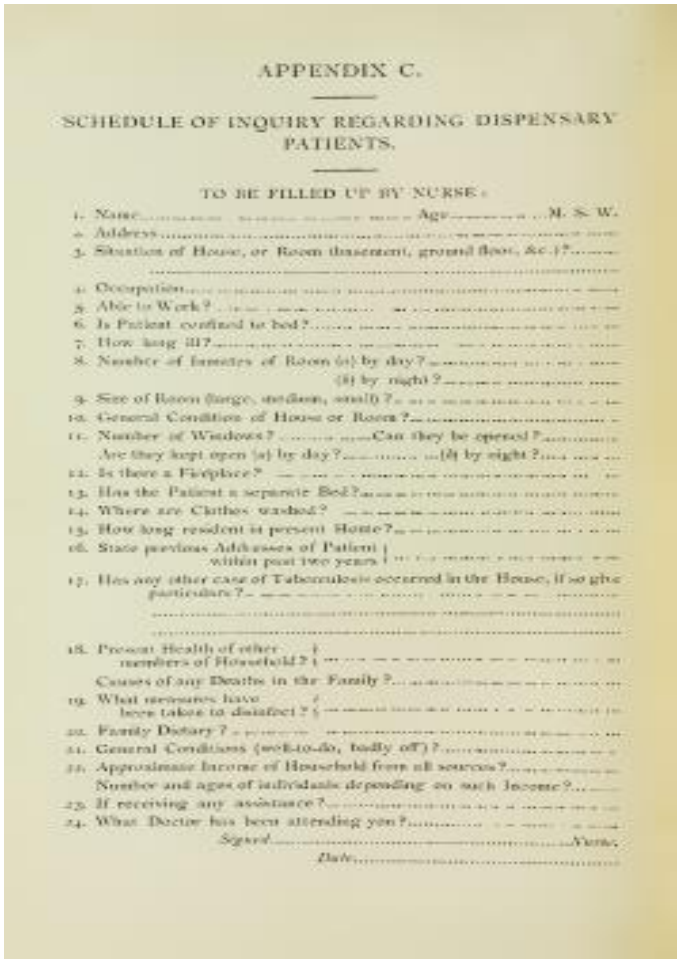
Please visit ....

at.....

....*Floor* .....*Room.*

Signed .....

Plate 5.1 Form to be sent to Women's National Health Association requesting a nurse to visit a tubercular patient, 1907 (Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis*, vol. 2)



APPENDIX C.

SCHEDULE OF INQUIRY REGARDING DISPENSARY PATIENTS.

TO BE FILLED UP BY NURSE:

1. Name..... Age..... M. S. W.
2. Address.....
3. Situation of House, or Room (basement, ground floor, &c.)?.....
4. Occupation.....
5. Able to Work?.....
6. Is Patient confined to bed?.....
7. How long ill?.....
8. Number of feet/cc of Room (a) by day?.....
(b) by night?.....
9. Size of Room (large, medium, small)?.....
10. General Condition of House or Room?.....
11. Number of Windows?.....Can they be opened?.....
Are they kept open (a) by day?.....(b) by night?.....
12. Is there a Fireplace?.....
13. Has the Patient a separate Bed?.....
14. Where are Clothes washed?.....
15. How long resident in present Home?.....
16. State previous Addresses of Patient within past two years.....
17. Has any other case of Tuberculosis occurred in the House, if so give particulars?.....
18. Present Health of other members of Household?.....
Causes of any Deaths in the Family?.....
19. What measures have been taken to disinfect?.....
20. Family Dietary?.....
21. General Conditions (well-to-do, badly off)?.....
22. Approximate Income of Household from all sources?.....
Number and ages of individuals depending on such Income?.....
23. If receiving any assistance?.....
24. What Doctor has been attending you?.....

Signed.....*Visitor.*

Date.....

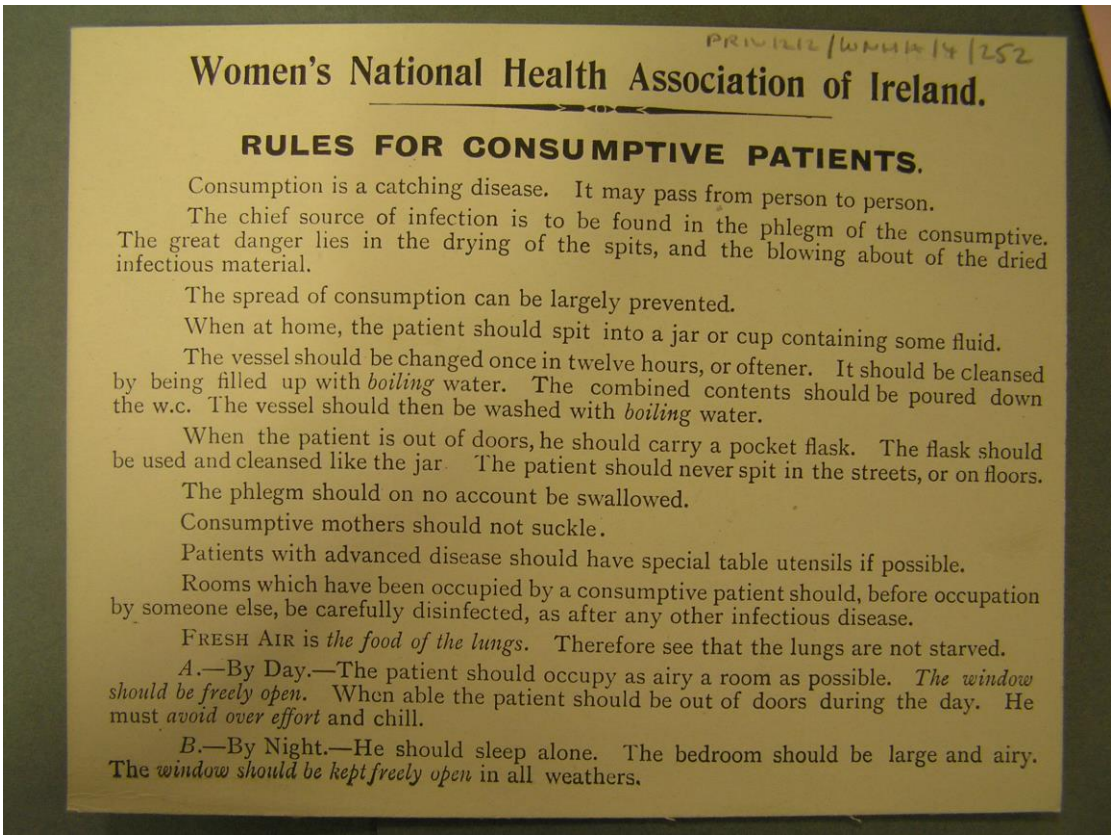
Plate 5.2 Inquiry form to be filled in by Women's National Health Association nurse when visiting tubercular patients, 1907 (Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis*, vol. 2)

utensils and beds and the proper ventilation of premises (plate 5.3).[59]

In their first year of operation the nurses attended 274 families making 7,087 separate visits. The fact that only 60% of the referrals were from hospitals demonstrates the community impact of the nurses. 121 of the families attended had an average size of six persons and were accommodated in a single room. The average earnings of such families were 7*s*. per week having dropped from a pre-illness high of 13*s*.[60] In the following six months 3,504 visits were made to 247 patients which number included 122 new cases, almost two-thirds of which were self-referrals. The economic position of the families continued to decline with average earnings dropping below 5*s* per week, where the illness affected the breadwinner. In their second year the two nurses attended 332 cases of which 207 were new cases, making a total of 6,786 visits. Sixty of these cases died during the year reflecting the advanced condition of the disease amongst the patients. By this stage the average earnings of families with an ill breadwinner had dropped below 4s.per week, a level at which it was impossible to provide nourishment, leading to Dr Joseph Daniel finding some patients 'almost on the verge of starvation'. In May 1909 the Terenure branch of the WNHA appointed a jubilee nurse referring all cases requiring home treatment in its administrative area to her. In her first four months of employment she paid 214 visits to twenty-two consumptive patients. [61]

The Dublin branch of the WNHA established a Samaritan's Committee in early 1908, to fill the care void identified by the nurses. This committee created a fund to provide nourishing food, blankets to facilitate night-time opening of windows and extra beds to allow patients to sleep alone. The committee linked patients into other philanthropic societies, which were able to cater for their needs. [62] Most prominent amongst these were the Society of St Vincent de Paul, the Sick and Indigent Roomkeepers' Society, the Soldiers' and Sailors' Help Society and the Strangers' Friend Society.[63] During the year ending March 1909 the committee provided or arranged for nourishment for 106 families, clothing and beds for 90 families and the payment of rent for a further 7

[59] *Irish Times*, 2 Mar. 1909; WNHA, *Rules for consumptive patients* (NAI, Priv/1212/wnha/4/252).
[60] 'Home treatment and nursing of pulmonary tuberculosis in Dublin' in *Sláinte*, i, no. 4 (1908), pp 68-71; *Irish Times*, 2 Mar. 1909.
[61] *Irish Times*, 15 Sept. 1909; 'Dublin home treatment of tuberculosis' in *BMJ*, ii, no. 2542 (1909), p. 815; Second annual meeting of HTC, 11 Mar. 1910 (NAI, Priv/1212/wnha/1/15). During this period the average weekly income of families where a member, other than the breadwinner, was ill was 14/6.
[62] Thompson, 'Home treatment'; *First annual report of the WNHA, April 1908* (NAI, Priv/1212/wnha/1/2).
[63] WNHA, *Report of Dublin branch 1910-11* (NAI, Priv/1212/wnha/6/30).



Women's National Health Association of Ireland.

RULES FOR CONSUMPTIVE PATIENTS.

Consumption is a catching disease. It may pass from person to person.

The chief source of infection is to be found in the phlegm of the consumptive. The great danger lies in the drying of the spits, and the blowing about of the dried infectious material.

The spread of consumption can be largely prevented.

When at home, the patient should spit into a jar or cup containing some fluid.

The vessel should be changed once in twelve hours, or oftener. It should be cleansed by being filled up with *boiling* water. The combined contents should be poured down the w.c. The vessel should then be washed with *boiling* water.

When the patient is out of doors, he should carry a pocket flask. The flask should be used and cleansed like the jar. The patient should never spit in the streets, or on floors.

The phlegm should on no account be swallowed.

Consumptive mothers should not suckle.

Patients with advanced disease should have special table utensils if possible.

Rooms which have been occupied by a consumptive patient should, before occupation by someone else, be carefully disinfected, as after any other infectious disease.

FRESH AIR is *the food of the lungs*. Therefore see that the lungs are not starved.

A.—By Day.—The patient should occupy as airy a room as possible. *The window should be freely open*. When able the patient should be out of doors during the day. He must *avoid over effort* and chill.

B.—By Night.—He should sleep alone. The bedroom should be large and airy. The *window should be kept freely open* in all weathers.

Plate 5.3 Cardboard mounted instructions issued to tuberculosis patients by Women's National Health Association of Ireland, *c.* 1908 (NAI, Priv1212/wnha/4/252)

Plate 5.4 Open-air camp on roof of P. F. Collier tuberculosis dispensary Charles Street, Dublin in 1912 (*First annual report of the P. F. Collier memorial dispensary* (Dublin, 1912), p. 22)

families. The needs of children were specifically catered for when 27 children of affected families were sent to the country for respite care funded by Pearson's Fresh Air Fund and the children of 5 families were boarded out while their mothers received treatment.[64] The committee also raised funds to allow the nurses refer suitable cases to sanatoria.[65] Using these funds 11 patients were sent to Newcastle and 3 to other sanitoria. In addition the jubilee nurses secured admission for 40 patients to the South Dublin Union Hospital, 11 to the North Dublin Union Hospital and 26 to the hospices for the dying. In order to improve the financial circumstances of families, employment was secured for 18 family members.[66] By April 1910, fifty-nine further branches had established Samaritan committees to carry out similar work, twenty-nine of which were located in Leinster.[67]

During February and March 1909 only ten notifications, sourced through the hospitals, were delivered to the nurses. The majority of new referrals were through The Police Aided Society, The Society of St Vincent de Paul, The Society for the Prevention of Cruelty to Children and The Sisters of Charity in Gardiner Street. The committee, alarmed at this drop in notifications, circularised hospitals, drawing attention to the situation. It also decided to enlist the co-operation of the sixteen poor law dispensary medical officers in Dublin. A supply of request cards was forwarded to them. To secure their co-operation it was agreed to expand the committee by inviting them to nominate two representatives from the north side of the city and two from the south side to join.[68]

A further problem associated with the falling off in notifications through the hospitals emerged. Many of the patients referred from non-medical sources did not have recourse to the advice of a doctor and the nurses were experiencing increasing difficulty in obtaining medical advice for such patients. To resolve this situation, the WNHA, suggested employing a doctor for such purposes, a proposition with which the committee agreed.[69] The Association appointed Dr J Daniel to this role. Prior to taking up duty he was required to undertake a course of study in Edinburgh under the tutelage of Dr Philip.[70]

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[64] 'Home treatment and nursing of pulmonary tuberculosis in Dublin' in *Sláinte*, i, no. 4 (1908), pp 68-71.
[65] 'Home treatment and nursing of pulmonary tuberculosis in Dublin' in *BMJ*, ii, no. 2487 (1908), p. 621.
[66] Minutes of first annual meeting of HTC, 1 Mar 1909.
[67] WNHA, *Summary of report submitted to council, 19 Apr. 1910* (NAI, Priv/1212/wnha/1/2).
[68] Minutes of first annual meeting of HTC; Minutes HTC 29 Apr. 1909.
[69] Minutes of first annual meeting of HTC.
[70] Minutes HTC 29 Apr. 1909.

Dr Philip, in April 1909, delivered a lecture in Dublin in which he criticised the 'time and energy [...] wasted on ill-considered and partial measures' advocating as the solution his system of dispensaries, notification, isolation hospitals/hospices, sanatoria and work colonies. His lecture provided a detailed analysis of the organisation and work of the dispensary, which he considered of 'first importance'.[71] Following his lecture Philip met the members of the committee who provided him with an account of their origin and working. During the ensuing discussion Philip expressed the opinion 'that the system as carried on in Dublin by the committee lacked concentration and was too scattered', requiring a consumption dispensary to co-ordinate matters. He provided details of the costs of the Edinburgh operation following which Lady Aberdeen intimated that the WNHA would support a similar institution for Dublin. It was agreed to convene a special meeting to discuss the subject.[72]

When the committee met eight days later, it decided that the time was inappropriate for starting such a dispensary. Lady Aberdeen may have been partly responsible for this decision in explaining that the Tuberculosis Ireland Act 1908, which was about to come into operation, would if adopted give a sanitary authority power to erect tuberculosis hospitals and dispensaries. The committee felt that the WNHA should seek the co-operation of the 'different medical corporations and associations' in pressurising the sanitary authorities to provide the facilities permitted by the Act.[73] However the following month the committee agreed to extend Dr Daniel's brief to include visiting the homes of reported cases, with their doctors' consent, for the purpose of examining other family members for signs of the disease and if possible their contacts thus bringing 'the work of the committee more in line with the working of a separate 'Tuberculosis Dispensary''.[74] At that meeting a report by Dr Frank Dunne[75] was considered. The report explained that, following Dr Philip's lecture, some members of the WNHA had proposed organising a collection to fund the provision of a dispensary in Crumlin similar to Edinburgh. Dunne and two prominent doctors Edmond McWeeney[76] and William

[71] R. W. Philip, *The role of the consumption dispensary in the tuberculosis campaign* (Dublin, 1909).
[72] Minutes HTC 21 Apr. 1909.
[73] Minutes HTC 29 Apr. 1909.
[74] Minutes HTC 21 May 1909.
[75] Dr Dunne was the medical superintendent of the South Dublin Union Hospital and proprietor of a small private sanatorium at Kilcoole County Wicklow.
[76] Edmond Joseph McWeeney was professor of pathology and bacteriology at the Catholic University school of medicine, Dublin.

Lombard Murphy[77] offered their services as voluntary medical attendants to the proposed dispensary. As the project would deal mainly with the detection of early cases and the prevention of the onset of the disease, Dunne viewed it as complementary to the work of the committee, which the nurses' reports revealed dealt mainly with advanced cases. From his own experiences, he found that it was mainly advanced cases attending hospital dispensaries. The proposed dispensary could fill a void by providing premises, which would be frequented by early sufferers. However the committee again found that 'the establishment of a special tuberculosis dispensary […] is at present inopportune'. [78]

Lady Aberdeen accompanied by Sir William Thompson left Ireland on 29 May 1909 to attend the quinquennial meeting of the International Congress of Women in Vancouver. In accordance with her well-developed strategy, she was to avail of the opportunity presented by the trip to address meetings of tuberculosis associations in New York and Boston, seeking support for her Irish anti-tuberculosis projects.[79] Thompson's role may have been to provide medical legitimacy to her endeavours. Upon her return she reported to the committee that following her New York address the publisher Robert Collier had offered her £1,000 per annum for five years for the purpose of erecting and equipping a tuberculosis dispensary in Dublin to be named in memory of his late father Peter J. Collier, a Carlow native. The committee promptly overturned their previous decisions and agreed to contact the Dublin hospitals seeking their co-operation in the work of the proposed dispensary.[80]

Following application from the committee, in mid 1910 the corporation agreed to allocate a semi-derelict site at Charles St. off Upper Ormond Quay for the proposed dispensary.[81] The committee appointed the architect Charles Ashworth to draw up plans and supervise the construction of the dispensary, which commenced in September.[82] The building was a red brick two storey over basement structure. The basement contained storerooms, a laundry for the sterilization of used linen before dispatch to a public laundry and a furnace for the destruction of infected linen. The ground floor contained a

[77] William Lombard Murphy was the surgeon in charge of the throat and nose department in St Vincent's Hospital Dublin. He was the son of the Dublin businessman William Martin Murphy, the proprietor of the Irish Independent newspaper.
[78] Minutes HTC 21 May 1909.
[79] *Weekly Irish Times*, 5 June 1909.
[80] Minutes HTC 16 July 1909.
[81] Minutes HTC 9 Sept. 1909 and 17 June 1910.
[82] *The P. F. Collier memorial dispensary for the prevention of tuberculosis Charles Street Dublin* (Dublin, 1911). Brochure prepared for the official opening of the institution. (NAI, Priv/1212/wnha/4/113). (Henceforth *The P. F. Collier memorial dispensary*).

waiting room, separate men's and women's dressing rooms and examination rooms, a special examination room equipped for throat examinations and a pharmacy/office. On the first floor the boardroom, the bacteriologist's room, the nurse's room with separate laundry and bathroom facilities and the caretaker's bedroom and living room were located. The premises had a flat roof suitable for use as an open-air camp for patients (Plate 5.4).[83] The building was constructed, furnished and equipped at a cost of £2,519, which expenditure was met from Robert Collier's bequest.[84] Dr J. T. Crowe the senior medical officer at Newcastle sanatorium was appointed as medical officer and Dr Daniel as his assistant.[85] The committee's two jubilee nurses were reassigned to the dispensary and an additional jubilee nurse appointed as dispensary nurse. Dr Lombard Murphy was appointed as honorary throat surgeon and Professor McWeeney as honorary bacteriologist.[86] King George V officially opened the premises 11 July 1911.[87] In October 1911 with the dispensary fully operational it was agreed to dissolve the Hospital's Tuberculosis Committee and transfer its functions to the advisory committee of the dispensary, on which committee most of the members were already serving.[88]

With dispensary expenditure rapidly rising (by 16 December 1912 it totalled £4,115) in mid 1912 Lady Aberdeen approached Dublin Corporation with a view to it assuming responsibility for the dispensary as provided for in legislation, subject to the repayment to the WNHA of its capital expenditure less a sum for depreciation. The refund was to be used to finance WNHA anti-tuberculosis measures. Costs incurred by the corporation in acquiring the premises could be recovered from the treasury as part of the parliamentary grant of £145,623 allocated to Ireland under the Insurance Act 1911. The proposal involved the retention of the existing staff for a two-year period. At a meeting on 2 September 1912 the corporation accepted the proposal, subject to satisfactory financial agreement. In November William Thompson on behalf of the WNHA agreed to accept compensation of £2,000. The corporation took over the premises on 16 December

[83] *The P. F. Collier memorial dispensary;* Floor plans of P.F. Collier dispensary in *Sláinte*, iv, no. 42 (1912).
[84] *First annual report of the P. F. Collier memorial dispensary for the prevention of tuberculosis Charles Street Dublin* (NAI, Priv/1212/wnha/6/61). (Henceforth *First annual report of the P. F. Collier dispensary*).
[85] *Irish Times*, 11 July 1911; *The P. F. Collier memorial dispensary*.
[86] *First annual report of the P. F. Collier dispensary*.
[87] *Irish Times*, 12 July 1911.
[88] Minutes HTC 27 Oct. 1911.

1912.[89] It was to form the city hub of the corporation's anti-tuberculosis efforts in the coming decades.

Pigeon House Road Isolation Hospital

The lack of provision for advanced cases of tuberculosis in Dublin convinced the WNHA to secure an isolation hospital for such patients at the Pigeon House Road Hospital. The hospital had been developed by Dublin Corporation following a governance crisis at Cork Street Hospital, Dublin's first major fever hospital.

On 28 October 1801 a number of Dublin citizens, concerned that no adequate hospital accommodation had been provided in the city for fever cases, especially contagious cases, decided to establish a house of recovery, to which such patients could be removed from their dwellings. The isolation of infected patients would help stem the spread of diseases.[90] By March 1803 over £6,330 had been subscribed to their project enabling them to acquire a three acre site at Cork Street where they erected a hospital, which opened for the reception of patients on 14 May 1804.[91]

Smallpox epidemics, in the early 1890s, increasingly brought pressure on the then overcrowded hospital, partly caused by the occupation of beds by recovering patients. Medical staff had consistently identified the need for a convalescent home. In 1896 the executors of the will of Miss H. J. Wolfe used monies she had left for charitable purposes to purchase Benavin House, Glasnevin and twenty acres of adjoining land, which they bequeathed to the hospital for use as an epidemic convalescent home.[92] A separate board of trustees was established to manage this new facility.

An outbreak of smallpox in Glasgow in April 1900 had by January 1901 reached epidemic proportions.[93] This focused attention on the urgent need to provide facilities for the isolation of smallpox patients in Dublin. In February, Charles Cameron, the Dublin medical officer of health, worried at the impact an outbreak would have on the city and

[89] *First annual report of the P. F. Collier dispensary; Minutes of special meeting of Dublin Corporation public health committee*, 24 Sept. 1912, pp 276-9; *Minutes of meeting of Dublin Corporation public health committee*, 12 Nov 1912, p. 337 and 22 Jan. 1913, p. 384 (DCCA).
[90] *Report of the committee of management in annual report of the fever hospital and house of recovery Cork Street, Dublin, for the year ended March 31 1901*, pp 6-7 (Cherry Orchard/Cork Street Hospital Archive, uncatalogued).
[91] J. Warburton, J. Whitelaw and Robert Walsh, *History of the city of Dublin* (2 vols, London, 1818), ii, pp 707-16.
[92] *Report of the committee of management in annual report of the fever hospital and house of recovery Cork Street, Dublin, for the year ended March 31 1897*, pp 7-8.
[93] J. C. McVail, 'Smallpox in Glasgow-1900-1902' in *BMJ*, ii, no. 2166 (1902), pp 40-3.

mindful that the only facility available was the 'floating cholera hospital', an eighteen-bed ship which had been commissioned by the South Dublin Union as an isolation facility for cholera patients in 1873, wrote to the Cork Street authorities inquiring as to what facilities they could make available in the event of an outbreak, as city hospitals had indicated their inability to accept smallpox cases.[94] Following prolonged negotiations, agreement was reached in February 1902 to refer patients suffering from a new outbreak of smallpox to Beneavin, the LGB having refused to sanction the use of the hospital ship.[95] In early March the trustees of Beneavin, realised that the hospital board had exceeded its legal powers. They requested them to restore the institution to the use for which it had been intended 'as soon as the smallpox patients presently in it can be safely removed', threatening legal action in the event of their request not being complied with.[96]

The withdrawal of Benavin left Cameron with no facility to treat further outbreaks. In April 1902 he reported to the public health committee that expert opinion considered that the site of the former submarine station at Pigeon House Road, which had been acquired by the corporation to erect electricity generating and sewerage facilities, could be 'admirably adopted as the site of an isolation hospital for smallpox and for cholera and other sea-borne diseases' as it already contained buildings, formerly part of a military fort, which could be cheaply adopted as wards and staff facilities.[97] The site had been developed when, following the rebellion of 1798 and fearing a French invasion, the government leased a site at Pigeon House Road, at the mouth of the river Liffey and erected thereon a fort, for the protection of Dublin port.[98] Further lands, extending to sixty-four acres, were acquired from Dublin Corporation in 1814 and the facilities considerably enhanced at a total cost of over £152,000 to provide accommodation for three-officers and eighty-men.[99] Additional expenditure in the 1830s had extended the

[94] *Irish Builder*, 15 Nov. 1873; Minutes of meeting of management committee of Cork Street Hospital, 19 Feb. 1901. (Cherry Orchard/Cork Street Hospital Archive, uncatalogued).
[95] *Report of the committee of management in annual report of the fever hospital and house of recovery Cork Street, Dublin, for the year ended March 31 1902*, pp 6-7; minutes of meeting of management committee of Cork Street Hospital, 13 Feb. 1902.
[96] Minutes of meeting of management committee of Cork Street Hospital, 13 and 20 Mar.1902.
[97] *Report of the public health committee-on isolation hospital*, Dublin Corporation reports 1902, report no. 80, pp 61-3.
[98] Desmond F. Moore, 'The port of Dublin' in *Dublin Historical Record*, xvi, no. 4 (1961), pp 131-44.
[99] *Estimate of the charge of the Office of Ordnance, for that part of the United Kingdom called Great Britain, for the year 1812. Also, of the said charge in Ireland, for the said year. Land service*, p. 3, H.C. 1812 (81), ix, 115. *Estimate of the charge of the Office of Ordnance, for Great Britain, for the year 1813: also, of the said charge in Ireland, for the said year. Land service*, p. 3, H.C. 1812-13 (220), xii, 113; *(Ireland.) The third report of the Commissioners for Auditing Public Accounts in Ireland*, p. 4, H.C. 1814 (67), vi, 1861; *Barracks, Ireland. A return of the names of places where barracks and barrack establishments are kept for the army in Ireland; distinguishing whether for cavalry or infantry, stating the number of officers, men and horses, each barrack is calculated to contain, and the greatest numbers*

capacity of the fort to accommodate 158 men although this number was frequently exceeded with 221 soldiers occupying extremely overcrowded conditions in 1849.[100] Cameron's report was adopted by the corporation.[101]

However before proceeding the corporation's improvements and lighting committees and the borough engineer objected to the proposal on the grounds that houses would be required in the vicinity for corporation workmen and the proximity of a smallpox hospital to the sewerage works and electric station 'would make it difficult to get workmen to remain constantly there'. Accordingly it was decided to advertise for an alternative site. A site in north county Dublin at Dardistown was recommended by the public health committee.[102] When the matter came to be considered by the full council, a deputation was received from local landowners, the parish priest of Swords, the rector of Santry and the chairman of Dublin County Council, objecting to the proposed use of site. Having listened to these objections, the council determined to proceed with the Pigeon House site.[103]

In December 1902 matters were brought to a head when a sailor was found to be suffering from smallpox. The Hardwicke Hospital agreed to treat the patient but had to vacate an entire ward in order to isolate him. In response to this the corporation agreed to raise a loan of £3,000 to secure and equip an isolation hospital on the Pigeon House Road site.[104] The sum was used to remodel the submarine station and to erect an iron hospital with accommodation for sixty patients.[105] Arrangements were made with Cork Street

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quartered at any time in each of them, in the year ending 5th January 1822; and also the expense in supporting each of these barracks, distinguishing the amount of pay of the establishment, from the expense of repairs, p. 1, H. C. 1822 (291), xviii, 433; *Army (military stations, &c.) Return of the names of all military stations in the United Kingdom, including the Channel Islands, and all lands, tenements, and appurtenances whatsoever, at present or within the last twelve years held by the military or ordnance departments, particularising the county; name of station; acreable extent of each; &c.*, p. 2, H.C. 1862 (305), xxxii, 577.

[100] *Ordnance estimates: for the year 1831*, p. 2, H. C. 1830-31 (177), vi, 195; *III. Ordnance estimates: for the year 1832-1833*, p. 2, H. C.1831-32 (145) (240), xxvii, 307, 341; *Barracks. Return from each barrack in the United Kingdom, relative to the date of erection, materials; &c.*, p. 2, H. C. 1847 (169), xxxvi, 321; *Index to second report from the Select Committee on Army and Ordnance Expenditure*, p. 3, H.C. 1849 (499) (499-11), ix, 5, 1185.

[101] *Minutes of meeting of municipal council, 2 June 1902*, minute 325, pp 235-6 (DCCA).

[102] *Report of public health committee- establishment of a smallpox hospital*, Dublin Corporation reports 1902, report no. 161, pp 55-8 (DCCA).

[103] *Minutes of meeting of municipal council, 3 Nov. 1902*, minute 521, pp 385-6 (DCCA).

[104] *Minutes of meeting of municipal council, 2 Jan 1903*, minute 2, pp 2-3; *Report of public health committee on the recent outbreak of smallpox*, Dublin Corporation reports 1903, report no. 110, pp 535-82 (DCCA).

[105] *Report of public health committee for quarter ending 31 March 1903*, Dublin Corporation reports 1903, report no. 67, pp 207-28 (DCCA).

Hospital to provide medical, nursing and ancillary personnel to staff the new facility.[106] The provision was timely as a fresh outbreak of smallpox occurred infecting sixty-five cases in the first quarter of 1903.[107] The first eleven-cases of this fresh outbreak were treated in the Hardwicke hospital. However when the Pigeon House Hospital opened on the 4 March 1903, all cases occurring thereafter were referred there. By the time the outbreak terminated on 18 July 1903, 255 persons had been infected of whom thirty-three died.[108] Following the termination of the outbreak the hospital was thoroughly disinfected, with one room kept in readiness to admit patients, in the event of reoccurrence of the disease.[109]

The impetus for the provision of an isolation hospital arose from a decision of the members of the WNHA that 'more than anything else' accommodation was needed in Dublin for advanced cases of tuberculosis. This need was starkly brought to their attention by the reports of their two tuberculosis nurses, who found a marked reluctance amongst poor sufferers, with advanced tuberculosis, to seek shelter in workhouse infirmaries. The nurses also identified the lack of provision made for such sufferers in existing institutions, due to shortage of funds, a fact confirmed by the medical representatives on the hospital's tuberculosis committee.[110]

During her June 1909 visit to New York, Lady Aberdeen met Allan A. Ryan, the son of the philanthropist Thomas Fortune Ryan, who was one of America's twenty richest men with an estimated fortune exceeding $70m.[111] He had offered £1,000 annually for five years to facilitate the WNHA's anti-tuberculosis campaign.[112] Having taken medical advice that the most appropriate use of the funds would be to establish a hospital 'for the more advanced, though not hopeless cases', the WNHA approached Dublin Corporation with a view to obtaining the now vacant Pigeon House Road Hospital and its contents for

[106] Minutes of meeting of management committee of Cork Street Hospital, 22 Jan., 19 Feb. and 26 Feb. 1903.
[107] *Report of public health committee for quarter ending 31 March 1903*, Dublin Corporation reports 1903, report no. 67, pp 207-28 (DCCA).
[108] *Report of public health committee on the recent outbreak of smallpox*, Dublin Corporation reports 1903, report no. 110, pp 535-82 (DCCA).
[109] *Report of public health committee for quarter ending 30 September 1903*, Dublin Corporation reports 1903, report no.170, pp 321-37 (DCCA).
[110] 'The Allan A. Ryan Home Hospital for Consumption. Pigeon House Road, Dublin' in *Sláinte*, ii, no. 22 (1910), pp 190-2. (Henceforth Allan A. Ryan Home).
[111] 'Americas Richest' in *Forbes* (27 Sept. 1902).
[112] Allan A. Ryan Home,

the treatment of such cases.[113] As all the expenses of the proposed facility were to be borne by the WNHA, the corporation agreed to lease part of the premises to Lady Aberdeen on behalf of the Association, at a weekly rent of 1*s.*, subject to the proviso that the tuberculosis patients would be removed at twenty-four hours notice, if the need arose to receive cases of cholera or smallpox.[114]

The hospital, named the Allan A. Ryan Hospital for Consumption after its benefactor, was officially opened on 23 August 1910 receiving its first patients on 31 October.[115] It consisted of a two-storey red brick building, with accommodation for twenty-five patients, set in two acres of ground. Male patients were housed in two wards on the ground floor, which floor also incorporated, a matron's room, a staff dining room and kitchens. Female patients were accommodated in two first floor wards accessed by an external stairs and balcony; this floor also contained a nurse's room. Set in the grounds, some distance from the main building, were two wooden galvanised structures, one used as a laundry and disinfection chamber and the other as nurses' quarters. A small mortuary was erected to the east of the main block. Four shelters donated by Lord Londsdale to the North Kildare branch of the WNHA were erected in the grounds (Plate 5.5). The hospital was managed by a matron, who prior to taking up duty, visited the Victoria Hospital at Edinburgh and sanatoria at Rotherham, Frimley, Sheffield and Beneden, to familiarise herself with then current best practice. She was assisted by two sisters, two probationary nurses, a cook, a laundress and four maids. Medical supervision was exercised by two consultant physicians, two visiting physicians, a consultant surgeon and a consultant bacteriologist, drawn from the leading tuberculosis practitioners in the city, all under the general direction of Sir William Thompson the hospital secretary.[116] Following on the ideas expounded by Dr Philip it was decided to provide on site 'interesting and suitable employment for all patients who are able to take part in it'.[117] This graduated labour included gardening and woodcarving (Plate 5.6).[118] For those

[113] Allan A. Ryan Home; *Report of public health committee for quarter ending 31 December 1909*, Dublin Corporation reports 1910, report no. 61, pp 577-615.
[114] *Report of public health committee for quarter ending 31 December 1909*, Dublin Corporation reports 1910, report no. 61, pp 577-615; *Minutes of meeting of municipal council, 4 April 1910*, minute 232 p. 137 (DCCA); Allan A. Ryan Home.
[115] *Report of fifth annual meeting of the general council of the WNHA, 18-20 April 1912* (NAI, Priv/1212/wnha/1/1).
[116] *Freeman's Journal*, 24 Aug. 1910; *Irish Independent*, 24 Aug. 1910; *Weekly Irish Times*, 27 Aug. 1910.
[117] Philip, 'An address on the public aspects of the prevention of consumption'; *Freeman's Journal*, 24 Aug. 1910.
[118] *Fifth annual report of the WNHA, 1911-12* (NAI, Priv/1212/wnha/6/2). (Henceforth *Fifth annual report of the WNHA).*

Plate 5.5 Allan A. Ryan Hospital, Pigeon House Road, Dublin showing external stairs and balcony to access first floor and shelters in grounds, 1910 (*Sláinte*, October 1910)

Plate 5.6 Allan A. Ryan Hospital, Pigeon House Road, Dublin, tuberculosis patients engaged in graduated labour, observed by patient looking out window of adapted shelter, 1912 (*Sláinte*, June 1912)

patients able to pay, a minimum charge of 7*s.* per week was levied.[119] The religious needs of the patients were taken care of by chaplains from various local churches who had offered their services as honorary chaplains.[120]

By the end of December 1911, 106 patients had been treated in the hospital with 31 still undergoing treatment on that date. The use of shelters had increased capacity to 36 patients. 6 patients had died. However the positive discharge figure of 69 disguises the fact that 4 of these patients were referred to the Royal Hospital for Incurables, 5 to the Hospice for the Dying and 2 to the Rest for the Dying, clearly all in the final stages of the disease. On the positive side 15 of the discharged patients had recovered so completely that they were able to return to their normal employments. The form of treatment applied was 'recognised open air treatment combined with special nourishing dietary'. 42 of the patients were treated with tuberculin. The average stay of the patients in the hospital was thirteen weeks, during which time they achieved an average weight gain of 19*lbs*. Despite increased accommodation the number of patients on the waiting list seeking admission rose to 23. This resulted in delayed admissions. When patients eventually presented themselves, the disease had frequently so far advanced, that they were deemed ineligible for admission.[121]

Matters proceeded as normal in the first six months of 1912 with twenty-eight male and four female patients admitted. However the passing of the Insurance Act 1911 had a considerable impact on the operations of the institution. The hospital was approved under the act for the care of insured consumptives. Accordingly it came under considerable pressure to accept patients, referred to it by county insurance committees. Between 15 August and 31 December 1912, 115 insured persons were admitted, with a further 193 insured persons admitted in the first three months of 1913. Such was the number of referrals from rural areas that it was found necessary to send nurses to the railway stations to meet patients. Many of the patients, post admission, were found to be in the early stages of the disease and referred on to Peamount sanatorium.[122] However problems

[119] WNHA, *Institutions in Dublin carried on under the auspices of the central association…*(Dublin, undated) (NAI, Priv/1212/wnha/4/75).
[120] *Freeman's Journal*, 24 Aug. 1910.
[121] *Fifth annual report of the WNHA.*
[122] Sixth annual meeting of general council of WNHA, Apr. 1913 in supplement to *Sláinte*, v, no. 53 (1913).

Plate 5.7 Women's National Health Association's preventorium at Sutton, County Dublin in 1909 (*Sláinte*, May 1909)

Plate 5.8 Peamount House, County Dublin. The house and adjoining lands were acquired by the Women's National Health Association in 1912 and Peamount tuberculosis sanatorium erected thereon. Photograph taken *c.* 1998 (South Dublin County Council Libraries)

were experienced with insurance committees referring patients found to be in 'such an advanced stage of consumption as to be practically hopeless'.[123]

In April 1913 Lady Aberdeen informed the general council of the WNHA that the corporation were considering taking over the premises for their own advanced patients to comply with their statutory obligations.[124] That November she announced that, having made plans to enlarge the hospital to 200 patients, from 1 December the corporation would assume responsibility for the premises and use it for its own patients.[125] It was agreed that the existing WNHA staff, which had been expanded by the addition of two probationary nurses and a maid, would remain in situ until 1 February 1914. The corporation appointed Dr Frank Dunne (who already occupied the position) and Dr T. Conway as visiting physicians to the hospital at an annual salary of £150 each.[126] During its last year of operation under the control of the WNHA the hospital had treated 725 patients, of whom 504 had been transferred to Peamount and 15 to the hospice for the dying, 132 had been returned to their own homes of whom 45 showed 'marked improvement' and 15 had died in the institution.[127]

In 1917 Dublin Corporation approached several orders of nuns with a view to them taking over the management and nursing duties in the Pigeon House Road hospital, as 'owing to the unfortunate conditions of the patients admitted to this institution it would be of the greatest benefit that they should be afforded the comfort and consolation which a community of nuns would be eminently able to give'. In addition the appointment of nuns would 'show a financial economy in the cost of the nursing staff'. Only the Sisters of Charity of St Vincent de Paul, having consulted their father provincial, Rev. William Byrne, responded to the request.[128]

The origins of the Sisters of Charity of St Vincent de Paul lie in the 'Confrèrie de la Charité', a confraternity of women and girls founded by St Vincent de Paul with the assistance of Louise de Marillac (Mademoiselle Le Gras), in 1627, 'for the relief of the

[123] *BMJ*, i, no. 2770 (1914), p. 269.
[124] Sixth annual meeting of general council of WNHA.
[125] General meeting of WNHA, Nov. 1913 in supplement to *Sláinte*, v, no. 61 (1914).
[126] *Minutes of adjourned meeting of municipal council, 8 Dec. 1913*, minutes nos. 924-5, pp 581-3 (DCCA).
[127] *BMJ*, i, no. 2770 (1914), p. 269.
[128] *Report of tuberculosis committee of management recommending the adoption of a scheme for the appointment of nuns in connection with the nursing at the tuberculosis hospital Pigeon House Road,* Dublin Corporation reports 1917, vol. 3, report no. 194, pp 373-7 (DCCA).

sick poor'.[129] In 1629, having established themselves in the Paris parish of Saint Sauveur, they were carrying remedies and nourishment to the sick. This service having quickly spread to other Paris parishes, in 1633, a novitiate 'where young girls could learn the practice of a Christian charitable life before being sent to nurse the sick' was established. In 1634 the services to the sick were extended to the patients in the Hotel Dieu (hospital) in Paris, although this was partly as a proselytising exercise. In 1640 the order assumed the nursing duties at St Johns hospital in Angers.[130] Within twenty years of their establishment as a religious order they occupied over 200 houses and hospitals and in the following years spread all over Europe.[131]

Four sisters arrived in Ireland in 1855 from Paris at the invitation of Archbishop Dixon to minister to the poor sick in Drogheda.[132] In 1857 they took charge of the orphanage in North William Street in Dublin. Shortly thereafter they took over the nursing of the female patients in the Richmond asylum on the outskirts of Dublin. The nuns engaged at the Dublin locations, with the exception of the French superioress in North William Street, came from 'the great number of Irish and English ladies (who) have of late years joined their ranks'.[133]

The sisters agreed to provide four nuns for the Pigeon House Road Hospital, one as sister superior, who would assume the managerial duties of the lady superintendent, at a salary of £60 per annum, the others being paid £35 per annum in addition to normal boarding allowances. At least two of the sisters would be fully trained certified nurses whilst the others would have hospital experience. They required the conversion of the recreation room into a temporary chapel pending the provision of a permanent building.[134] They also required the appointment of a resident chaplain in lieu of the existing arrangements for a visiting chaplain. This chaplain was required to say daily mass for the nuns and provide bi-weekly benediction. He was also required to say an additional Sunday mass for the patients and give religious instructions to the patients at the Sunday afternoon

[129] Alice Mary Weld-Blundell Fraser Lovat, *The life of Mademoiselle La Gras (Louise de Marillac)* (New York, 1917), p. 70.
[130] Ibid, pp 70-8, 111-2, 129-31 and 171-4.
[131] Mrs Jameson, *Sisters of charity and the communion of labour* (London 1859), p. 29.
[132] *Irish Times*, 8 Nov. 1955.
[133] Fanny Taylor, *Irish homes and Irish hearts* (Boston, 1867), pp 70-79.
[134] *Report of tuberculosis committee of management,* Dublin Corporation reports 1917, vol. 3, report no. 194.

benediction. A salary of £60 per annum was offered for the position.[135] It was found necessary to spend £78 on upgrading the gate lodge to make it suitable as a chaplain's residence.[136] The nuns took up duty on 24 October 1918.[137] It was agreed that non-catholic patients would be attended to by a lay nurse. This nurse would notify a clergyman of that patient's denomination who would be allowed access to the hospital at all times.[138]

The separation of the nursing care of non-catholics could be regarded as a political stance by the Corporation to ensure that it could not be seen to assist in any proselytising activities. In order to counteract such activities separate protestant and catholic lay nursing organisations had been founded (see chapter 3) and separate facilities established to care for the dying members of both religions (see chapter 6). Many hospitals had a distinct religious ethos either catholic or protestant and recruited only staff with the appropriate religious affiliations. Although theoretically open to members of all religions their practices discouraged patients not of their religious persuasion from attending. This was particularly evidenced in certain institutions for the care of tubercular children (see chapter 8).

From the foundation of the order the sisters regarded themselves as the servants of the sick poor. As part of the provision of this service the members of the order travelled to wherever their ministrations were required. They established missions throughout Europe, Asia, Africa and America and extended their operations to Australia in 1926. Accepting the invitation to provide their services in the Pigeon House Road Hospital provided a perfect opportunity for the geographical expansion of the order in accordance with its established practice. It also enabled the order to provide employment for the increasing number of females entering it.

Sutton Holiday Home and Preventorium

Attempts by Lady Aberdeen to expand the treatment facilities provided by the WNHA led to the establishment of Ireland's first preventorium.

[135] *Report of the tuberculosis committee relative to appointment of nuns in connection with the nursing at the Tuberculosis Hospital pigeon house Road and consequent arrangements for the services of a chaplain,* Dublin Corporation reports 1919, vol. 1, report no. 117 (DCCA).
[136] *Report of the tuberculosis committee, breviate for the quarter ended 30 September 1918,* Dublin Corporation reports 1919, vol. 1, report no. 66, pp 521-51 (DCCA).
[137] *Report of the tuberculosis,* Dublin Corporation reports 1919, vol. 1, report no. 117.
[138] *Report of the tuberculosis committee, breviate for the quarter ended 31 March 1918,* Dublin Corporation reports 1918, vol. 2, report no. 102, pp 315-44 (DCCA).

As part of the reorganisation of its services the British Admiralty closed fifty-two coastguard stations in Ireland between May 1905 and April 1909.[139] Lady Aberdeen saw this as an opportunity to acquire the leases on these disused properties and use them as sanatoria or convalescent homes. Following negotiations she secured agreement to acquire the remaining seven year lease on the coastguard cottages at Sutton. The buildings comprised a terrace of eight three-room cottages all in good repair (Plate 5.7).[140] The rent of the premises was fixed at £50 per annum.[141] Lady Aberdeen announced the successful result of her negotiations at the annual meeting of the general council of the WNHA on 22 April 1909.[142]Her announcement unleashed a storm of local protest. A memorial was signed by 200 local residents, protesting against the use of the premises as a home for consumptives on the grounds that it would injure the reputation of Sutton as a summer resort and thus impact on the means of living of house owners, by depriving them of rents achieved from seasonal lettings. The objectors also feared the impact on the health of local children from being in contact with children from the proposed facility. The memorial was presented to Lady Aberdeen by a deputation from the Howth/Sutton area on 17 May 1909. Lady Aberdeen enlisted the assistance of the presidents of the RCPI and RCSI in an attempt to allay the fears of the residents. The residents left the meeting with an undertaking that no persons suffering from pulmonary tuberculosis would be admitted to the premises and 'that for the present… the health home will be used only for preventative cases, which have been duly examined and pronounced non-infective by a competent medical authority'. However they were unhappy that the undertaking only applied for present circumstances.[143] The *British Medical Journal* in commenting on the meeting feared that choosing 'favourite places of resort' as the location of tuberculous health homes could result in the anti-tuberculosis movement losing public support feeling that 'it would be more politic to choose places not frequented by health and pleasure seekers in large numbers'.[144]

The local residents were supported in their objections by Dr Alexander Charles O'Sullivan, the professor of pathology at Trinity College, Dublin, who expressed astonishment that any premises in such close proximity to a public road and other

[139] *Hansard 5 (Commons)*, iv, cc 326-27 (London, 1909).
[140] *Irish Times*, 23 Apr. 1909.
[141] Ibid.*; First annual report of the Sutton holiday home and preventorium, 1910* (NAI, Priv/1212/wnha/6/62). (Henceforth *First annual report of the Sutton holiday home*).
[142] *Irish Times*, 23 Apr. 1909.
[143] Ibid., 18 May 1909; *Freeman's Journal*, 18 May 1909.
[144] 'Ireland, tuberculosis homes at health resorts' in *BMJ*, i, no. 2525 (1909), p. 1266.

dwellings could be considered for use as a sanatorium where isolation was required. His objections extended to the use of the premises as a convalescent home on the grounds that 'a non-infectious case could at any time turn into an infectious one' and that even with stringent precautions taken, local residents would 'have no adequate guarantee that infection will not be conveyed to them'. H. C. Earl, the pathologist to the Richmond Hospital, supported the objectors stating that on account of the very limited grounds attached to the cottages, their use as a sanatorium 'would be attended with much risk of infection to those who live in the locality'.[145] Local clergy opposed the proposal as being 'contrary to the wishes of the great majority of our respective flocks'.[146] The local branch of the WNHA protested against the proposal reiterating the medical objections, while pointing out that it would prevent children's holiday excursions to the nearby Sutton strand. However it also pointed out that the implementation of the project would 'make it impossible to continue the work of the Association in our district' and use of Association funds for such purposes would be a 'source of discord and disunion amongst its various branches'.[147]

John Lentaigne the president of the RCSI found that this ongoing debate had caused panic amongst the public on the question of tuberculosis. He attempted to quell the panic by elucidating how the taking of proper precautions could render patients harmless at all stages of the disease. He quoted examples of how the 300-bed Brompton Hospital for Consumption in London did not impact on the local neighbourhood and how no staff at the Royal Hospital for Incurables in Donnybrook had been infected in over ten years contact with the forty advanced consumptive patients accommodated there. As the premises was intended to deal with the poorer classes, he pointed out that wealthy consumptives, often disguising the nature of their complaint, posed more of a threat to local residents by purchasing, renting or lodging in premises to avail of the recommended benefits of fresh air, sunshine and healthy surroundings and while there taking improper precautions or none whatsoever.[148] In an astute political move Edward Culverwell[149], a local resident, explained to the local branch of the WNHA that it was only for constitutional reasons that Lady Aberdeen had placed an 'at present' restriction on the use of the premises, as she could not bind future decisions of the WNHA executive. He

[145] *Freeman's Journal*, 27 May 1909.
[146] *Irish Times*, 28 May 1909.
[147] *Weekly Irish Times*, 29 May 1909.
[148] *Irish Times*, 26 May 1909.
[149] Culverwell who resided in Howth was the professor of education at Trinity College, having been appointed to fill the newly founded chair of education in 1905.

detailed how on his initiative she elucidated her personal view 'that the future arrangements should be on the same conditions as those she had approved for the present' a view she would support when addressing the executive on the matter. The present conditions included her undertaking 'to send no one to Sutton who would be a source of danger' but only 'persons who are not suffering from the disease at all, but who are in the weak condition, which predisposes them to take it'. As it was 'inconceivable' that the executive would oppose this view, this appeared to largely assuage the local opposition.[150]

Because of her visit to North America, Lady Aberdeen played little direct part in the debate. On 8-9 June 1909, in Boston, she addressed several public meetings organised by Abraham Schuman[151] a local merchant and philanthropist. Following her explanation of the intended role of the Sutton preventorium, a local committee, under the chairmanship of Schuman, was formed to support her initiative. The committee raised £543, which was applied to equipping the premises to accommodate twenty-two patients and maintaining the preventorium during its first year of operation.[152]

The Sutton Holiday Home and Preventorium was officially opened on 4 August 1909. Applications for admission had to be accompanied by a medical certificate stating that the applicant was free from tuberculosis and from any infectious disease. The application had to provide full details of the applicant and their family circumstances in addition to providing a reference from a clergyman or other responsible person. Admission was open to all females and boys up to fifteen years of age (subsequently revised downwards to ten years of age). The boarding charge was 10*s* per week, reduced to 7*s.* 6*d.* for applicants supported by WNHA branches. Special consideration was given to individual deserving cases. [153] Lady Aberdeen regarded the facility as the first step in the tuberculosis crusade, its primary objective being 'to prevent consumption altogether' by finding 'persons who are in that weak state of health, which renders them liable to attack, or who have been exposed to infection' and provide them with suitable treatment in the form of good food, rest and exposure to open air.[154] As most referrals were generally malnourished the early

[150] *Irish Times*, 30 June and 2 July 1909.
[151] Schuman was president of the board of Boston City Hospital and had had helped Lady Aberdeen organise the Irish industrial village at the world fair in Chicago in 1893.
[152] *First annual report of the Sutton holiday home; Fifth annual report of the WNHA.*
[153] *First annual report of the Sutton holiday home;* WNHA, *Institutions in Dublin carried on under the auspices of the central Association, to which visitors desirous to see something of the work of the Association will always be welcome* (Dublin, undated) (N.A.I. Priv/1212/wnha/4/75).
[154] *First annual report of the Sutton holiday home*.

part of their treatment focused on weight gain, with average weekly gains of 1*lb* for adults and 1½*lbs* for children reported. The majority after a short stay, with an average weight gain of 5½*lbs,* were restored to full health and able to resume normal activities.[155]

During its first year of operation the preventorium treated seventy-five adults and fifty children. In accordance with Lady Aberdeen's undertaking, two patients were removed from the premises when they displayed signs of tuberculosis. Fifty-two of the patients were referred from and supported by branches of the WNHA with the remaining seventy-three supported from a variety of private sources. Fee income in respect of patients amounted to £93. With the concentration on nourishment, the heaviest item of expenditure was food, accounting for £338 from a total expenditure of £612. Despite the generosity of its American benefactors (a further £19 had been received from Boston during the year), the home required a subvention from WNHA central funds to balance its books. The preventorium was accepted by the local community, gauged by the fact that Dr Ahern, a member of the objector's deputation, was now honorary physician to the institution, while Father Colohan, the Catholic parish priest and a deputation member, looked after the needs of Catholic patients. The Church of Ireland rector Rev. Arthur Barton, who had objected to the proposal administered to the patients from his congregation, describing the home as 'a boon to the neighbourhood'. Donations of books, magazines, flowers and fruit were made by Mrs Keating, Guinness and Jameson, all members of the objector's deputation.[156]

In the following eighteen months to the end of December 1911 the preventorium treated sixty-seven adults and eighty-two children, forty-six of whom were referred from branches of the WNHA, who were given preference in obtaining accommodation. Although cases were admitted from thirteen different counties, the greatest number came from Dublin City. Most of the latter came from tenements where their families ranging in size from five to seven persons lived 'day and night in one room, with, in several cases, one or more members ill and confined to bed'.[157] The overall costs of running the institution continued to escalate with each patient costing 10*d* per day on food and 1*s.* 2*d* on other requisites.[158] The pattern continued in 1914, forty adults and eighty children were treated seventy-two of whom were supported by WNHA branches. These patients

[155] Ibid.
[156] Ibid.*; Irish Independent*, 1 Sept. 1910.
[157] *Fifth annual report of the WNHA.*
[158] Ibid.

came from fourteen different counties, with again the one-room Dublin tenements being heaviest represented.[159] However, due to wartime stringencies and the continuing burden placed on central funds, financial difficulties caused the closure of the facility in 1915.[160]

Dalkey

In Dalkey political and local opposition operated to frustrate Lady Aberdeen's objectives.Lady Aberdeen's April 1909 announcement, that she was in negotiations with the admiralty regarding disused coastguard stations, raised fears amongst the members of Dalkey UDC that that she might acquire the Dalkey coastguard station for use as a sanatorium. They passed a resolution objecting to any such use.[161] Unhappy with her response that any coastguard stations acquired would be used as 'health homes' for 'harmless' patients, compounded by her statements at the opening of the Rathmines tuberculosis exhibition that 'the intention was really to use them for cases in the preventative stages', the council determined to have the matter raised in parliament and to organise a petition objecting to any such proposal.[162]

The matter was raised in parliament on 16 June 1909 by the local MP Walter Long who, in response to his query regarding the possible future use of the premises as a sanatorium, was informed by Reginald McKenna, the first lord of the admiralty, that although it was intended to dispose of the premises 'no decision as to its future purpose had been taken'.[163] A report was commissioned from Dr Wright, the Dalkey medical officer of health, who condemned the site, which was in an exposed location subject to winds, as unsuitable. He also felt that an attempt to foist a sanatorium on Dalkey was unfair, as Dalkey was one of the few authorities who had agreed to levy a rate to contribute to the Dublin Joint Hospital Board scheme.[164] On 2 August, Lady Aberdeen met a deputation from the UDC who presented her with a petition signed by 254 protestors setting out similar grounds of objection as had been presented by the Sutton/Howth delegation. At the meeting lady Aberdeen undertook that if the premises was to be acquired it would be used solely as a holiday home for 'tired workers', with no cases of pulmonary tuberculosis admitted, under the joint management of the WNHA and the UDC.[165] However due to the extent of the political objections, the restrictions on the use of the

[159] Report of the AGM of the WNHA, 13 Apr. 1915 (NAI, Priv/1212/wnha/3/13).
[160] WNHA, *Some facts in its history* (Dublin, 1943) (NAI, Priv/1212/wnha/4/90).
[161] *Irish Times*, 20 May 1909.
[162] Ibid., 20 May and 3 June 1909; *Freeman's Journal*, 21 May 1909.
[163] *Hansard 5* (*Commons*), vi, c. 1085 (London, 1909).
[164] *Irish Times*, 22 July 1909; *BMJ*, ii, no. 2535 (1909), pp 294-5.
[165] *Irish Times*, 3 Aug. 1909.

premises and the necessity of funding preventoria at Sutton and in the recently acquired coastguard cottages at Clifden, County Galway the leasing of the Dalkey premises was not proceeded with.

Peamount Sanatorium

The allocation of £145,623 to Ireland, under the National Insurance Act 1911, to assist in the building of sanatoria, provided the WNHA with the means to further develop its services. This was achieved by the construction of its flagship development, Peamount Sanatorium.

A departmental committee on tuberculosis was appointed in February 1912 to report 'on the general policy in respect of the problem of tuberculosis in the United Kingdom'. Its interim report, published in mid 1912, found that, despite enabling legislation, in Ireland, apart from the beds provided by boards of guardians, virtually no provision was made by sanitary authorities, in particular for sanatoria or dispensaries.[166] This glaring error in the report, ignoring the local authority provided sanatoria at Streamhill in Cork and Crooksling in Dublin, appears not to have been picked up, despite the presence of Thomas Stafford, the medical commissioner of the LGB for Ireland on the committee. However it may be indicative of the lack of regard Stafford had for the work of local authorities in this field. In his report to the committee on provision for tuberculosis treatment in Ireland neither institution was mentioned in the text, although both featured in a table attached to the report. Lady Aberdeen, at his request, had submitted for consideration an extensive report on the activities of the WNHA [167] The committee was highly complementary of the work of the WNHA, being of opinion that 'every effort should be made to assist and develop the work of the Association'. It recommended that aid from the grant of £145,623 should be directed to the voluntary bodies, then engaged in doing 'good work in the treatment and prevention of tuberculosis', to enable them provide 'further accommodation' for the treatment of patients.[168]

Lady Aberdeen viewed the report as an opportunity to advance her proposals. She immediately embarked for London, to meet Charles Masterman the financial secretary to the treasury, seeking an allocation of £25,000 from the grant. Masterman saw no difficulties in furnishing this sum provided the Irish LGB were in favour. Following the

[166] *Interim report of the Departmental Committee on Tuberculosis*.
[167] *Final report of the Departmental Committee on Tuberculosis. Volume II*.
[168] *Interim report of the Departmental Committee on Tuberculosis*.

meeting she wired Sir Henry Robinson, vice-president of the LGB, requesting him to signify his agreement to Masterman and Augustine Birrell the chief secretary for Ireland. Satisfied with her 'successful afternoon at the house', she returned to Ireland to secure a site for a sanatorium and to instruct architects and lawyers to draw up plans and deeds.[169]

A site was identified at Peamount, County Dublin, eleven miles from the city centre and two miles from the railway station at Lucan.[170] The site contained a detached, five-bay, three-storey, palladian style country house (Plate 5.8), which had been constructed *c.* 1800, on an elevated site 200 feet above sea level, surrounded by 120 acres of farmland.[171] The house could be adapted as administrative quarters and suitable ward structures erected adjacent thereto.[172] The site was very isolated. The population density in the area was one person to fifteen acres with the nearest neighbours located over half a mile away. Lady Aberdeen arranged to examine its suitability, from a medical perspective, by a team consisting of Professor McWeeney, John Lentaigne and Michael Cox[173]. They found the site 'eminently suitable for a sanatorium'. Engineer's reports on the water and sanitary aspects of the site concurred in its suitability.[174]

However problems were looming, through a clash of wills. Robinson, who regarded the WNHA as an association of 'voluntary and irresponsible women', headed up by a 'masterful' president, who through her 'burning desire to further public health reform […] wanted to direct and dominate the LGB' had written to the treasury protesting against the grant being handed over.[175] This setback necessitated Lady Aberdeen's return to Westminster. There she attended a meeting, chaired by Masterman with Birrell and Robinson present, to discuss her application. The application had the support of several local authorities, who viewed entering into an arrangement to use the proposed facilities as a means of satisfying their statutory obligations to provide treatment for tubercular patients.[176] This support had been secured at the central health conference organised by

[169] Ishbel to Lord Aberdeen 20 May 1912 quoted in Majorie Pentland, *A bonnie fechter, the life of Ishbel Majoribanks Marchioness of Aberdeen* (London, 1952), pp 168-9.
[170] *Irish Times*, 25 June 1912.
[171] 'Editorial notes' and 'Peamount as a sanatorium' in *Sláinte*, iv, no. 43 (1912), pp 445-8; South Dublin County Libraries 'National inventory of architectural heritage collection' (http://source.southdublinlibraries.ie/handle/10599/5323) (7 Dec. 2012).
[172] 'Ireland-consumption sanatorium' in *BMJ*, ii, no. 2688 (1912), p. 45.
[173] Michael Cox was the senior physician to St Vincent's Hospital, Dublin from 1881 to 1925.
[174] 'Editorial notes' and 'Peamount as a sanatorium' in *Sláinte*, iv, no. 43 (1912), pp 445-8; Medical notes in parliament' in *BMJ*, ii, no. 2692 (1912), pp 272-4.
[175] Henry Robinson, *Memories wise and otherwise* (London, 1923), p. 199; Pentland, *A bonnie fechter*, pp 168-9.
[176] Ishbel to Lord Aberdeen 20 June 1912 quoted in Pentland, *A bonnie fechter*, pp 168-9.

the WNHA in Dublin on 23-24 May 1912, at which Lady Aberdeen outlined a scheme whereby the WNHA would make temporary provision for the treatment of patients, pending the provision of permanent accommodation by the local authorities.[177]

Lady Aberdeen described the meeting as 'war open and declared' with Robinson making 'no pretence of concealing his open hostility' and not giving 'way an inch'. It was only following the intervention of Lloyd-George the Chancellor of the Exchequer that the grant was approved.[178] The fact that the association could provide facilities at short notice, within timeframes local authorities would find impossible given the restraints under which they operated, as demonstrated in the provision of the Cork and Dublin sanatoria, no doubt influenced the decision. The approval was subject to all works being approved by the LGB and beds being provided to any county council or insurance committee requiring such accommodation under the Insurance Act.[179] The Peamount lands were promptly purchased for £2,500 and contracts entered into to erect wooden pavilions and chalets to accommodate 144 patients.[180] The construction of the works was subject to the micro-management of the LGB with its inspectors carefully examining the buildings during the course of construction. In addition board sanction was required for the purchase of all equipment.[181]

When the location of the proposed sanatorium was announced protests followed. On 15 May the magistrates of the Celbridge Petty Sessions District passed a motion, protesting against the establishment of the sanatorium, considering it an unnecessary source of danger to the people living in the district.[182] Following receipt of a deputation from local protestors, on 19 July, the Celbridge Board of Guardians passed a motion opposing the proposal on the grounds of unsuitability and the dangers posed to the health of neighbouring residents and those of the villages of Celbridge, Clondalkin, Newcastle, Rathcoole, Leixlip, Saggart and Lucan a popular health resort, all of which were within a radius of approximately three miles of the site. They condemned the lack of public

[177] WNHA, proceedings central health conference, Leinster House, 23rd and 24th May 1912 (NAI, Priv/1212/wnha/3/8).
[178] Ishbel to Lord Aberdeen 20 June 1912 quoted in Pentland, *A bonnie fechter*, pp 168-9.
[179] Ishbel Aberdeen, *Memorandum explaining the arrangements made in connection with the grant of £25,000 made to the WNHA from the special sanatorium grant for the building of sanatoria and dispensaries under the insurance act* (Dublin, 1915) (NAI, Priv/1212/wnha/4/162); WNHA, minutes of first meeting of the sanatorium grant committee, 24 June 1912 (NAI, Priv/1212/wnha/1/16).
[180] 'Editorial notes' in *Sláinte*, iv, no. 43 (1912), pp 445-6; Ishbel Aberdeen, *Memorandum explaining the arrangements made in connection with the grant of £25,000; Freeman's Journal,* 31 July 1912.
[181] *Hansard 5* (*Commons*), xli, c. 2667 (London, 1912).
[182] *Kildare Observer*, 20 July 1912.

consultation on the proposal. They instructed their officials to seek legal advice as to the possibility of injuncting the promoters from proceeding with the scheme. The Celbridge No. 2 RDC passed a similar motion. During that debate it was pointed out that the estate had been acquired by the Estates Commissioners for distribution amongst evicted tenants, thus bringing a further political element to the objections.[183] John Clancy the MP for Dublin North took up this latter point, challenging the legality of the transfer to Lady Aberdeen on the basis that the lands had been acquired under the Evicted Tenants Act. However it was pointed out to him by Birrell that, although acquired by the Estates Commissioners for the ostensible purposes of the Evicted Tenants Act, the lands were in fact purchased in the Land Judges' Court under the Irish Land Act 1903 and subsequently exchanged, in fee simple, with the registered owner for lands in his possession in County Clare, urgently required for the relief of congestion.[184]

On 22 July the Tallaght magistrates joined the protest, condemning the action of the LGB in approving the project and objecting to 'the bringing of consumptive patients to such a place from other counties when there is a suitable sanatorium[185] within the distance of a few miles'. They pointed out that 99% of local residents opposed the scheme and that a 'grave doubt exists as to the sufficiency of the water supply'.[186] Lord Aberdeen attempted to defuse these objections by pointing to the Glen O'Dee Sanatorium in Aberdeenshire, located only a half-mile from the popular holiday village of Banchory. Although originally opposed by the locals, such opposition had entirely disappeared and any proposals to close the facility would be met with protests, 'partly because of the extra business which the institution had brought to the town'.[187]

On Sunday 21 July, forty to fifty men, armed with ropes, pickaxes and sledgehammers, under the direction of Nicholas Fitzsimons, a member of the Celbridge No. 2 RDC, demolished one of the newly-erected pavilions intended to accommodate eighty patients. It was the intervention of the site foreman Thomas Woods, who repeatedly discharged his rifle in the air, which prevented further damage. Following the attack six fully armed guards were assigned to the premises to prevent further attacks.[188] The *Daily Express* described the attack as 'a remarkable instance of the unpopularity of the proposal, which

[183] Ibid., 27 July 1912; *Freeman's Journal*, 23 July 1912.
[184] *Hansard 5* (*Commons*), xli, cc 998-1000 (London, 1912).
[185] This was a reference to Crooksling sanatorium located only five miles from the Peamount site.
[186] *Kildare Observer*, 27 July 1912.
[187] *Irish Independent*, 24 July 1912; *Kildare Observer*, 27 July 1912.
[188] *Evening Herald*, 22 July 1912; *Freeman's Journal*, 25 July 1912; *Irish Independent*, 25 July 1912.

is one of the features of the Insurance Act, to stud the country with sanatoria', while also blaming the stupidity of the promoters in not explaining their objectives clearly.[189] The *Irish Times* felt that local residents had 'a legitimate grievance' in not being consulted about the proposal, it coming upon them as 'a complete and disagreeable surprise' and considered the attack the inevitable outcome, when people were not afforded an opportunity to protest. It felt that, with the 'excellent case' the WNHA had, the trouble could have been averted by holding public meetings to explain the plans and convince residents that 'such sanatoria are innocuous'.[190] Lady Aberdeen countered such opposition by explaining that when the objectives of a sanatorium were properly understood, opposition would 'calm down', quoting Sir William Osler that 'the best place for a person who is afraid of tuberculosis is near a sanatorium'.[191] She arranged for the immediate publication of a leaflet, based on recent research carried out by the American NAPT, which concluded that 'a tuberculosis sanatorium may be regarded as a benefit to any community'. Their research demonstrated that property and land prices in the vicinity of sanatoria increased, health standards in surrounding areas improved and sanatoria acted as a trade stimulus to local merchants and farmers.[192]

Four local men including Fitzsimons were arrested and brought to trial for the attack on 1 August 1912. The jury having heard alibi evidence placing two of the defendants other than at the scene of the crime found them not guilty. However the case was found proven against Fitzsimons and another defendant James Brien, both being sentenced to six-months' imprisonment.[193] On 7 September it was reported that Lord Aberdeen in a conciliatory gesture had ordered the release of the two men.[194] This gesture to a large extent defused the situation. At a public meeting held in Lucan on 9 September a motion protesting against the erection of the sanatorium was withdrawn.[195] A public meeting, organised in Newcastle on 17 September to oppose the sanatorium, concluded by calling on Lady Aberdeen to form a local committee to 'inspect and report on the management of the Peamount sanatorium, with a view to preventing the slightest risk of the disease

[189] *Daily Express*, 23 July 1912.
[190] *Irish Times*, 24 July 1912.
[191] *Irish Independent*, 23 July 1912.
[192] WNHA, *The tuberculosis sanatorium as a neighbour* (Dublin, undated) (NAI, Priv/1212/wnha/4/145). The research was carried out in the areas surrounding 37 institutions located in 22 different states, by Philip P. Jacobs the assistant secretary of the American National Association for the study and prevention of tuberculosis, in 1909 (The National Association for the Study and Prevention of Tuberculosis, *Effects of tuberculosis institutions on the value and desirability of surrounding properties* (New York, 1914) pp 10-11).
[193] *Irish Independent*, 2 Aug. 1912.
[194] Ibid., 7 Sept. 1912.
[195] Ibid., 10 Sept. 1912.

being conveyed to the local residents'.[196] The threat of legal proceedings faded, when the Celbridge Board of Guardians was informed that a sanatorium as proposed would not come under the definition of a nuisance under the Public Health Act, a prerequisite to it seeking an injunction.[197]

It was agreed to facilitate county councils who had sought an allocation of permanent beds in the institution in return for a capital payment of £70 together with a weekly maintenance payment of £1 per bed.[198] These councils could obtain exclusive use of beds for a weekly payment of £1-5-0. Depending on the availability of beds, temporary accommodation at a charge of £1 per week could be secured by county councils who had not entered into alternative arrangements. Under these arrangements nine local authorities[199] contracted for permanent beds, four authorities[200] took beds for their exclusive use, while thirteen authorities[201] entered into negotiations for temporary accommodation.[202]

A board of management was formed, consisting of six-representatives of the WNHA and twelve-representatives of those county councils that had contracted for permanent beds.[203] However the LGB advised that this would not be an official committee under the board, but simply a committee appointed by the WNHA, in which organisation responsibility for the sanatorium would still vest. This committee decided that the president of the WNHA assisted by the association's officers should be empowered to act in relation to the sanatorium.[204]

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[196] *Freeman's Journal*, 18 Sept. 1912; *Irish Independent*, 18 Sept 1912.
[197] *Daily Express*, 20 Aug. 1912.
[198] Ishbel Aberdeen, *Memorandum explaining the arrangements made in connection with the grant of £25,000*. In a complex financial arrangement approved by the LGB, the payment of each £70 per bed did not financially benefit the WNHA, being used instead to offset the original grant of £25,000 made to the association. Each contributing county had the £70 deducted from their allocation of the grant. The total sum offset was then redistributed to the councils proportionately to their original allocation from the grant of £145,000.
[199] The county councils of Kerry, Meath, Westmeath, Leitrim, Donegal, Cavan, Louth, Roscommon and Carlow.
[200] The county councils of Tyrone, Kilkenny, King's County and the County Dublin insurance committee.
[201] The county councils of Kilkenny, Kildare, Londonderry, South Tipperary, Queen's County, Monaghan and Fermanagh and the county insurance committees of Armagh, Derry, Limerick, South Tipperary, Clare and Dublin Borough.
[202] Minutes of meeting of the sanatorium grant committee, 10 Oct. 1912 (NAI, Priv/1212/wnha/1/16).
[203] 'Ireland-the question of Peamount sanatorium ' in *BMJ*, i, no. 2739 (1913), pp 1391-2.
[204] *Irish Times*, 18 June 1913.

The first patient was admitted to the sanatorium on 24 October 1912.[205] By December 3 pavilions and some outdoor shelters providing for 110 patients had been completed with a further pavilion under construction (Plates 5.9 and 5.10).[206] By mid-April 1913, 214 patients had been treated in the sanatorium of whom 2 had died and 80 were discharged with 132 remaining under treatment. All these patients were insured people, the only category of patients with which the institution was dealing. Notable amongst these early patients were the high number of males in the seventeen to twenty-four age-group and the high number of patients engaged in the tailoring trade, indicating that the working conditions in this trade were conducive to the transmission of the disease amongst workers. [207] The category of patient dealt with widened when the government implemented its decision to make an annual grant of one half of the outlay incurred by local authorities in extending sanatorium treatment to uninsured persons and the dependants of insured persons.[208]

Construction of accommodation continued during 1913-14 with 217 beds available for patients by mid April 1914.[209] As grant aid was inadequate to fund these additional facilities, it was necessary for the WNHA to provide £7,000 from its own resources. The works included refurbishment of the farm buildings and stocking the farm.[210] The work on the farm was necessary in order to pursue Dr Philip's recommended scheme. It was intended to train patients in outdoor and agricultural work such as tobacco growing, so that following discharge they could pursue economic activities 'more suited to those who have suffered from consumption'.[211] 621 patients had been treated by mid-November 1913, with *c*. 200 remaining in the sanatorium at that time, two-thirds of whom were men and boys. However problems were experienced with councils and insurance committees referring patients whose disease was too far advanced. Lady Aberdeen felt that sending patients 'in almost a dying condition' long distances to the institution, which could not do anything to help them, was 'a cruelty to them and their friends' in addition to adversely affecting the morale of other patients. Yet they were admitted to the

[205] 'Ireland-Women's National Health Association and sanatoriums' in *BMJ*, i, no. 2782 (1914), p.938.
[206] *Minutes of special council meeting of the WNHA, 5-6 Dec. 1912* (NAI, Priv/1212/wnha/1/1).
[207] *Minutes of sixth annual meeting of the general council of the WNHA*, 15 Apr. 1913, contained in the supplement to *Sláinte*, v, no. 53 (1913).
[208] Local Government Board Dublin, circular No. 8: M: 1913- Miscellaneous- tuberculosis schemes- financial arrangements in *Forty-first annual report of the LGB*. During the passage of the 1911 Act through parliament sanatorium benefit had already been extended to the dependants of insured persons.
[209] *Irish Times*, 16 Apr. 1914.
[210] Ibid., 21 June 1913.
[211] *Minutes of special council meeting of the WNHA, 5-6 Dec. 1912* (NAI, Priv/1212/wnha/1/1).

Plate 5.9 Wooden pavilion at Women's National Health Association's Peamount Sanatorium, County Dublin, *c.* 1913 (www.peamount.ie)

Plate 5.10 Wooden shelters, to accommodate tuberculosis patients, at the Women's National Health Association's Peamount Sanatorium, County Dublin, *c.* 1913 (NAI, Priv1212/wnha/7/162)

sanatorium although on occasion the medical officer had to immediately send for a clergyman for them.[212]

To cater for the religious needs of the patients, Lady Aberdeen instructed the architects to prepare plans for a Catholic church. However the lowest tender received, £700, was beyond the financial capabilities of the association, especially as a similar structure would be required for Protestant patients. Accordingly it was decided to accept a stock design for the two chapels, which were constructed by the on-site contractor for the sum of £464.[213] The dedication of the Protestant chapel took place on 27 April 1913, the ceremony being performed jointly by the Church of Ireland and Presbyterian chaplains. The same day the Catholic church was dedicated by the Catholic chaplain to the sanatorium.[214]

Amongst the patients referred by the councils to Peamount was a large cohort of children, many under six years of age. In June 1913 Lady Aberdeen announced an allocation of £5,000 from WNHA funds, to provide a special pavilion with separate administration to cater specifically for their needs. Construction of the 60-bed facility, incorporating an open-air school, commenced in early 1914.[215] Herbert Asquith the prime minister officially opened the new facility on 26 September 1914.[216]

Conclusion

The endeavours of the Dublin local authorities and the WNHA had ensured that by 1914 two large sanatoria, a hospital for advanced cases and a preventorium had been established in the Dublin region. However in providing these facilities persistent local opposition, arising from concerns about the infectious nature of the disease, had to be overcome. This opposition was supported by certain local politicians who were also concerned about the financial impact providing facilities would have on local rates. In Charles Street a central tuberculosis dispensary had been opened and run in accordance with the treatment principles developed by Robert Philip in Edinburgh.

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[212] *Minutes of general meeting of the WNHA*, 12 Nov. 1913, contained in the supplement to *Sláinte*, v, no. 61 (1914).
[213] *Irish Times*, 26 Apr. 1913.
[214] Ibid., 28 Apr. 1913.
[215] Ibid., 21 June 1913; 'Ireland-Women's National Health Association and sanatoriums' in *BMJ*, i, no. 2782 (1914), p. 938; Minutes of sixth annual meeting of the general council of the WNHA, 15 Apr. 1913, contained in the supplement to *Sláinte*, v, no. 53 (1913).
[216] *Irish Times*, 27 Sept. 1914.

Lady Aberdeen, who enjoyed a high political profile, had over the course of her career developed many important political connections, which she used to enlist political support for her objectives. She used her social position and persuasive powers to recruit suitable individuals to the committees she formed to further her anti-tuberculosis objectives. Her international social connections provided her with avenues of funding not normally available. Without her organisational and fundraising abilities the WNHA facilities would not have existed.

Chapter 6

Dispensaries, domiciliary treatment, workhouse infirmaries and approved institutions—Implementation of the National Insurance Act 1912-1918

Overall responsibility for overseeing the implementation of the tuberculosis provisions of National Insurance Act 1911 in Ireland fell largely to the LGB. It set out to achieve this duty mainly through the micro-management of the authorities directly charged with providing the required facilities and services and by exhorting the use of existing resources to achieve the acts objectives.

Implementation of National Insurance Act 1911

With the tuberculosis provisions of the national insurance act coming into operation on 15 July 1912, the departmental committee on tuberculosis[1] found it necessary to issue an interim report, to ensure that both central and local arrangements for the implementation of the act would be in 'general harmony' with any scheme it recommended.[2]

The departmental committee envisaged the development of local authority schemes broadly along the lines of Philip's 'Edinburgh Scheme' but available for the whole community and with hospitals augmenting the role of the sanatorium. It acknowledged that in many areas a single central dispensary would not suffice and would need to be supplemented by branch dispensaries, which the tuberculosis officer and nurse would visit on stated days in order to 'get in touch with as large a number of persons as possible'. The dispensary and its branches would be managed by a tuberculosis officer who was required to develop an intimate working relationship with the dispensary medical officers of health, the local general practitioners and the medical officers of sanatoria and hospitals. The tuberculosis officer, who would be advisor to the insurance committee on tuberculosis matters, would in co-operation with the general practitioners and institutional medical officers determine the most appropriate form of treatment for patients. The link between the tuberculosis officer and the insurance committee was necessary as this committee decided who amongst the insured was entitled to 'sanatorium

[1] The committee had been appointed in February 1912 to report 'on the considerations of general policy in respect of the problem of tuberculosis in the United Kingdom, in its preventative, curative and other aspects'. *Interim report of the Departmental Committee on Tuberculosis*.
[2] *Interim report of the Departmental Committee on Tuberculosis.*

benefit' (treatment).[3] While the act had provided for 'sanatorium benefit' to be provided in 'sanatoria or other institutions or otherwise', the departmental committee considered that the principles of tuberculosis treatment although developed in sanatoria had 'a wide application outside these special institutions' and could be delivered to patients while 'living in their own homes or in shelters'.[4] Home treatment had the added advantage of permitting many consumptives to continue in employment.[5] As it was envisaged that the medical care of persons receiving such 'domiciliary treatment' would be provided by general practitioners under the supervision of tuberculosis officers, the chancellor of the exchequer announced that 6*d* per person out of the 1*s* 4*d* reserved for defraying the expenses of sanatorium benefit would be allocated for the remuneration of the general practitioners.[6]

The departmental committee considered it essential that only 'suitably qualified and experienced medical men' should be appointed to senior posts in dispensaries and sanatoria. It believed that only registered medical practitioners of not less than twenty-five years of age who had received at least six months hospital training and had worked in a tuberculosis institute for a similar period, where they had become 'enough of an expert on the subject of tuberculosis to command general confidence', would fulfil this requirement. The committee also recommended that tuberculosis dispensary nurses should have special training in tuberculosis work. The committee acknowledged that, owing to the lack training facilities, very few doctors or nurses possessed the necessary experience. However they felt that appointments could be made on the understanding that successful candidates would immediately 'make adequate arrangements to secure the necessary training and experience'.[7]

The WNHA, realising that no facilities existed in Ireland for the provision of such training, sought and obtained approval from the LGB to run courses in Dublin.[8] The doctor's post-graduate course in tuberculosis was provided in the Collier dispensary and the Pigeon House Road hospital. The first course commenced on 8 July 1912 with

[3] Ibid.
[4] National Insurance Act, 1 & 2 Geo. V, c. 55 (16 Dec. 1911); *Interim report of the Departmental Committee on Tuberculosis*.
[5] *Thirty-eighth annual report of the LGB.*
[6] *Final report of the Departmental Committee on Tuberculosis. Volume I*.
[7] *Interim report of the Departmental Committee on Tuberculosis*.
[8] The nearest locations where approved courses were available were London, Liverpool and Edinburgh.

eighteen attendees. By December 1912 thirty-two doctors had completed the course.[9] With trained physicians now available, twenty-five councils had appointed doctors to manage their tuberculosis dispensaries by 31 March 1913.[10] Nurses' courses were provided in the same two institutions under the supervision of Dr Crowe. Only three nurses could be accommodated on the course, which involved a fortnights training at the dispensary followed by a fortnight in the hospital learning topics such as the care of tubercular patients, the disinfection of clothing and the workings of tuberculosis institutions. By the beginning of December 1912 forty-four nurses had completed the course. However such was the pressure on course places that by that date a three to four month waiting list had built up.[11]

The 1911 act permitted insurance committees to extend sanatorium benefit to the dependants of insured persons. If funds proved insufficient to meet a demand thus created, the benefit could be supplied providing the additional expenditure was sanctioned by both the treasury and the relevant county council, who would meet the shortfall in equal shares.[12] In July 1912 Lloyd George, the chancellor for the exchequer, 'in order that schemes for the treatment of tuberculosis should relate to the whole community', confirmed a government decision to provide the Irish LGB annually with half the cost of providing treatment for non-insured persons in addition to the dependants of insured persons.[13] These monies were to be distributed, in accordance with LGB regulations, to authorities, which undertook schemes approved by the board 'for the general treatment of tuberculosis in their areas'.[14] The balance of funding would come from the county rate.

The detailed supervision of the act's implementation entailed a considerable amount of additional work for the Irish LGB.[15] As sanatorium grants applied to the treatment of persons suffering from non-pulmonary tuberculosis, a treatment which most county

[9] Minutes of meetings of sanitorium grant committee of WNHA, 8 July 1912 (NAI, Priv/1212/whna/1/16); 'P. F. Collier memorial dispensary transferred to corporation' in *Sláinte*, iv, no. 47 (1912), pp 517-8. With thirty-two doctors completing the course by December 1912, there appears to have been some relaxation in the requirement that the course be of six-months duration, although this compromise does not appear to have been officially acknowledged.
[10] *Forty-first annual report of the LGB.*
[11] Minutes of special council meeting of WNHA, 5-6 Dec. 1912 (NAI, Priv/1212/whna/1/1).
[12] National Insurance Act, 1 & 2 Geo. V, c. 55 (16 Dec. 1911).
[13] The schemes were to be organised and implemented by county councils and county boroughs.
[14] D. Lloyd George to Henry Hobhouse, 31 July 1912 in *Forty-second annual report of the Local Government Board, 1912-1913, part III.- (a) Public health and local administration, (b) County council administration, (c)Local taxation and valuation*, 1 [Cd 6982], H.C. 1913, xxx1, 413.
[15] *Forty-first annual report of the LGB.*

infirmaries were well adapted to deliver, the board urged that councils bring the infirmaries within the scope of their schemes.[16] To facilitate councils in drawing up schemes the services of the board's medical inspectors were placed at their disposal. In addition model plans for central tuberculosis dispensaries were circulated. The plans contained two options. The preferred option was to erect the dispensary, with four observation beds provided, within the grounds of the county infirmary, wherein staff could be accommodated with consequent economic benefits. The second dearer option provided for stand-alone premises with six observation beds together with bedroom, living and sanitary accommodation for two nurses and a ward maid.[17]

During the year ending 31 March 1913 all the Leinster authorities adopted schemes, with the exception of Longford, which 'refused to make any scheme for the treatment of tubercular cases'.[18] The schemes covered such matters as the location of central and branch dispensaries, the appointment of tuberculosis officers and nurses, arrangements for the provision of sanatorium treatment for patients and the provision of shelters.[19] The approach adopted by Meath differed from the others, in that it adopted only a partial scheme incorporating an agreement, which had been entered into with the WNHA, for that organisation to provide the services on behalf of the council.[20]

Dispensaries

The LGB saw the central dispensaries delivering 'modern methods of treatment' to patients in addition to providing instructions as to proper ventilation, sleeping accommodation, the disposal of sputum, rest, nutrition and 'how to minimise the risk of spreading infection'. The board saw the dispensary nurse, in addition to her dispensary duties, visiting the homes of patients to rectify 'any faulty or unhygienic conditions

[16] Local Government Board circular no. 64,201/1913. miscellaneous. 5 Dec. 1913 in *Forty-second annual report of the LGB.*
[17] *Forty-first annual report of the LGB.*
[18] *Forty-first annual report of the LGB; Forty-second annual report of the LGB.* Although Dr T. J. Browne the medical inspector for most of Leinster stated in his report for the year ending 31 March 1913 that Wicklow County Council had not prepared a scheme they had in fact adopted a scheme at the council meeting held on 8 July 1912 probably with no assistance provided by him (*Sláinte*, iv, no. 42(1912), p.436.(NAI, Priv/1212/whna/4/2)). However as no exchequer grants were received by the council as evidenced by the LGB annual reports 1913 to 1920 the scheme was not implemented. The Wicklow insurance committee from at least March 1913 had placed patients in Newcastle sanatorium, entering into an agreement to reserve beds for its patients from September 1913 (Minutes of meetings of board of governors, 13 Mar. and 4 Sept. 1913(NHA)).
[19] *Sláinte*, iv, no. 42(1912), pp 430-6.
[20] *Sláinte*, iv, no. 43(1912), pp 450-2.

found there' and gathering information required by the tuberculosis officer.[21] However many councils experienced difficulties in finding premises or sites for dispensaries due to 'local apprehensions of the danger of infection'. To overcome this difficulty and begin providing a network of branch dispensaries arrangements were entered into in many cases to use existing poor law dispensaries, although many tuberculosis sufferers were reluctant to attend such local dispensaries fearing the publicity and resultant stigmatisation. [22]

By the end of March 1913 Dublin Corporation had taken possession of the Charles Street dispensary, which was to serve the entire city. [23] Proposals by the WHNA to establish a central dispensary for county Meath in the old seminary building in Navan, which it had acquired, were frustrated, following protests, from forty ratepayers and other influential residents. Despite support from the public health committee of the urban council who were 'quite convinced that there is not the slightest cause for alarm and that such a dispensary instead of being a danger is, on the contrary, a great protection to the public' the proposal was abandoned and the premises used as a milk depot. An alternative offer, from the Navan Board of Guardians, to make available the smallpox buildings adjoining the Navan workhouse, was accepted and a temporary central dispensary was established there, opening in late 1912; the first county tuberculosis dispensary in the country.[24] Westmeath county council secured the use of the dispensary in Mullingar as a central dispensary pending the erection of new premises on a nearby site, which had been acquired. [25] Carlow County Council, with the aid of a £200 gift from the WNHA purchased a former auxiliary workhouse at Monacurragh on the outskirts of Carlow town for conversion to a central dispensary.[26] Kilkenny County Council purchased the former militia stores in Kilkenny for similar conversion (see Plate 6.1). Dublin County Council and King's County Council made arrangements to construct central dispensaries in the grounds of their county infirmaries. Louth County Council entered into temporary arrangements with the county infirmary to use part of its premises as a central dispensary pending the provision of permanent premises in Dundalk. [27]

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[21] Local Government Board circular 4/M. 1913. miscellaneous. 17 Jan. 1913 in *Forty-first annual report of the LGB.*
[22] *Forty-second annual report of the LGB.*
[23] Ibid.
[24] *Evening Telegraph*, 5 and 23 July 1912; *Daily Express*, 13 July 1912; *Irish Times*, 22 July 1912; *Forty-second annual report of the LGB;* Minutes of meetings of sanitorium grant committee of WNHA, 8 July and 5 Dec. 1912. (NAI, Priv/1212/whna/1/16).
[25] *Forty-second annual report of the LGB.*
[26] *Carlow Sentinel*, 6 July 1912; *Forty-second annual report of the LGB.*
[27] *Forty-second annual report of the LGB.*

The contrasting experiences of three counties, Queens County, Kildare and Wexford, illustrate the difficulties encountered in providing central dispensaries, sanatoria and facilities to treat advanced cases.

Queen's County

A bazaar was held in mid 1909 to raise funds for an operating theatre at the Queen's County infirmary in Maryborough, Queens County. The Maryborough branch of the WNHA, at the instigation of its president Lady Coote, suggested that some portion of the bazaar proceeds (£415) should be allocated to make provision for tuberculosis patients then housed in the infirmary. In September the infirmary's management committee agreed that surplus bazaar funds should be 'devoted to the construction of separate accommodation for tuberculosis patients'.[28] As no progress had been made on the matter by January 1910, Lady Coote proposed that with the consent of the management committee she would organise an appeal for funds and arrange for the construction of a tuberculosis annex. Her proposal was readily accepted.[29] She arranged for the Dublin firm of Keenan and Sons Limited to present plans for one of their prefabricated sanatoria which were approved by the committee in August 1910.[30] In the presence of a large invited assembly of subscribers Lady Coote, having raised over £600 laid the foundation stone for the structure on 28 September 1910.[31]

Lady Aberdeen performed the official opening ceremony for the new sanatorium on 11 May 1911. It was a timber-framed structure clad with galvanised iron sheeting comprising a centre day room flanked by two wings, each containing a four-bed ward and two single bedrooms (Plate 6.2). To the rear of the centre room were a kitchen, bathrooms, nurses' rooms and a sterilisation room. Both wings were fronted by a verandah with a glazed roof, accessible from the wards through French windows. The design availed of the sloping nature of the site to create an open air shelter under the building for the use of male patients. Kathleen O'Connell who had worked at Frimley Sanatorium, Surrey was recruited as matron to supervise the institution.[32] Upon opening

[28] Minutes of proceedings of the conjoint committee of management of the Queen's County infirmary, 29 Sept. 1909 (LSCCA) (Henceforth Minutes Queen's County infirmary)
[29] Minutes Queen's County infirmary, 19 Jan. 1910.
[30] Ibid., 2 Aug. 1910.
[31] Ibid., 28 Sept. 1910: *Freeman's Journal*, 28 Sept. 1910: *Irish Times*, 1 Oct. 1910.
[32] Lady Coote, 'Queen's County Sanatorium- report' in *Sláinte*, iii, no. 34 (1911), pp 275-6; *Irish Times*, 11 May 1911.

Plate 6.1 The former militia stores Kells Road, Kilkenny which was converted for use as the County Kilkenny central tuberculosis sanatorium in 1912. The premises is currently in use as luxury apartments (Alan Carthy, 2014)

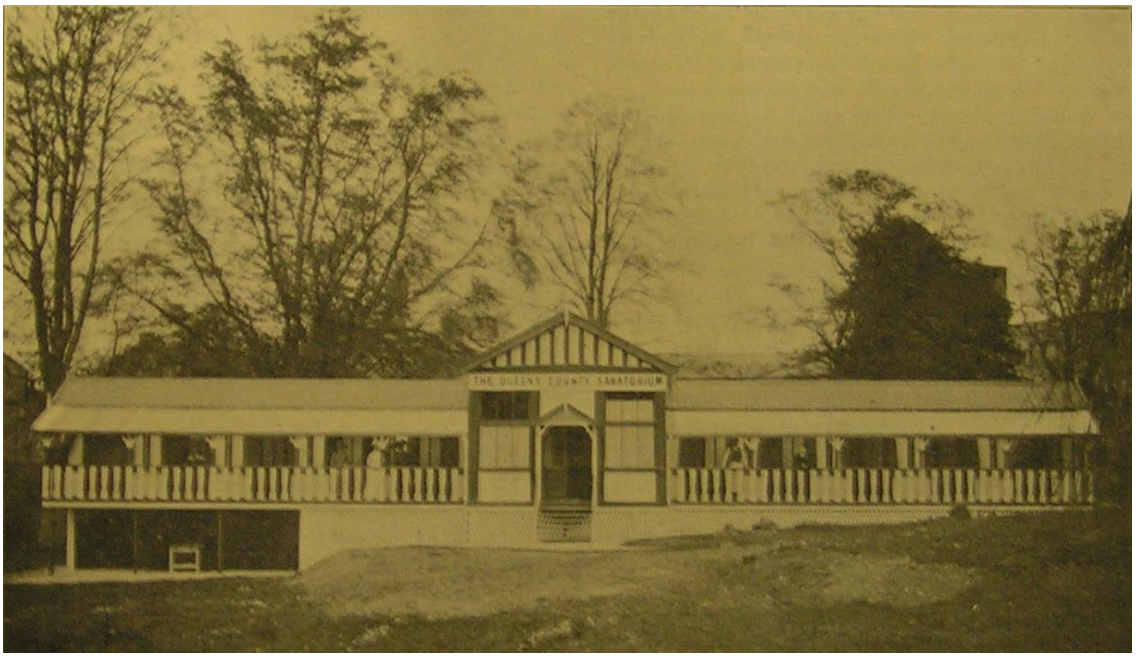

Plate 6.2 Queen's County sanatorium Maryborough (Portlaoise) 1911. The wooden sanatorium opened in May 1911 but was burnt down in November 1912 (*Sláinte*, Nov. 1911)

there were insufficient funds to meet outstanding bills. However by September Lady Coote had raised £1,000, sufficient to completely discharge the sanatorium's debts leaving a small credit balance.[33] It was agreed to hand over the sanatorium to the people of Queen's County, to be run by the infirmary's joint committee of management on their behalf. In this role the committee decided that eight of the beds would be provided free of charge with four being reserved for paying patients at a minimum weekly charge of 7/- , which was increased to such an amount as the means of the patient would permit.[34]

On Sunday 10 November 1912 a fire broke out in a nurse's bedroom. Assistance was immediately summoned from infirmary staff and from the staff of the prison located across the road. They succeeded in removing the five patients in the sanatorium to safety. Despite assistance from the town fire-brigade, the police and members of the 4th Leinster Regiment within two hours the wooden structure was reduced to a twisted metal frame.[35]

The county council adopted a tuberculosis scheme in mid 1912, which provided inter alia for the acquisition of the sanatorium and its redevelopment as a central dispensary with six beds. Following the fire, a joint committee of the council's tuberculosis committee and the infirmaries management committee was established to agree terms to give effect to this proposition.[36] Pending the provision of this dispensary in August 1913 it was agreed to provide two beds to the county council in the infirmary's isolation ward at a weekly cost of 12*s.* 6*d* per occupied bed. The council was to provide any special nursing needs required.[37] In April 1913 the infirmary was approved by the LGB for the treatment of surgical tuberculosis cases, at a weekly fee of £1 per patient.[38]

The joint committee agreed in May 1914 to use part of the existing infirmary as a central dispensary. In return the council would erect a new tuberculosis dispensary in accordance with plans to be approved by the LGB, on a site within the infirmary grounds. All services required for the dispensary, including nursing of in-patients, were to be provided by the infirmary. It was to be responsible for 'carrying out the directions of the tuberculosis officer in so far as the dieting and treatment of patients is concerned'. To

[33] *Fifth annual report of the WNHA, 1911-1912* (NAI, Priv/1212/whna/6/2).
[34] Minutes Queen's County infirmary, 26 Feb. 1911.
[35] *Irish Independent*, 11 Nov. 1912.
[36] 'Specimen schemes adopted by some of the county councils in Ireland for the treatment of tuberculosis under the national Health Insurance Act' in *Sláinte*, iv, no. 42 (1912), pp 430-6; Minutes Queen's County infirmary, 28 May 1914.
[37] Minutes Queen's County infirmary, 4 Aug. 1913.
[38] Ibid., 28 Apr. 1913.

cover the cost of such services and the maintenance of the facilities the council were to contribute £150 per annum, in addition to the weekly fee of £1 per patient. [39] A tuberculosis nurse was appointed in October 1914 to attend at the tuberculosis dispensary and other dispensaries throughout the county in relation to the attendance of patients during tuberculosis dispensary hours.[40]

The new facility was not completed until January 1917. Due to rising costs, mainly attributed to the war, it was not possible to give effect to the original agreement, it proving necessary to seek increases in the annual subvention to £180 and the weekly patient charge to £1-5-0.[41] However, in order to maintain the service charge at existing levels, rather than appoint an extra nurse specifically for the central tuberculosis dispensary it was agreed that nursing staff from the infirmary would, on a rota basis, take charge of nursing duties in the dispensary.[42]

Kildare

The provision of a sanatorium was first considered by Kildare County Council in February 1909 when Lady Mayo offered the council £900, which she had collected for this purpose.[43] However in June 1910, estimating it would cost £5,000 to erect a sanatorium and having obtained figures from the Abbey Sanatorium in Belfast, showing the average weekly cost per patient in that institution was 17*s.* 3¼*d.*, because of the financial implications it was decided to adjourn consideration of the matter.[44]

A tuberculosis scheme was adopted by the council in July 1912. It provided for the acceptance of a WNHA offer to set aside fifteen beds in Peamount, to treat Kildare tuberculosis patients at a weekly cost of £1 per patient and failing this arrangement to refer patients to the Royal National Hospital for Consumption in Newcastle. Under the scheme a central dispensary with not less than six observation beds was to be provided in Kildare town. A sites committee was appointed to secure a site for this dispensary and to establish suitable locations for branch dispensaries to be initially located in Naas, Athy

[39] Ibid., 28 May 1914.
[40] Minutes of meetings of the Queen's County tuberculosis committee, 13 Oct. and 8 Dec. 1916 and 10 Jan 1917 (LSCCA).
[41] Minutes Queen's County infirmary, 29 Jan. 1917.
[42] Ibid., 1 Feb. and 28 Mar. 1917.
[43] *Minutes of quarterly meeting of Kildare County Council*, 15 Feb. 1909, minute no. 3202 (KCCA).
[44] *Minutes of meeting of committee appointed by the county council to collect statistics and to report as to the cost of erection of a sanatorium under the Tuberculosis Prevention (Ireland) Act, 1908*, 5 Nov. 1909 and 25 Apr. 1910; *Minutes of special meeting of Kildare County Council*, 8 June 1910, minute no. 3478 (KCCA).

and another unidentified town.[45] The council appointed Dr Joseph Daly as tuberculosis officer to take charge of the proposed dispensary and administer the scheme.[46] In March 1913 it was agreed to purchase a one-acre site located a short distance from the town of Kildare for the sum of £100.[47] The provision of water and sewerage services to the site would cost an additional £185.[48] The county surveyor was instructed to prepare plans for the erection of a ten-bed central dispensary on this site at a projected cost of £600.[49]

In November 1913 the council wrote to the various boards of guardians in the county seeking the free use of their dispensaries as branch tuberculosis dispensaries.[50] The following February, Dr Daly based on the paucity of observation cases[51] in the county, having discovered only one doubtful case in the previous four months, expressed the opinion that the establishment of branch dispensaries in the various districts would be adequate for the treatment of the disease. On hearing this view the council decided to postpone consideration of a central dispensary for six months.[52] In August it was decided to abandon any proposal to erect a central dispensary at Kildare but alternatively to take steps 'to procure a suitable building in the neighbourhood for the purpose'.[53] In December 1914 the LGB wrote to the council stressing the necessity of establishing a central dispensary 'without further delay' and pointing out that a sum of £750 was available from the sanatorium grant for this purpose.[54] In February 1915 Dr Daly suggested that procuring a two-bed house preferably in Athy would meet this need. In this suggestion he was supported by the council's chairman Matthew J. Minch himself a resident and representative of Athy.[55]

Athy as a location was vetoed by the LGB who did not consider it 'a suitable place for patients from all parts of the county', arguing that Kildare would be more central, enjoying the added advantage of having a better railway service. The board pointed out

[45] *Minutes of special meeting of finance committee*, 17 June 1912; *Minute of special meeting of county council*, 5 July 1912, minute no. 3911 (KCCA).
[46] *Minute of special meeting of county council*, 23 Sept. 1912, minute no. 3975 (KCCA).
[47] *Minutes of meeting of sites committee*, 28 Mar. 1913, minute no. 12 (KCCA).
[48] *Minutes of meeting of finance committee*, 24 Feb. 1913, minute no. 2432 (KCCA).
[49] *Minutes of meeting of sites committee*, 5 Feb. 1913, minute no. 10; *Minutes of quarterly meeting of county council*, 26 May 1913, minute no. 4107 (KCCA).
[50] *Minutes of quarterly meeting of Kildare County Council*, 24 Nov. 1913, minute no. 4223.
[51] Observation cases were patients with suspected tuberculosis who would be detained under observation in the beds in the central dispensary to determine the existence of the disease. Patients showing positive signs of the disease would be placed under domestic treatment or referred to a sanatorium.
[52] *Minutes of quarterly meeting of Kildare County Council*, 23 Feb. 1914, minute no. 4299; *Kildare Observer*, 28 Feb. 1914.
[53] *Minutes of quarterly meeting of Kildare County Council*, 17 Aug. 1914, minute no. 4442.
[54] Ibid., 23 Nov. 1914, minute no. 4519.
[55] *Kildare Observer*, 27 Feb. 1915.

that ‘in consequence of the exigencies of the country financially (as a result of the war), money for the erection of a building would not now be advanced’, suggesting as an alternative that ‘advantage should be taken of an existing institution where accommodation could be obtained’.[56] Accordingly approaches were made to the county infirmary committee to accommodate the dispensary within the infirmary premises. However in February 1916, when that committee refused to meet representatives of the council to discuss the dispensary, it was decided to ‘adjourn consideration of the whole matter until after the termination of the war’.[57] In mid 1916, an attempt to provisionally adopt the Kildare dispensary as a central dispensary, conditional upon two observation beds being made available in the Kildare infirmary, was frustrated by the refusal of the management of the infirmary to co-operate in the interim proposal.[58] Efforts to rent suitable central dispensary premises in either Naas or Kildare in December-January 1917-18 met with no success, as a result of which further overtures were made to the county infirmary committee again to no avail.[59]

In early 1916 Dr Daly reported that the branch tuberculosis dispensaries at Kildare, Monasterevan, Athy, Rathangan, Newbridge and Kilcock were all fairly well attended.[60] However by the end of that year matters changed substantially in Athy, when the local branch of the WNHA due to lack of financial support practically ceased to exist. This ended the employment of the Jubilee nurse. It was the absence of this nurse that Dr Daly attributed the fall off in attendance at the dispensary which had changed from being well attended to badly attended.[61]

In February 1918 the Athy Board of Guardians agreed to admit advanced cases of tuberculosis to their hospital where both a male and a female ward were already dedicated to the treatment of incipient cases.[62] That June the Celbridge Board of Guardians made a similar decision. As a result of these provisions seventeen beds were made available for the treatment of advanced cases.

[56] Ibid., 16 Oct. 1915.
[57] *Minutes of quarterly meeting of Kildare County Council*, 21 Feb. 1916, minute no. 4777.
[58] Ibid., 29 May 1916, minute no. 4820 and 26 Feb. 1917, minute no. 5026.
[59] Ibid., 26 Feb. 1918, minute no. 5260 and 27 May 1918, minute no. 5332.
[60] Ibid., 21 Feb. 1916.
[61] Ibid., 20 Nov 1916.
[62] Ibid., 26 Feb. 1918, minute no. 5276.

Wexford

In October 1913 Wexford County Council advertised for a site 'in the immediate neighbourhood of Wexford town' on which to establish a central dispensary. It also decided to establish branch dispensaries at Enniscorthy, Gorey and New Ross together with a temporary facility at Wexford pending the opening of the central dispensary.[63] In response to the advertisement the Sisters of St John of God offered a site, adjacent to their convent, at Windmill Hill for £100, 'on the understanding that the community will be placed in charge of the nursing arrangements in the sanatorium'. They indicated that further lands could be made available to extend the facility. As Dr William O'Connor, the tuberculosis officer appointed by the council, had advised that a sanatorium for curable cases together with a home for advanced cases should be provided, it was decided to ascertain if the nuns would sell a site of *c.* 4 acres 'of the field furthest from the town for the purpose of a central dispensary and a sanatorium'. That November the purchase of the field for £350 was agreed.[64] It was intended that the sanatorium would replace the existing arrangement entered into with the Royal National Hospital for Consumption for Ireland in Newcastle.

In June 1912 Wexford County Council had approached the Newcastle hospital authorities enquiring as to the possibility of reserving beds in that institution for tubercular patients. Following this approach, the hospital board circulated all local authorities, offering to accept local authority patients affected with pulmonary tuberculosis, upon the local authority entering into a three-year agreement to reserve each bed required at a charge of £1-1-0 per week, subject to the proviso that advanced cases would not be accepted.[65] The following month Wexford County Council indicated its intention of accepting the offer although it did not in fact do so until April 1917 when it reserved four beds.[66] In October 1913 the Wexford insurance committee took up the offer, reserving ten beds for its patients.[67]

Local residents organised a petition opposing the proposed Windmill Hill site and formed a deputation to the council's tuberculosis committee to state their objections. The deputation, representing nearly 1,000 petitioners, pointed out that the town was rapidly

[63] Minutes of first meeting of the management committee established under the Tuberculosis Prevention (Ireland) Act 1908, 21 Oct. 1913 (WCCA).
[64] Minutes of quarterly meeting of tuberculosis management committee, 24 Nov. 1913 (WCCA).
[65] Minutes of special meeting of board of governors, 20 June 1912 (NHA).
[66] Minutes of meetings of board of governors, 11 July 1912 and 12 Apr. 1917 (NHA).
[67] Ibid., 9 Oct. 1913.

expanding in the direction of Windmill Hill where a large population of young people and children resided alongside the Protestant charity Tate School. They felt that the proposed facility 'in such close proximity to the town, would be exposing the inhabitants to an altogether unnecessary risk and would be a source of great anxiety and dread to the residents of the locality'. They explained that it would have a severe negative impact on property values and could halt the expansion of the town with subsequent deleterious economic consequences.[68]

However another group was formed in favour of the proposal. It drew up a petition pointing out that the site, in an isolated elevated position, had already been approved by the LGB whose inspector regarded the site 'as an admirable one for the purpose'. They claimed that the site posed no danger to public health, quoting expert opinion that consumption was not 'strictly speaking […] an infectious or contagious disease'. It pointed out that the existence of workhouses 'with wards for persons in advanced stages of consumption' and fever hospitals had no effect on residential property values quoting the example of Wexford where some of the best residential properties in the town were in the immediate vicinity of the workhouse where such a ward existed. They considered that the site, located a short distance from the railway station, could accommodate a sanatorium 'constructed in accordance with the latest modern plans' to combat the disease, while strongly objecting to 'any old building being acquired for the purpose'. Having heard both arguments and being informed that it was impossible to acquire an alternative site the tuberculosis committee decided to proceed with the proposal.[69]

In April 1914 the committee decided that two separate buildings would be provided on the site a dispensary and a twenty-bed sanatorium to which 'only patients who have a reasonable hope of cure or improvement will be admitted'. The estimated total cost of the project including land acquisition and legal fees was £2,815.

As Dr O'Connor had no place to examine patients in Wexford, efforts were made to secure temporary accommodation in the town. However approaches to landlords with vacant premises to let in Selskar Street and West Gate were met with refusals to let them for a tuberculosis dispensary.[70] Despite these refusals the committee adopted a schedule

[68] Minutes of special meetings of tuberculosis management committee, 11 Feb. and 25 Feb. 1914 (WCCA).
[69] Ibid., 25 Feb. 1914.
[70] Minutes of meetings of tuberculosis management committee, 11 Mar., 1 and 15 Apr. 1914 (WCCA).

for the provision of tuberculosis dispensary services throughout the county (see appendix 9).[71]

The schedule was adopted although premises had not been secured in all of the proposed locations. The Enniscorthy Board of Guardians consented to using Enniscorthy dispensary. The committee spent £12 on carrying out alterations to the premises to render them suitable for the proposed use.[72] A single room, with a partition to separate waiting patients from the visiting doctor, was leased at Ballycullane in the south-west of the county at an annual rent of £10 to include caretaking and the supply of coal.[73] Although the New Ross Board of Guardians had agreed to the use of their dispensary in mid-April 1914 they withdrew this consent.[74] It was only in December 1914 that agreement was reached with New Ross Urban District Council to lease a house and field at an annual rent of £18.[75] This expenditure was partially offset by an annual conacre letting of the field for £6.[76] Such was the run down nature of the premises that spending £19 was necessary to bring it into a state of repair whereby portion of it could be used as a dispensary and £26 to make the balance of the premises habitable for a caretaker.[77] However in return for a right of residence the caretaker received only a nominal salary of 1*d.* per week.[78] In July 1914 the Enniscorthy Board of Guardians agreed to using Newtownbarry dispensary for tuberculosis purposes provided that 'the ordinary dispensary days were not interfered with and subject to a contribution of £3 per annum towards caretaking costs.[79] Gorey Rural District Council agreed in November 1914 to set aside the west wing of Gorey workhouse for the treatment of tuberculosis patients and for use as a tuberculosis dispensary.[80]

The discovery of title difficulties in May 1914 delayed the acquisition of the Windmill Hill site[81]. The solution was achieved by the council redeeming the head rent at an additional cost of £231 in March 1915. Ongoing discussions with the LGB had resulted in modified plans for the premises. Constructing the modified buildings in concrete

[71] Ibid., 15 Apr. 1914.
[72] Ibid., 1 Apr. 1914.
[73] Ibid., 15 Apr. 1914.
[74] Ibid., 6 May 1914.
[75] Ibid., 11 Dec. 1914.
[76] Ibid., 23 Dec. 1914.
[77] Ibid., 3 Feb. and 19 May 1915.
[78] Ibid., 23 Dec. 1914.
[79] Ibid., 14 July 1914.
[80] Ibid., 12 Nov. 1914.
[81] Ibid., 6 May 1914.

would cost £1,800. However the delays and wartime government economies meant that the finances to proceed with the project were no longer available. Arrangements were made with the Sisters of St John of God to defer payment of the land purchase price £581 for five years by paying an annual fine of 5% on this capital sum.[82] The county council in May 1915 decided to proceed only with the central dispensary element of the plan. Later that month the scope of the project was further diminished when it was agreed to erect only a temporary dispensary constructed of timber with a felt roof, at a cost not exceeding £200.[83] In November a tender to erect the building for £180 was accepted.[84] Furniture and medicines were procured in March 1916 allowing the temporary central dispensary to open in April 1916.[85]

The lack of finance impacted severely on the provision of accommodation for advanced cases of tuberculosis. An offer in July 1914 by the Enniscorthy Board of Guardians to transfer the Newtownbarry and Oulart fever hospitals to the local district council to treat such patients was turned down as finance was not available to engage nursing staff.[86] A similar offer in September 1914 from the Gorey Board of Guardians in relation to Gorey fever hospital was rejected on the same grounds.[87]

Branch dispensaries

In adopting their tuberculosis schemes, all the aforementioned county councils with the exceptions of Meath and Dublin had projected the establishment of a network of branch tuberculosis dispensaries in poor law premises throughout their respective counties (see Appendix 10). These were to be visited weekly by tuberculosis officers in the more populous areas and fortnightly or monthly in areas of dispersed population.[88]

In Dublin county four locations were identified for branch dispensaries. [89] However when approaches were made, to the Rathdown Board of Guardians, to use the first location, Kingstown dispensary, permission was refused. The refusal was supported by the dispensary doctor who argued that the dispensary was used daily by large numbers of

[82] Ibid., 23 Mar. 1915.
[83] Ibid., 19 May 1915.
[84] Ibid., 22 Nov. 1915.
[85] Ibid., 7 Mar. and 17 Apr. 1916.
[86] Ibid., 14 July 1914.
[87] Ibid., 30 Sept. 1914.
[88] *Forty-second annual report of the LGB.*
[89] Ibid.

patients, 'whose low condition…renders them particularly liable to contamination'.[90] Meath County Council had identified fourteen locations for branch dispensaries. However difficulties similar to Dublin were experienced. Trim Board of Guardians the owner of four of the premises refused to permit their use for tuberculosis purposes.[91] The Oldcastle Board of Guardians owner of two of the premises, similarly refused permission, following arguments advanced by Councillor William Ahern that consumptives would 'expectorate about the place' and 'when this spittle dries up microbes will rise up and have an effect on people who are run down'.[92] The Kells Board of Guardians the owner of three of the premises initially granted permission for their use in March 1913.[93] However following objections from their medical officer of health, who reported that his colleague in Deptford Borough Council had 'often analysed the dust and air taken from such places and inevitably found [...] them most heavily germ-laden […] the greater portion of the germs are those of tuberculosis [...] this means that any person in a poor state of health might contract consumption', the consent was withdrawn.[94] Attempts by Wicklow County Council to use the Bray poor law dispensary as a tuberculosis dispensary were thwarted by the Rathdown Board of Guardians, when they refused consent to use the premises in the manner proposed or any other dispensary under their jurisdiction.[95] These instances provided evidence, whereby the fears engendered by the disease, often supported by medical advice, caused political difficulties in attempting to locate treatment facilities.

In June 1914, while a permanent central dispensary was under construction at the Meath Hospital, Dublin County Council secured the use of an adjoining building as a temporary tuberculosis dispensary. In addition two small wards in the hospital were provided for the detention of patients while under observation.[96] Many of the other schemes for the provision of central dispensaries were ready to commence building operations by July 1914. However the outbreak of war and the consequent rapid rise in the cost of building materials and general financial pressures impeded progress. Nevertheless work on central dispensaries in counties Dublin and Kilkenny was completed by March 1915.[97] Because of the necessity 'of restricting the employment of labour and materials' to uses required

[90] *Irish Times*, 22 Oct 1914.
[91] *Meath Chronicle*, 22 Mar. and 3 May 1913.
[92] Ibid., 19 Apr. 1913.
[93] Ibid., 17 May 1913.
[94] Ibid., 24 May 1913 and 14 June 1913.
[95] *BMJ*, *ii*, no. 2693 (1912), p. 335.
[96] *Irish Times*, 23 June 1914.
[97] *Forty-third annual report of the LGB.*

to meet 'the urgent and overwhelming demands of the […] war upon all the resources of the country' the treasury in 1915 decided to temporarily suspend payments from the sanitorium grant in respect of the provision of dispensaries. However the restriction did not apply to proposals where construction contracts had already been entered into. Thus work proceeded, albeit rather slowly because of the 'abnormal cost of building material', on central dispensaries for Carlow, King's County and Louth. The dispensaries at Carlow, Tullamore and Dundalk opened in 1915-16. [98]

Institutions

Pursuant to the insurance act prior LGB approval was required for institutions where it was proposed to treat tubercular recipients of sanatorium benefit. To secure approval institutions had to keep proper records of all patients treated and be open to inspection by board staff at any time.[99] In the year to 31 March 1914 twenty-eight institutions in Leinster were approved, with a further seven the following year and six additional institutions during the period 1914 to 1920 (see appendix 11). Of these only seven, the local authority run sanatoria at Dublin (two), Kilkenny and Tullamore and the private sanatoria at Newcastle, Peamount and Larch Hill were approved for the treatment of pulmonary tuberculosis in its early or 'curable' stages. The majority were approved for the treatment of surgical and other forms of what was considered to be non-infectious tuberculosis. These comprised one Wicklow and eighteen Dublin voluntary hospitals, the three Dublin hospitals established in conjunction with the House of Industry and nine county infirmaries. The latter was in line with the policy being pursued by the LGB, which had circularised local authorities advocating the use of county infirmaries for the treatment of surgical tuberculosis.[100] The remaining institutions were approved for the treatment of advanced cases of pulmonary tuberculosis, those considered to be in the terminal stages of the disease. These institutions were in effect hospices for the dying.

[98] *Forty-fourth annual report of the LGB; Forty-fifth annual report of the LGB; Irish Independent*, 25 January 1916. Although the LGB, in listing the central dispensaries provided and in the course of completion in March 1917, makes no mention of Carlow, in the 1916 annual report it refers to the payment of an instalment, from the sanatorium grant in respect of the central dispensary at Monacurragh. As no further payments in respect of this project are recorded it may be assumed that restoration works were completed in 1915-16.
[99] *Forty-first annual report of the LGB.*
[100] Circular 4/M 1913 – Miscellaneous. 17 Jan. 1913. Treatment of tuberculosis in *Forty-first annual report of the LGB.*

Our Lady's Hospice for the Dying

In the early 1800s, Daniel Murray, the coadjutor archbishop of Dublin, conceived a project to form an order of nuns who would emulate the French Sisters of Charity by visiting the sick and poor in their own homes. He recruited Mary Aikenhead the daughter of a Cork doctor to establish the order, arranging for her to enter the Micklegate Bar Convent in York as a novice in 1812. Having completed her novitiate she returned to Dublin in 1815 and took over the existing orphanage in North William Street founding the Religious Sisters of Charity to run the establishment.[101] From the early days of the new congregation the nuns undertook visitations to the sick. In 1819 as their second foundation they assumed control of the Stanhope Street refuge from whence they undertook visitations to the Charitable Hospital in Jervis Street.[102]

In 1832, during the Asiatic cholera epidemic in Dublin, members of the congregation nursed patients in the temporary cholera hospital, which had been established in Grangegorman.[103] They also provided nursing services to the poor cholera sufferers 'in their wretched hovels at Ringsend and Ballsbridge' (both on the outskirts of Dublin).[104] These experiences brought home to Aikenhead the realisation that 'the only way in which proper assistance could be given to the sick poor was by the provision of a properly equipped and properly staffed hospital'.[105] In 1833 she bought the Earl of Meath's house located on St Stephen's Green, Dublin, for the sum of £3,000 using the dowry of one of her novices to fund the purchase. She dispatched three of her nuns to the Hospital of Notre Dame de la Pitie in Paris to train in hospital nursing and management. Upon their return, St Vincent's hospital opened for the reception of patients in January 1834. It was the first hospital founded, administered and staffed by women in the United Kingdom.[106]

Our Lady's Hospice for the Dying opened in December 1879, under the auspices of the Religious Sisters of Charity, to cater for 'those on whom the hand of death was

[101] Moira Lysaght, 'Daniel Murray, Archbishop of Dublin, 1823-1852' in *Dublin Historical Record,* vol. 27, no. 3 (1974), pp 101-8.
[102] Beatrice Bayley Butler and Katherine Butler, 'Mrs John O'Brien, her life, her work, her friends' in *Dublin Historical Record,* vol. 33, no. 4 (1980), pp 141-56.
[103] Timothy P. O'Neill, 'Fever and public health in pre-famine Ireland' in *The Journal of the Royal Society of Antiquaries of Ireland,* ciii (1973), pp 1-34.
[104] Eibhlín De Buitléir, 'Mary Aikenhead. Foundress of the Irish Sisters of Charity (continued)' in *The Irish Monthly,* vol. 53, no. 622 (1925), pp 188-192.
[105] Ibid.
[106] Lysaght, 'Daniel Murray'. Hylda J. Beckett, 'St Vincent's Hospital, Dublin 1834-1984 in *Dublin Historical Record,* vol. 37 no. 3/4 (1984), pp 137-43.

manifestly laid and who, for that very reason, were not, strictly speaking, admissible into the existing hospitals'. The institution though Catholic in its ethos was 'open to all religious denominations and to all classes' with a guarantee from the nuns that 'non-Catholic patients shall not be at all interfered with'.[107] The thirty-five bed hospice was located in the former nun's novitiate. It was adapted and outfitted, with the aid of bequests from two wealthy Dublin families, to provide an alternative to a 'deathbed' in the poorhouse infirmary or tenement. During its first three months of operation the hospice received forty patients, nineteen of whom died. Nursing care was provided by members of the congregation with daily visits paid by a Catholic priest and a visiting physician.[108] By the time the now forty-two bed hospital was two years in operation it had treated 275 patients. 'Nearly all' deaths were caused by pulmonary consumption.[109] Most patients had died 'very fast' having only entered the hospice 'when hope was at an end'.[110]

Not all the patients were paupers reliant solely on charity. To raise finances, the nuns had adapted part of the premises as private rooms for paying patients.[111] Other methods of fundraising included charity sermons and charity concerts.[112] Such was the demand for hospice places that by September 1884 applications for admission were refused.[113] To address this situation various fund raising drives were organised culminating in the laying of a foundation stone for a new extension in July 1886. As was usual on such occasions a subscription list was opened to fund the works resulting in the raising of £1,145 on the day.[114] The new two-storey extension, which increased the capacity of the hospice to 110 beds contained eight large wards, four smaller wards, twelve private rooms, patient sitting rooms, staff accommodation and separate catering facilities. Archbishop Walsh, the Catholic Archbishop of Dublin, performed the opening ceremony in August 1888. It had cost almost £21,000 to provide, £12,000 of which had been subscribed, leaving the sisters facing a debt of over £8,000 to be met in addition to

[107] *Freeman's Journal*, 23 Dec.1879 and 19 June 1880.
[108] Sarah Atkinson, 'Hospice for the dying' in *The Irish Monthly*, viii, no. 82 (1880), pp 200-205; Rosa Mulholland Gilbert, 'A servant of the dying' in *The Irish Monthly*, *xx*vii, no. 311 (1899), pp 252-4; *Freeman's Journal*, 6 August 1888.
[109] Sydney Starr, 'Christmas in the hospice' in *The Irish Monthly*, x, no. 104 (1882), pp 105-111; *Freeman's Journal*, 23 Dec. 1881 and 6 Aug. 1888.
[110] Rosa Mulholland, 'Our Lady's hospice for the dying' in *The Irish Monthly*, xxiii, no. 269 (1895), pp 585-589.
[111] Starr, 'Christmas in the hospice'.
[112] *Freeman's Journal*, 11 Aug. 1880, 25 Mar. and 7 Apr. 1881.
[113] Katherine Butler, 'Our Lady's Hospice, Harold's Cross' in *Dublin Historical Record*, xxxiv, no 4 (1981) pp 122-135.
[114] *Freeman's Journal*, 19 and 20 July 1886.

increased annual running costs, which amounted to £2,500 per annum.[115] In 1882, Dublin Corporation provided assistance in the form of a grant of £160 from its annual vote for hospitals.[116] Over the years this sum was gradually increased rising to £175 in 1883, £200 in 1884, £250 in 1886, £350 in 1890 and £400 in 1891 reflecting the increased political awareness of the importance of the role played by the hospice for the Dublin poor.[117]

Rest for the Dying

In 1904 Colonel Frederick Charles Trench-Gascoigne gifted a sum of £5,000 to Rev. Joseph Peacocke, the Protestant Archbishop of Dublin, to be used for charitable Church of Ireland purposes in Dublin. The Archbishop summoned a meeting at which Canon Gilbert Mahaffy argued that it was necessary to 'reflect upon the benefits conferred upon the Catholic poor by the hospice at Harold's Cross' and follow its example. It was decided to use the funds, to

> 'provide for the Protestant poor a means by which, when their end on earth is near they can be removed from uncomfortable and uncongenial surroundings to a quite and well ordered resting place, where they will be tended with medical skill and careful nursing during their few remaining days; and where they can receive, undisturbed, spiritual help and consolation from their accustomed guides in spiritual matters'.[118]

A church owned premises at Camden Row was acquired and the twenty-four bed Rest for the Dying opened there in June 1904.[119] Canon Mahaffy rector of the local St. Peter's church was appointed honorary chaplain.[120]

The institution relied entirely on philanthropy for its funding. Addressing the annual meeting, in February 1906, Archbishop Peacocke stated that 'as a young institution…it had not yet received the sympathy and support of the general public, which he was sure it would receive when it was better known and its operations were more widely extended'. Fifty-four patients had been admitted during 1905 adding to the four in the institution at the beginning of the year. Of this number forty-one had died and eight were discharged leaving nine beds occupied at the end of the year. Running costs for the year amounted to over £500. As subscriptions providing only £301 the remainder was funded from the

[115] Ibid., 19 July and 2 Oct. 1886, 17 Nov. 1887 and 6 Aug. 1888.
[116] Ibid., 24 Oct 1882.
[117] Ibid., 27 Oct 1883, 23 Oct. 1884, 26 Oct 1886, 22 Oct. 1890 and 24 Oct. 1891.
[118] *Irish Times*, 21 Nov. 1904 and 2 Mar. 1929.
[119] *BMJ*, i, no. 2268 (1904), p. 1457; *Irish Times*, 23 Feb. 1910.
[120] *Irish Times*, 28 Feb. 1914.

unexpended balance of subscriptions raised to equip the premises.[121] Matters improved marginally by 1907. That year a total of fifty-two patients were admitted adding to the thirteen in the hospice at the beginning of the year with thirty-seven deaths and twelve discharged, sixteen remained in the hospice at the end of the year. These patients came from thirty-five different Church of Ireland parishes. Six were members of different denominations. The funding gap between donations and expenditure amounted to £112. This was met in part by £40 from a drawing room sale and £30 from an annual endowment of a bed.[122]

Sixty-nine patients were treated in 1908, twenty-nine suffering from tuberculosis. All but six were Church of Ireland members. The clergy of the other denominations 'were always welcome whenever they came to visit any of their own people'.[123] That year the hospice was added to the list of hospitals benefitting under the 'Dublin Hospital Sunday Fund', a fund established in Dublin in 1874 to take up a special collection on a designated Sunday in November from places of divine worship and distribute the proceeds to certain hospitals and convalescent homes.[124] The hospice received £102 from the fund, being one of sixteen institutions to benefit from a fund of £3,540, which had been collected in 275 churches.[125] However, as this money did not arrive in time to balance the books, it was necessary to organise a charity lantern show and concert, which produced £19.[126] Financial matters improved during 1909 with a credit balance of £19 showing at year's end. The number of patients continued to increase with seventy-three being treated including members of the Presbyterian, Methodist and Moravian churches.[127] In 1911 the hospital received £500 from the distribution of Lord Iveagh's gift to the King.[128] This left the finances in a 'satisfactory state'.[129] By 1914 the hospice's finances had reached a state of equilibrium despite a slight falling off in donations owing to the war. That year seventy-two patients underwent treatment with 'as usual tubercular cases by far the most numerous'.[130]

[121] Ibid., 28 Feb. 1906.
[122] Ibid., 26 Feb. 1908.
[123] Ibid., 15 Feb. 1909.
[124] *BMJ*, i, no. 961(1879), p. 839; *Irish Times*, 8 Dec. 1908.
[125] *Irish Times*, 10 and 20 Mar. 1909.
[126] Ibid., 18 and 19 Jan. and 11 Feb. 1909.
[127] Ibid., 23 Feb. 1910.
[128] In July 1911 Lord Iveagh to commemorate the King's visit to Ireland presented the King with a gift of £50,000 for the benefit of the hospitals of Dublin and the RNHCI at Newcastle.
[129] *Irish Times*, 1 Mar. 1912.
[130] Ibid., 26 Feb. 1915.

Our Lady of Lourdes Hospital, Dun Laoghaire

In 1827 Catherine McAuley, a wealthy Dublin heiress, founded a house for destitute women of good character, orphans and scholars. She was assisted in this endeavour by a number of women who formed a pious association of ladies. In November 1828 Daniel Murray, the Archbishop of Dublin, granted approval to these ladies to visit the sick and poor in their own homes. Through McAuley's influence with the head physicians in Dublin hospitals, with whom she was well acquainted in a social capacity, she received permission for her association to visit sick hospital patients. Initially such visits were to provide spiritual comfort to catholics from members of their own community and prevent proselytising. Several members of the association were professed as nuns in 1830 and the sisters were formally approved as an order of nuns 'The Sisters of Mercy' in March 1835.[131] The order was to be 'exclusively devoted to the care of the poor' with the fourth vow taken by sisters requiring them to devote 'their lives to the service of the sick and poor'.[132] One of McAuley's requirements for potential members was that they must have 'a particular interest for the sick and dying'.[133]

In following their rule of care for the sick, McAuley and her fellow sisters took up residence in the cholera hospital in Townsend Street, Dublin, to provide nursing services during the outbreak of Asiatic cholera in 1832. Similar services were provided to the patients in Barrington's and St John's hospitals in Limerick during the cholera outbreaks of 1849 and 1854. In 1854, one of Dublin's major hospitals, the Charitable Hospital in Jervis Street was placed under the care of the sisters.[134] The order opened the newly converted forty-bed Mercy Hospital in Cork in April 1857.[135] Work commenced on the 500 bed Mater Misercordiae Hospital in Dublin in 1856, as the sisters were anxious to have a hospital of their own 'in which the spiritual and temporal wants of the poor could be perfectly administered to, believing there to be a great difference between the attendance of hired persons and those who devote themselves to the sick for the love of god'.[136] In laying the foundation stone Archbishop Paul Cullen of Dublin stated that under the ministrations of the sisters patients were

[131] Mother Mary Teresa Austin Carroll, *Leaves from the Annals of the Sisters of Mercy* (3 vols, New York, 1888-9), i, pp 22-27. Mother Mary Teresa Austin Carroll, *Life of Catherine McAuley* (New York, 1871), pp 109-110.
[132] Frances Margaret Taylor (Sr Mary Magdalen), *Religious orders* (London, 1862), p. 305.
[133] Carroll, *Leaves from the Annals*, p. 72.
[134] Ibid., pp 315-25.
[135] Ibid., p. 246. *Freemans Journal*, 7 April 1857.
[136] Carroll, *Leaves from the Annals*, pp 56-7. *Freemans Journal*, 16 Mar. 1856.

> ‘prepared with the greatest care for their passage to eternity and this is a thing to which all catholics should look. Our fate for eternity depends upon the way we are prepared for death and no one can attend better to the sick and inspire them with greater sentiments of confidence in the mercy of god – no one can better prepare them for their passage to eternity than the Sisters of Charity or Mercy’.[137]

The first 100 beds opened to receive patients in September 1861.[138]

In early 1914 Mother Mary Ligouri Keenan, the former superior of the Sisters of Mercy in Dublin, sought the aid of Thomas Clarke[139] to ascertain if a ‘large house and grounds could be purchased at a reasonable price in a convenient locality’, capable of providing ‘a home and heaven of rest for the dying and destitute poor’. Her motivation was the lack of any place in Dublin ‘to shelter the hopelessly incurable cases of tubercular or consumptive disease’, which the existing hospitals and sanatoria refused to admit, leaving them with no alternative but to remain in their ‘stuffy and stifling tenements uncared for to the great danger of everyone coming in contact with them by spreading the disease’.[140] By late February Clarke had identified ‘The Cedars’ at Kill-o-the-Grange, Monkstown, a rundown mansion on ten acres of land with fifty acres of adjoining farmland.[141] The premises were held on a fee farm grant with no restrictive covenants to prevent its use ‘as a public institution for any purpose’. The premises was served with both a public water supply and main drainage, it was within easy walking distance of both Blackrock and Kingstown, locations served with public transport and it was convenient to a cemetery ‘for internment of the numerous persons who must die therein’.[142] Because of its isolated location it was unlikely to pose any ‘danger of infection or contagion to the people of the locality’ and thus attract objections from local residents.[143] It was also within walking distance of St Michael’s a public voluntary hospital in Kingstown which the sisters had operated since 1876.

[137] *Freemans Journal*, 25 Sept. 1855.
[138] *Freemans Journal*, 27 Sept. 1861.
[139] Clarke was a county magistrate and property owner.
[140] Thomas Clarke to Mother Mary Malachy, 6 Feb. 1914 and 24 Nov. 1914 (CSMA D7/11/4/3). Thomas Clarke to R. Ryan 8 Nov. 1914 (CSMA D7/11/4/4).
[141] Clarke to Mother Mary Malachy, 27 Feb. 1914 (CSMA D7/11/4/3).
[142] Clarke to Ryan 8 Nov. 1914. Clarke to Mother Mary Malachy, 27 May 1914 (CSMA D7/11/4/3).
[143] C. J. Nixon to Mother Mary Malachy 2 July 1914 (CSMA D7/11/4/1). Clarke to Ryan 8 Nov. 1914.

On the instructions of Mother Mary Malachy Mulhern[144], who had assumed control of the project from Mother Ligouri, Clarke negotiated the purchase of the premises and farmland for £2,375.[145] He also agreed terms for the purchase of the head title bringing the total purchase price to £2,900.[146] Clarke encouraged Mother Malachy to proceed with the project explaining that he had recently been co-opted as a member of the county council and the county insurance committee and in his new role would be in a position to 'look after the interests of the new undertaking […] and have as many patients as you could accommodate sent there at a fixed charge', of £1 per patient per week.[147] Having secured the premises Mother Malachy obtained the consent of Archbishop William Walsh to refurbish the premises, funded by borrowings from the internal resources of the community.[148] At the Archbishop's insistence, to ensure complete Catholic control with no outside government interference, the project was to be completed without any government grant aid.[149] The Dublin architects William H. Byrne and Son were appointed to design and oversee the works, which were completed at a total cost of £13,638.[150] To overcome local objections a new entrance from the premises was created onto Cabinteely Road for use by patients, their visitors and for funerals. This entrance was surmounted by a sign stating 'Our Lady of Lourdes Hospital'. An undertaking was given that the word 'consumptive' would not appear. The use of the existing entrance was confined to the nuns, their visitors, doctors and clergymen. The sign at this entrance stated solely 'Sisters of Mercy'.[151]

In January 1918 Clarke lobbied Dr Coey Biggar the medical commissioner at the LGB seeking his assistance in approving the institution for the treatment of tuberculosis.

[144] Mother Mary Malachy Mulhern was appointed as superior of the Sisters of Mercy in Dublin in May 1912.
[145] Clarke to Mother Mary Malachy, 12 June 1914 (CSMA D7/11/4/3).
[146] Draft letter Mother Mary Malachy to Archbishop William Walsh undated *c*. May 1915 (CSMA D7/11/4/6).
[147] Clarke to Mother Mary Malachy, 27 May and 7 July 1914 (CSMA D7/11/4/3).
[148] Draft letter Mother Mary Malachy to Archbishop William Walsh undated *c*. May 1915.
[149] M. J. Curran to Mother Mary Malachy, 23 Nov. 1915 (CSMA D7/11/4/6).
[150] William H. Byrne and Son to Mother Mary Malachy, 20 Sept. 1915 (CSMA D7/11/4/6). The firm had been responsible for completing numerous ecclestiastical commissions in the early twentieth century including new churches at Crosna and Loughlynn, County Roscommon; Greystones, County Wicklow; Ballyhaunis, Toomore, Achill Sound, Laherdane, Cornboy and Straide County Mayo; Suncroft, County Kildare; Ranelagh and Ringsend, County Dublin; Pomeroy, County Tyrone; Summerhill, County Meath; Edenderry, County Offaly and Crossabeg, County Wexford. It was also responsible for convents at Wexford town and Kilmore, County Wexford; Tullow, County Carlow; Greystones, County Wicklow and Foxford, County Mayo, in addition to designing schools and works of extension and repair to buildings owned by church authorities throughout the country. Specifically for the Sisters of Mercy the firm had designed schools at Woodford and Eyrecourt, County Galway; Blackrock, County Dublin and Belturbet, County Cavan, a new convent at Achill Sound, County Mayo and extensive additions to the Mater Misericordiae Hospital, Dublin.
[151] File note, 1 Mar. 1917 probably by A. O'Hagan and Son (CSMA D7/11/4/4).

Biggar greeted the proposal with 'delight and pleasure', expressing 'a fervent wish that each province in Ireland would follow this generous and exalted example and provide similar homes'. Following his meeting with Biggar, Clarke drafted the necessary letters of application for approval.[152] He also sought out Biggar's appointed inspector T. J. Browne briefing him on the application in order to expedite his report. In his role as a member of the insurance committee he secured approval for the sending of 'poor afflicted people' to the hospital.[153] Following approval the four-ward, fifty-two bed hospital opened for the reception of chronic and advanced, pulmonary and surgical tubercular patients on 11 February 1918.[154] It had been provided at no cost to the state.

Workhouse infirmaries

Developed from then 1840s onwards workhouse infirmaries were to play a key role in providing accommodation for the tubercular poor.

In August 1836 George Nicholls an English poor law commissioner, 'well acquainted with the operation of the […] system of poor laws in England' was dispatched to Ireland to 'examine how far it is judicious or practicable to offer relief to whole classes, whether of the sick, the infirm or orphan children'.[155] His recommendation to establish workhouses similar to England to deal with the destitute poor, under the direction of elected boards of guardians, was enacted in the Poor Law Ireland Act 1838.[156] Steps were immediately put in train to establish poor law unions to administer the act. By March 1839, twenty-two such unions were formed. A further eighty-two unions were declared the following year.[157] Progress continued on establishing unions during 1840-41 with the final three unions being formed in May 1841 bringing the total number to 130. Thirty-four of the unions were located in Leinster. Appointed boards of guardians acquired sites and contracted for the erection of workhouses thereon. By March 1841 fourteen workhouses nationally were completed and opened for the relief of the destitute poor, including the North and South Dublin Unions and Balrothery in north County Dublin.[158]

[152] Clarke to Mother Mary Malachy, 25 Jan. 1918 (CSMA D7/11/4/9).
[153] Same to same, 4 and 8 Feb. 1918.
[154] Undated file note (CSMA D7/11/4/4); 'History of NRH' (www.nrh.ie) (14 Feb.2013); *Irish Independent*, 9 Apr. 1918.
[155] *Report of Geo. Nicholls, Esq., to His Majesty's Principal Secretary of State for the Home Department, on Poor Laws, Ireland*, 1 [69], H.C. 1837, li, 201.
[156] An act for the more effective relief of the destitute poor in Ireland (1 & 2 Vic., c. 56 (31 July 1838)).
[157] *Sixth annual report of the Poor Law Commissioners*, 1 [245], H.C. 1840, xvii, 397.
[158] *Seventh annual report of the Poor Law Commissioners, with appendices*, 1 [327], H.C. 1841, xi, 291.

A further fourteen workhouses were provided in Leinster during 1841 with the final seventeen Leinster workhouses completed in 1842.[159]

However as the 1838 act had 'failed to produce the good effect expected from it' the government in early 1843 began to gather information with a view to introducing amending legislation.[160] This process revealed that in some places extensive provision was made for the sick poor, whereas in other places it was 'wholly inadequate'.[161] Amended legislation passed in August 1843 permitted guardians, under the direction of the poor law commissioners, to receive and treat poor persons 'affected with fever or other contagious disease', in either houses rented for such purposes or in such 'portions of the union workhouses as [is] safe and convenient'.[162] Initial approaches by guardians 'to appropriate portions of existing workhouse buildings' for sick persons were met with refusals by the commissioners who exercising 'sound discretion […] could not permit the guardians to incur the great risk of introducing contagion among hundreds of persons predisposed to disease by their previous circumstances'. As an alternative they suggested building out-wards on workhouse sites, 'sufficiently distant from the main building to secure the inmates of the house from any risk of infection'. The commissioners supplied model plans of structures, which could be suitably adapted to individual circumstances.[163] Twelve boards of guardians were provided with plans in 1844 including the Leinster unions of Ardee, Balrothery, Drogheda, Dundalk, Longford and New Ross. [164] In Leinster, by May 1847, eleven unions had provided permanent fever wards ranging in size from 40-70 beds, four unions had permanent structures under construction, plans for permanent wards had been prepared by a further five unions, two unions had constructed temporary accommodation, nine had hired houses accommodating from 26-100 beds and four unions had made arrangements with neighbouring fever hospitals to treat their patients. Of the Leinster unions only the Wexford Board of Guardians had made no provision for the treatment of fever and contagious diseases.[165]

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[159] *Appendices A to C. to the tenth annual report of the Poor Law Commissioners*, 45 [589], H.C. 1844, xix, 57.
[160] The Duke of Wellington , *Hansard 3*(*Lords*), lxvi, c. 192 (London, 1843).
[161] Lord Eliot, *Hansard 3* (*Commons*), lxvii, c. 1377 (London, 1843).
[162] An act for the further amendment of an act for the more effective relief of the destitute poor in Ireland (6 & 7 Vic., c. 92 (24 Aug. 1843)).
[163] The plans were prepared by the architect George Wilkinson.
[164] *Tenth annual report of the Poor Law Commissioners, with appendices*, 1 [560], H.C. 1844, xix, 9.
[165] *Appendices to the thirteenth annual report of the Poor Law Commissioners*, 31 [873], H.C. 1847, xxviii, 35.

In 1852 the Irish poor law commissioners reported that the workhouses were 'assuming the character of hospitals for the reception of destitute sick persons, whether suffering from sudden and acute sickness, chronic infirmity or contagious disease'.[166] Returns for the period 1884-1900 show that most deaths occurred at home with only 15-17% occurring in institutions where patients were being treated. Of these institutions, workhouses played the most important role with between 70% and 78% of institutional deaths during that period occurring in them. From 1901 to 1920 the percentage of deaths occurring in institutions rose from 18% to an average of 22%. Workhouses continued to account for most institutional deaths although declining somewhat in importance. They treated 71% of those dying in institutions at the beginning of the century reducing to 60% in 1920 (see appendices 6.4 and 6.5).

In 1861, nuns from the Sisters of Mercy were engaged as nurses by the Limerick Board of Guardians in the Limerick workhouse. They were the first Catholic nuns to be so engaged in the country.[167] By 1873 eight workhouses nationally had engaged a total of thirty-three nuns from the Sisters of Mercy and St. John of God[168] orders. Wexford, the only Leinster workhouse to engage nuns, had employed two members of the local St John of God Order.[169] By 1903 thirty-one of the workhouses located in Leinster were employing a total of 141 nuns in a nursing capacity.[170] Clear has shown how after 1865 nuns had become increasingly involved in hospital nursing with ten per cent of Irish convents being attached to hospitals by 1882 increasing to 22.4 per cent by 1900.[171]

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[166] *Sixth annual report of the Commissioners for Administering the Laws for Relief of the Poor in Ireland: with appendices*, 1 [1645], H.C. 1852-3, l, 159.

[167] Matthew Potter, *The municipal revolution in Ireland* (Dublin, 2011), p. 149.

[168] In response to an invitation from Bishop Thomas Furlong of Ferns, Bridget Clancy (Sr Visitation a Bon Secours sister) founded the St John of God sisters, in October 1871, in Wexford 'to minister to the sick and destitute people of his diocese'. Amongst the first sisters were several who had trained as nurses with the Sisters of Bon Secours in France. The sisters commenced nursing duties in Wexford workhouse in 1873 being employed in a similar capacity in Enniscorthy, New Ross (both County Wexford) and Castlecomer (County Kilkenny) workhouses in 1875. Information accessed from 'Congregation of the Sisters of St John of God founding story' (http://www.ssjg.org) (9 Feb. 2015) and 'Sister of St. John of God' (http://www.evangeliseaustralia.com) (9 Feb. 2015).

[169] *Workhouses (Ireland) (nurses). Returns of the number and names of all workhouses in Ireland in which nuns are engaged as nurses; of the number of such nuns in each workhouse so engaged, specifying whether they are resident or non-resident, and if paid or gratuitous nurses, and the sums paid; and, of the names of the religious orders to which such nuns severally belong*, p. 1, H.C. 1873 (246), lv, 865.

[170] *Workhouse infirmaries (Ireland). (Nuns employed). Return to an order of the Honourable the House of Commons, dated 2nd April, 1903;--for a return showing the number of workhouse infirmaries in Ireland in which nuns are employed in any capacity, showing for each infirmary the number of nuns so employed, and the amount paid to them by way of salaries within the last financial year*, p.1, H.C. 1903 (115), lix, 506.

[171] Caitriona Clear, *Nuns in nineteenth century Ireland* (Dublin, 1987), p. 107.

Amongst the chronic infirm were many poor tuberculosis sufferers for whom the workhouse infirmaries were their last refuge. From the mid 1850s to 1910 between 16% and 22% of workhouse deaths were attributable to tuberculosis. From 1911 the number of tuberculosis deaths in workhouses declined, accounting for only 13% of total workhouse deaths in 1919-20. (See appendix 14). The decreasing numbers dying from tuberculosis in workhouses from 1911 to 1920 is in line with the national trend in the decline in mortality from the disease over the same period (see appendix 15). As Leinster workhouse infirmaries accounted for between 33% and 35% of the national workhouse deaths in the period 1899-1908 (see appendix 16), a rate which is likely to have persisted, based on national population figures, it is clear that they played a significant role in the treatment of the poor in the terminal stages of the disease .[172]

In 1901 the LGB wrote to all boards of guardians urging them, 'having regard to the infectious nature of consumption…to make proper provision in each workhouse hospital for the separate treatment of cases of consumption' by housing them in wards to which other patients would not be admitted.[173] The urgings appeared successful, as over the period 1901 to 1906 the numbers of tuberculosis patients dying in workhouses showed an increase in both percentage and absolute terms (see chart appendix 14). The LGB's 1906 contention, that 'patients suffering from consumption in the latter stages, to a larger extent than formerly, avail themselves of treatment in the infirmaries', was borne out by statistical evidence that the numbers of consumptives dying in workhouses in absolute terms, over the period 1904-1910, continued to increase at a time when mortality nationally from the disease was decreasing (see appendix 12).

However in 1906, despite several boards of guardians making such provision as 'the structure of their buildings would permit', the LGB found it difficult to induce some guardians 'to believe that consumption is infectious and preventable'. The board observed that very few workhouse infirmaries had made adaptations that 'would encourage patients to seek admission with a hope of being cured'. It pointed out the necessity of isolating patients with advanced tuberculosis and not permitting them to

[172] The national population figures published in the 1901 and 1911 censuses of Ireland and in the 1926 census of Saoratat Eireann and Northern Ireland show that the relative distribution of population in Leinster in percentage terms did not vary greatly, being 26% of the total population in 1901, 28% in 1911 and 27% in 1926.

[173] LGB circular no. 66,306:1900- miscellaneous 10 Jan. 1901 in *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1901, being the twenty-ninth report under the Local Government Board (Ireland) Act 1872, 35 & 36 Vic., c. 69*, 1 [Cd 1259], H.C. 1902, xxxvii, 1; LGB circular no. 127 M-miscellaneous tuberculosis 16 Sept 1901 in *Thirtieth annual report of the LGB.*

remain in 'crowded homes where suitable precautions cannot be carried out'.[174] The following year the LGB found that guardians were beginning to recognise more fully 'the nature of the disease' and were displaying 'a greater willingness to make provision for the care of patients suffering from it', however a problem persisted, outside the major urban centres, amongst poor sufferers living in overcrowded conditions who were exhibiting 'great reluctance' to enter union infirmaries.[175]

In 1909 Dr Coey Biggar[176] found that many boards of guardians had provided two small tuberculosis isolation wards. However patients accommodated therein considered the arrangements 'less agreeable' than those provided for patients in the larger general wards. As a result many consumptive patients were driven from the infirmaries and others refused to enter. By drawing comparison with the South Dublin workhouse infirmary, where active treatment was pursued in customised accommodation and the Abbey Sanatorium in Belfast, he concluded that it was 'characteristic of the disease that patients, even those in an advanced stage, are not without hope of recovery and they will readily enter an institution, where the arrangements are such as to increase their hope, whereas they will not voluntarily enter merely for the sake of being isolated'.[177] The following year Coey Biggar observed that the large majority of boards of guardians had made provision for the isolation of tubercular patients. He again cited the South Dublin Union workhouse, where a large number of patients were accommodated in ordinary wards awaiting transfer to the isolation tuberculosis units, as evidence of the eagerness of patients to enter workhouses, whenever proper provision for their treatment was made.[178] By mid 1910, ninety-one unions had either provided or set apart wards, exclusively for tuberculosis patients, while a further six unions had allocated wards for that purpose but due to pressure on space could not guarantee their exclusive use. In total over 1,500 bed spaces were made available. Of the remaining sixty-one unions, eight had proposals under active consideration.[179]

[174] *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1906, being the thirty-fourth report under the Local Government Board (Ireland) Act, 1872, 35 & 36 Vic., c. 69, 1* [Cd 3102], H.C. 1906, xxxvi, 495. (Henceforth *Thirty-fourth Annual report of the LGB*).
[175] *Thirty-fifth annual report of the Local Government Board*.
[176] Dr E. Coey Biggar was a medical inspector in the LGB.
[177] *Thirty-seventh annual report of the LGB.*
[178] *Thirty-eighth annual report of the LGB.*
[179] 'Provision of separate accommodation for tuberculosis patients in workhouse hospitals in Ireland' in *Sláinte*, ii, no. 21 (1910).

Following the passing of the 1911 National Insurance Act, certain boards of guardians formed the opinion that the act relieved them of any obligation to treat persons covered by its provisions. However the LGB quickly informed them that their responsibilities regarding the treatment of destitute persons remained unaltered and that the statute specifically precluded guardians refusing admission to workhouse infirmaries on the grounds that persons were covered by the act. Another financial drawback was that sickness benefit, payable to persons being treated in voluntary hospitals, was not payable to inmates of workhouse infirmaries. In addition poor law authorities were forbidden from entering into agreements with insurance committees for the provision of treatment for tuberculosis cases, thus even when treating insured persons they did not derive any of the financial benefits which accrued to other institutions providing such treatment.[180]

South Dublin Union Infirmary and the House of Industry

Cited in 1909 by the LGB's medical inspector Dr Coey Biggar as a model example of the proper provision for poor tuberculosis sufferers the South Dublin Union infirmary was initially developed in the early 1700s as a hospital for the poor and vagrants.

On 12 Oct 1704 the foundation stone was laid for a hospital on a fourteen acre site at James Street, Dublin, south of the river Liffey. The site had been granted by the city to found a hospital 'to supply maintenance and comfort to the aged and infirm; to compel the idle and lazy vagrant, by labour and industry, to contribute to his own support; and to free the city from the number of loathsome objects that everywhere infested the streets'. In 1730 the functions of the hospital were expanded by legislation to become an asylum for children of all ages and creeds, hence its assumed name of Foundling Hospital and Workhouse of the City of Dublin. In 1771 an act of Parliament was passed providing for the establishment of a House of Industry to relieve the adult poor. Premises were erected in Channel Row, north of the Liffey. [181] In 1774 two wards were allocated in the premises for medical and surgical patients.[182] This institution was augmented by the construction of three associated hospitals in the early nineteenth century, the Hardwicke Fever Hospital in 1803, the Richmond Surgical Hospital in 1810 and the Whitworth Chronic Hospital in 1817.[183] As the adult residents were moved to the new premises from

[180] LGB circular no. 11268/1913- miscellaneous. 12 Mar. 1913 in *Forty-first annual report of the LGB.*
[181] J. Warburton, J. Whitelaw and Robert Walsh, *History of the city of Dublin* (2 vols, London, 1818), i, pp 578-94, 618-20.
[182] *Freeman's Journal*, 30 Oct. 1885.
[183] Eoin O'Brien, Lorna Browne and Kevin O'Malley, *The House of Industry hospitals 1772-1987, a closing memoir* (Dublin, 1988), p. 292.

the Foundling Hospital children became its main focus, so that the hospital became 'one of the most gigantic baby finding, "baby farming, nursing, boarding out" and apprenticing institutions these countries ever saw'.[184] A three-storey twelve ward infirmary block with accommodation for 144 patients was added in 1810. By 1818, 1,011 children were accommodated in the institution with in excess of 5,000 others boarded out in various parts of Leinster.[185]

When following the passing of the Poor Relief (Ireland) Act 1838, the country was divided into poor law unions, Dublin because of its size required two unions and with the river Liffey forming a natural boundary, the North and South Dublin Unions were established, for the respective areas north and south of the river.[186] When these unions came into being on 10 June 1839 they assumed responsibility for the premises of the Foundling Hospital and the House of Industry, converting both to use as workhouses under the Act, admitting their first paupers under the new provisions on 24 April 1840 (South) and 4 May 1840 (North).[187]

By 1895 the South Dublin Union 'was regarded by the authorities as somewhat of a model for the other unions'. It accommodated over 3,000 inmates. The infirm and sick were treated in the sick department, which was divided into separate Catholic, Protestant and children's hospitals. Over 1,000 patients were packed into overcrowded wards under the supervision of a resident medical officer who was assisted by three visiting physicians, one for each hospital. Thirteen nuns, 'untrained as nurses', from the Sisters of Mercy congregation, provided nursing services for the Catholic and children's hospitals.[188] A special commission of *The British Medical Journal* while admiring the devotion of the nuns to their work, the care with which they ministered to their patients and the order and system they introduced to the wards, nevertheless found that 'their work was just lacking in that attention to details of nursing, which can only be learnt in a hospital'. Nursing for the Protestant hospital was provided by five deaconesses, some of whom had been trained in Tottenham Hospital, London. Assistance in nursing the

[184] William Dudley Wodsworth (ed.), *A brief history of the ancient foundling hospital of Dublin from the year 1702* (Dublin, 1876), p. 1.
[185] Warburton *et al. History of the city of Dublin*, i, pp 578-94.
[186] Helen Burke, *The people and the poor law in 19th century Ireland* (Littlehampton, 1987), p. 51.
[187] *Poor Law (Ireland). Returns of the date of the formation of each union in Ireland, and of unions in which the provisions of the act 6 & 7 Vict. c 92, have been acted on, in respect of fever patients*, p. 1, H.C. 1845 (467), xxxviii, 199.
[188] The Sisters of Mercy had commenced duty in the workhouse in June 1881 when ten members of the congregation were installed as nurses. Carroll, *Leaves from the Annals*, p. 46.

patients was provided by deputies drawn from the ranks of the workhouse inmates. They received extra rations and privileges in return for their labour.

The patients were divided into medical, surgical and phthisical, with the latter being housed in special wards maintained at a higher temperature than other wards. These wards contained several patients, whose disease was at an advanced stage.[189] Following LGB instructions, issued in January 1901, in 1904 the union converted some disused isolated one-storey pavilions into accommodation for sixty female consumptive patients. The pavilions were relatively new buildings having being constructed in 1886 at a cost of £1,200. The pavilions were surrounded by open space, which facilitated the patients in taking exercise. They contained their own separate cooking and laundry facilities. In October 1905 the seventy-two male consumptives accommodated in the infirmary were transferred to an isolated new two-storey building, with an enclosed exercise yard.[190] In 1907 two new isolation blocks were erected to cater for twenty-four female consumptives, costing just over £300. One of these blocks was dedicated to children.[191]

Domiciliary treatment

During the parliamentary debates on the 1911 national insurance bill several doctors averted to the shortcomings of reliance on treatment in sanatoria as the sole method of combating tuberculosis. Dr Christopher Addison pointed out the need for timely intervention, during the three to six months period, between diagnosis and sanatorium admission. He advocated treatment in 'shelters of cheap construction' in this intervening period, which method had proved successful throughout Britain.[192] Dr William Chapple recommended replicating the sanatorium environment of fresh air, ventilation and proper sanitary conditions in every infected home.[193] Dr John Esmonde found from his own experience that many doctors did not see cases until they had advanced to a stage 'at which it is utterly impossible to effect a cure' and even in a great many early cases it was 'almost impossible […] to get them to leave their homes'. He suggested the use of small

[189] Special commission of the British Medical Journal, 'Reports on the nursing and administration of Irish workhouses and infirmaries. South Dublin Union.' in *BMJ*, ii, 1813 (1895), pp 795-7.
[190] *Thirty-fourth Annual report of the LGB;* 'The construction of cheap sanatoria for working class consumptives' in The Countess of Aberdeen (ed.), *Ireland's crusade against tuberculosis* (3 vols, Dublin, 1908), ii, pp 119-22.
[191] *Thirty-sixth annual report of the LGB;* 'The construction of cheap sanatoria for working class consumptives'.
[192] Dr Christopher Addison, *Hansard 5* (*Commons*), xxviii, cc 398-9 (London, 1911). Addison was the MP for Shoreditch.
[193] Dr William Chapple, *Hansard 5* (*Commons*), xxviii, cc 435-7 (London, 1911). Chapple was the MP for Stirlingshire.

transportable huts or pavilions. In these the consumptive could sleep at night and live during the daytime and thus 'not be the focus of contagion the whole time to the family with whom he lives'. He considered that such facilities would allow certain consumptives continue working while undergoing treatment. However if they were provided he felt that 'if necessary, some compulsion should be exercised in making them use such places'.[194] Lloyd George considered the warnings 'not to trust exclusively to sanatoria' as timely and necessary, as 'sanatoria could not cover all the cases of consumption'. He felt that concentration on sanatoria would lead to neglect of the 'larger percentage of the people' who could not possibly receive sanatoria treatment. He believed that consideration of other methods of special treatment was necessary.[195] Following this debate Reginald McKenna successfully introduced an amendment to the bill providing for arrangements to be made for the treatment of insured consumptives 'otherwise than in sanatoria or other institutions […] in a manner approved by the LGB'.[196] John Whitley explained that the reference to treatment 'not in institutions' was in fact a reference to 'home treatment'.[197]

The manner, in which the Irish LGB implemented the section of the 1911 act dealing with domiciliary treatment of tuberculosis provides an example of the micro-management of health matters by the central authority. The departmental committee on tuberculosis viewed home treatment in suitable conditions 'under the advice of a medical man with special knowledge of modern methods' as in 'all essentials sanatorium treatment'.[198] Considering this view and having regard to the 'wide divergences in circumstances between urban areas and sparsely populated rural districts' the LGB decided to deal with each application for home treatment individually 'according to its merits and circumstances', until such time as 'the tuberculosis officers in each county had obtained experience of the most essential requirements in regard to domiciliary treatment'.

[194] Dr John Esmond, *Hansard 5* (*Commons*), xxviii, cc 443-5 (London, 1911). Esmond was the MP for Tipperary North.
[195] Lloyd George, *Hansard 5* (*Commons*), xxviii, cc 418-425 (London, 1911). Lloyd George was Chancellor of the Exchequer from April 1908 to May 1915.
[196] Reginald McKenna, *Hansard 5* (*Commons*), xxix, cc 532-3, 540 (London, 1911). McKenna, the MP for North Monmouthshire, was First Lord of the Admiralty from April 1908 to October 1911.
[197] John Whitley, *Hansard 5* (*Commons*), xxix, c. 536 (London, 1911). Whitley, the MP for Halifax, was the deputy chairman of the house from 1911 to 1921.
[198] *Interim report of the Departmental Committee on Tuberculosis*.

The LGB notified county councils that in each case they would require the patient's personal details including 'copies of all medical reports received in regard to the case', details of the treatment proposed 'including particulars of the medical attendance and supervision proposed' and details of the number of rooms in the house and occupants thereof. It considered this policy fully justified from the details supplied in applications. It found that in many instances treatment had been proposed 'without any regard to the patient's home surroundings', quoting evidence of overcrowding, insufficiency of isolation facilities and inadequate protection from infection for family members. Appreciating the need for segregation, where 'housing conditions do not admit of separate accommodation for patients', the board advised 'the provision of shelters as part of the equipment of the county tuberculosis dispensary'. Despite the restrictions imposed, by March 1913 the board had approved of domiciliary treatment for cases in the Leinster counties of Louth, Meath, Kilkenny, Queen's County and Wexford.[199] However the restrictions imposed by the LGB prevented the advancement of proposals or solutions for many patients.

With 31 appointed tuberculosis officers having completed their WNHA courses of special training, in November 1913, the LGB provided for domiciliary treatment to be administered locally. Under this regime treatment was provided by a medical attendant under the supervision of the tuberculosis officer, who needed to satisfy himself as to the suitability of the premises for the delivery of treatment. The medical attendant had to provide the tuberculosis officer with periodic reports on the condition of the patient and give the patient 'suitable directions as to his mode of living, diet, rest and exercise' and instructions on preventing the spread of infection. However he was not permitted 'to provide food for the ordinary subsistence of the patient'. If, at any stage, the tuberculosis officer formed the opinion that the place of treatment was unsatisfactory for the purpose, he was to immediately suspend the treatment. Even where he considered that treatment should proceed as a temporary arrangement, he was obliged to report the particulars of the case to the LGB and await instructions.[200] This new provision applied to all Leinster authorities with the exceptions of Meath, which received annual approval of cases from 1913 and Wicklow which had its first case approved for domiciliary treatment in 1919-20.[201]

[199] *Forty-first annual report of the LGB.*
[200] Local Government Board circular no. 48656/1913. miscellaneous. 26 Nov. 1913 in *Forty-second annual report of the LGB.*
[201] *Forty-eighth annual report of the LGB.*

Post sanatoria care of patients

The departmental committee on tuberculosis regarded the provision of after-care, 'so as to ensure that the benefit obtained from institutional treatment should be as permanent as possible', as an essential element in the treatment of tuberculosis. The committee envisaged the after-care being provided by the dispensaries through voluntary care committees formed from representatives of 'the local authorities, boards of guardians, insurance committees and from all charitable and social work organisations in the district'. However it recommended that the after-care should be provided 'with discretion', avoiding publicity, until prejudice against discharged patients occasioned by an 'exaggerated view […] of their infectivity' might be overcome.[202] In this the committee was guided by the Post Office Sanatorium Society which had advised that prospects of employment after discharge were considerably lessened by public knowledge that the patient had been treated in a sanatorium and even where employment had been obtained, the prejudices of co-workers resulted in the former patients being treated as lepers. Such prejudices were reflected even at the highest levels of the medical profession. Sir R. Douglas Powell, an acknowledged expert on consumption and president of the Royal College of Physicians of London from 1905 to 1910, in a letter to the departmental committee warned that 'it should be borne in mind that factory and indoor workers cannot return to their employment without the practical certainty of relapse and the chronic danger to others that such relapses entail'.[203]

Following the passing of the 1911 insurance act the Dublin city and Dublin county insurance committees accepted the offer of the Dublin Samaritan Committee of the WNHA to provide domiciliary treatment to tuberculosis patients. This included the provision of after-care following treatment in order to help 'the patient to maintain the standard of health at which he has arrived by improving his surroundings and the conditions under which he lives'. The committee also found suitable employment for patients in the after-care programme.[204]

Anxious to establish aftercare programmes nationwide and with the approval of the LGB, the WNHA convened a conference 'to consider how county councils and local health

[202] *Interim report of the Departmental Committee on Tuberculosis*.
[203] *Final report of the Departmental Committee on Tuberculosis. Volume II*..
[204] Minutes of meeting of general council of the Women's National Health Association 15 Apr. 1913 in *Sláinte*, v, no. 53(1913), supplement.

authorities and voluntary health workers can best co-operate to make the provisions for treating tuberculosis under the insurance act as effective as possible'. This central health conference, held on 23 May 1912, resolved 'that this conference of local bodies in Ireland recommends the county councils to accept the offer of the WNHA to give professional assistance in the care of tuberculosis patients coming under the Insurance Act'.[205]

In November 1912 a WNHA deputation headed by Lady Aberdeen attended the Irish National Health Insurance Commissioners to 'express the desire of the [...] WNHA [...] to act as or to organise voluntary care committees in conjunction with the tuberculosis dispensaries' and to act in the same capacity to the county insurance committees. Lady Aberdeen explained that many of the branches acting in co-operation with existing local charities had been 'carrying on in a greater or less degree […] the work [...] foreshadowed in the interim report as the function of the care committees' and as the insurance act relieved branches of the responsibility of providing for sanatorium treatment and nursing services, they were 'able to devote themselves […] to the homecare of patients and their families and to the after-care of patients returning from sanatoria and requiring their cure to be made permanent'. However the approach was rebuffed when the commissioners suggested that care committees should be established only under the aegis of the county councils at meetings especially arranged for that purpose by the respective chairmen of the councils.[206]

In December 1912 Lady Aberdeen requested all branches of the WNHA to call on the chairmen of their respective county councils to form voluntary care committees. She offered the services of the WNHA to explain to councils the functions of a care committee.[207] This offer was in response to a statement made by a member of Dublin County Council, Charles O'Neill, at a general meeting of county councils, on 5 December, that they had not sufficient information to decide on the question of care committees.[208] In 1913 the WNHA established a central committee to communicate with local branches, care committees and any individuals undertaking to contact the families

[205] Minutes of central health conference held in Leinster House on 23 and 24 May 1912, pp 20-21 (NAI, Priv/1212/whna/3/8).
[206] Minutes of deputation from the Women's National Health Association to the National Health Insurance Commissioners (Ireland) regarding care committee work and domiciliary treatment, 29 Nov. 1912 in *Sláinte*, iv, no. 47(1912), pp 513-6.
[207] Aberdeen, Ishbel, *Ishbel Aberdeen to all branches of the WNHA, 23 Dec. 1912* in *Sláinte*, iv, no. 47(1912), p. 517.
[208] Minutes of special council meeting of WNHA 5 and 6 Dec. 1912 in *Sláinte*, v, 48(1913), supplement.

of patients in sanatoria, to ensure that no family members were infected with tuberculosis, to assist families during the breadwinner's absence and to prepare for the homecoming of the patient. The central committee arranged for the making of monthly reports to assess the effectiveness of sanatorium treatment and also assisted in finding 'work suitable to the strength of the person'.[209] In order to promote the aims of this central committee a series of posters were circulated extolling the benefits to be derived from engagement with the care committees (Plate 6.3). These posters were prominently displayed at a special exhibit of care committee work under the WNHA, which formed part of the civic exhibition held at the Linenhall Buildings in Dublin in 1914.[210]

The First World War impacted severely on the work of the care committees. It was reported in August 1915 that although it had 'not been lost sight of' it was 'sadly difficult to obtain funds for this work at this time'.[211] Although in the year following the cessation of the war the central care committee, through its local organisations, dealt with 1,000 cases of ex-sanatorium patients and their families, their endeavours were clearly not meeting the needs of patients.[212] To address this situation in October 1918 Lady Aberdeen gifted £25 for the purpose of establishing the Peamount after-care guild. Future funding was obtained by the holding of dances, bridge tournaments and produce sales. The guild assisted patients and their families through what were considered the three stages of treatment. Prior to admission, the guild ensured that the patient had adequate clothing for their projected stay in hospital and that sufficient provision was made for the family in the absence of the breadwinner either through finding work for other family members or through obtaining increased relief from official or voluntary sources. If the prospective patient was the mother of young children, arrangements were made for their care. The guild, where possible, arranged for the medical inspection of all persons living in close contact with the proposed patient. While the patient was in the sanatorium, the second stage, the guild made arrangements for the disinfection of the patient's accommodation and its contents and the remedying of any sanitary defects in the premises or shortcomings in sleeping arrangements and ventilation. Following discharge, the final stage, the guild monitored each patient to ensure that he or she and their family practised the 'habits of health' learnt in the sanitorium regarding fresh air, proper diet, segregated sleeping accommodation, proper sanitation , disinfection and destruction of

[209] WNHA, *Scheme for the after-care of patients sent to Irish sanatoria and for the care of their families* (Dublin, 1913) (NAI, Priv/1212/whna/4/144).
[210] *Sláinte*, v, no. 70 (1914), pp 951-2.
[211] *Sláinte*, i, no. 1 (1915), p. 5.
[212] WNHA, *Objects of the Women's National Health Association* (1919) (NAI, Priv/1212/whna/4/59).

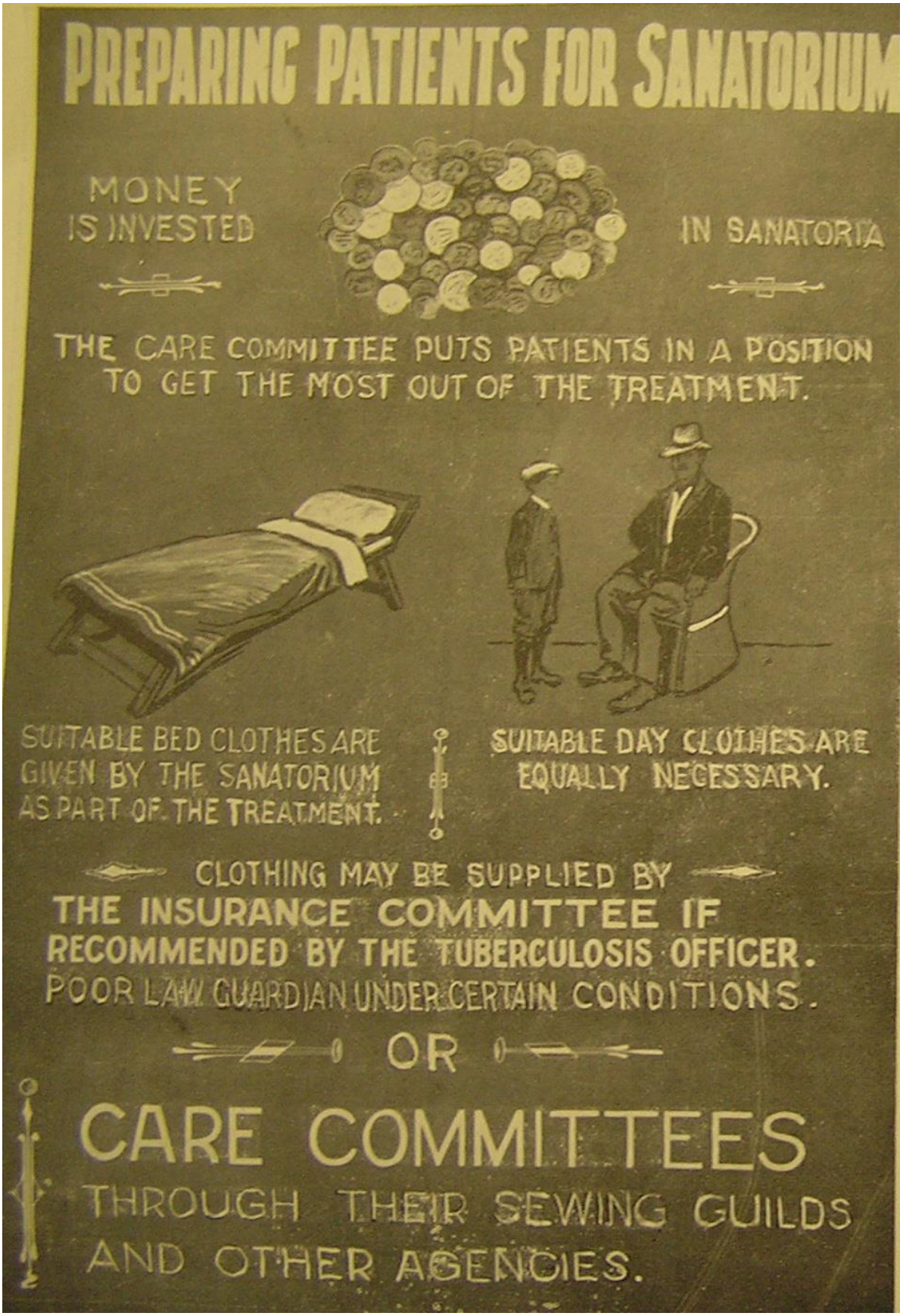

Plate 6.3 One of a series of posters issued by the Women's National Health Association in 1914 to encourage tuberculosis patients to engage with care committees (National Archives of Ireland)

sputum. The guild also sought suitable employment for ex-patients and insisted on regular attendance at the tuberculosis dispensary so that medical supervision might be continued. The provision of such after care was open-ended as all ex-patients of Peamount had access to the guild 'for all time'.[213]

Conclusions

By 1918, largely through the use of existing poor law facilities, a network of tuberculosis dispensaries had been established in Leinster. These dispensaries attempted to meet the needs of the poor tuberculosis sufferers through the provision of domiciliary treatment and the identification of suitable cases for sanatorium treatment. Their function was in many instances facilitated by the workhouse infirmaries whose role in the treatment of tuberculosis patients had been formalised. However the care of patients in the terminal stages of the disease relied on religious philanthropy administered by the Religious Sisters of Charity and the Church of Ireland in their respective hospices for the dying. Despite the efforts of the WNHA no proper system of after care for former sanatorium patients was in place with the exception of the ex-patients of the WNHA's own Peamount sanatorium for whom Lady Aberdeen had initiated an after-care guild.

The regulations of the Sisters of Mercy regarding hospital work stated that 'there are services the sisters should not perform as modesty must never be wounded'.[214] Clear has shown how other congregations engaged in the provision of hospital services had similar dictates. To comply with such rules restrictions were placed on the forms of nursing in which nuns could engage. Regulations prohibited assisting at surgical operations, attending for night-duty, performing any midwifery functions or nursing male patients while unaccompanied.[215] In the Dublin hospitals run by religious orders nurses were engaged by the sisters to perform such duties or secular women were trained by the sisters as ward maids specifically for night –duty. The most intelligent of these ward maids were subsequently trained as nurses. Derogation from the orders' rules was permitted 'in cases of gravity or emergency'.[216] However the provision of services to tubercular patients did not require any derogation from many of the various orders' rules

[213] Peamount after-care guild, *Silver jubilee souvenir book 1918-1943* (Dublin, 1943) (NAI, Priv/1212/whna/4/98): Peamount after-care guild, *Peamount after-care guild 1951-1952* (Dublin, 1952) (NAI, Priv/1212/whna/4/112).
[214] *The customs and minor regulations of the Sisters of Mercy* (Manchester, New Hampshire, 1915), p. 36.
[215] Caitriona Clear, *Nuns in nineteenth century Ireland* (Dublin, 1987), pp 75, 127-8.
[216] *Dublin hospitals commission, report of the committee of enquiry1887, together with minutes of evidence and appendices,* 1 [C 5042], H.C. 1887, xxxv, 1. (Henceforth *Dublin hospitals commission, report*).

pertaining to the institutional nursing of patients. Thus tuberculosis facilities from the orders' perspective provided ideal settings in which to engage nursing sisters.

In 1905 the Limerick priest Michael O'Riordan stated that 'it is the conviction of those who best know that workhouses and hospitals under the care of nuns are best managed as to efficiency and economy'.[217] He demonstrated how poor law guardians gained economic advantages by engaging the services of religious sisters. He cited Limerick workhouse, where thirteen nursing Sisters of Mercy were provide for £200 annually, a sum insufficient to support them. It was necessary to supplement this income from community funds to provide for the nuns daily needs.[218] He related how Newcastle West workhouse engaged two nursing nuns at £30 each per annum but the services of six sisters were provided.[219] Such examples were replicated throughout the country. The Sisters of Mercy in South Dublin Union workhouse were engaged at £30 each per annum without dietary and 'of course that does not pay for their maintenance'.[220] Clear has documented how the nursing nuns gained a 'reputation as good economic managers'.[221] She has demonstrated how this together with the fact that they were inexpensive, often providing free services, was an attraction to financially constrained local authorities.[222] Nuns brought 'to their task a devotion, which it is impossible to hire,' providing an immense gain to discipline and moral tone resulting from their presence'.[223] Such considerations acted as an inducement to the providers of tuberculosis facilities to engage the services of religious orders. In addition the nuns were able to provide patients with religious comfort. The provision of such religious comfort had a positive psychological impact on the patients especially having regard to the all pervasive influences of religion on society in early and mid twentieth century Ireland. This also provided solace to their families, who were attempting to deal with the inevitable consequences of tuberculosis on a family member, by satisfying them that the patient's religious needs were attended to on a daily basis. Without the substantial facilities and the inexpensive services, which religious orders made available, resources for the treatment of tuberculosis would not have been provided to the extent which had been achieved.

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[217] M. O'Riordan, *Catholicity and progress in Ireland* (London, 1905), p. 386.
[218] Ibid, p. 400
[219] Ibid, p. 402.
[220] *Dublin hospitals commission, report.*
[221] Clear, *Nuns in nineteenth century Ireland,* p. 130.
[222] Ibid, pp 130-1.
[223] *Dublin hospitals commission, report,* evidence of Arthur Chance surgeon Jervis Street Hospital..

Chapter 7

Reform and the consolidation of tuberculosis services— Inter war developments 1918-1940

During the first world-war, deaths from tuberculosis in Ireland increased from the relatively low level of 9,089 (2.07 deaths per 1,000), recorded in 1914, to 9,525 (2.20 deaths per 1,000) in 1915, 9,323 (2.14 deaths per 1,000) in 1916, 9,680 (2.21 deaths per 1,000) in 1917 and 9,576 (2.18 deaths per 1,000) in 1918. However from 1919 the downward trend in tuberculosis deaths experienced in the pre-war period was restored, with 8,643 (1.94 deaths per 1,000) recorded in 1919 and 7,651 (1.70 deaths per 1,000) recorded in 1920. Of the latter 2,381 occurred in Leinster (2.05 deaths per 1,000 the highest rate of the four Irish provinces), with Dublin city accounting for 817 (2.57 deaths per 1,000) of these and County Dublin for 522 (2.97 deaths per 1,000).[1]

The period following the first world-war in Ireland was one of political turmoil. This upheaval brought about administrative and legislative reform, which provided opportunities for increasing the provision for tuberculosis sufferers. Throughout the period the different Leinster counties pursued the treatment of tuberculosis differently, some more diligently than others and some hardly at all until forced to do so by their political masters. The further development of the tuberculosis dispensary service helped identify and provide treatment for greater numbers of sufferers.

Political developments

Following the general election in December 1918, the successful Sinn Fein candidates met on 21 January 1919 and formed a national parliament, Dáil Éireann, which ratified the establishment of an Irish republic.[2] Attempts by the British government to suppress this new institution led it into conflict with the former Sinn Fein volunteers, now styling themselves the Irish Republican Army, resulting in the Anglo-Irish war. The results of the local elections in June 1920 saw the nationalists take control of all the major Leinster

[1] *Fifty-seventh detailed annual report of the Registrar-General for Ireland containing a general abstract of the numbers of marriages, births and deaths registered in Ireland during the year 1920*, 1 [Cmd 1532], H.C. 1921, ix, 47.
[2] Dáil Éireann Debate Vol. F, No. 1, 21 Jan. 1919.

and southern Irish local authorities, promptly declaring their allegiance to the new Dáil and refusing to recognise established British government institutions such as the LGB.[3]

Opposition to the British government institutions was heightened in mid-July 1920 when Sir Harmer Greenwood the chief secretary for Ireland introduced into the UK parliament the Criminal Injuries (Ireland) Bill. The bill purported to make any decree for criminal injuries granted in Ireland a debt payable on demand by the treasurer of a county council. Even if rates proved inadequate to meet such expenses, payments could be staggered over five years. Provision was made for deducting from the local taxation account,[4] from funds administered by government departments and parliamentary grants any such debts.[5] Much of this damage had been and would continue to be caused in Ireland by the actions of British troops in, what were considered by the new Dáil to be, 'conditions of war, which the British government had forced on this country by its refusal to acknowledge the right of the Irish people to determine for themselves the form of government under which they would live'. William Cosgrave[6] described the situation thus 'the people of Ireland are not merely to have their throats cut, they are to be charged for the knife'.[7]

The LGB responded to the position being adopted by the local authorities by informing them that 'the government have given the board explicit instructions that no loans or grants from public funds' would be made 'without a definite assurance that they would

[3] *Kildare Observer*, 19 June 1920; *Meath Chronicle*, 26 June 1920.
[4] The Irish local taxation account was established under the Probate Duties (Scotland and Ireland) Act 1888, 51 & 52 Vict., c. 60 (24 Dec. 1888). It was intended to compensate Ireland for the loss in local revenue of taxes collected centrally in London in respect of probate duty, beer and spirit surtaxes and local license duties. It also included exchequer contributions from the consolidated fund in respect of the provision of labourers' cottages and the agricultural grant, which was applied to relieve the poor rate on agricultural land. It was operated by the lord lieutenant to provide additional financial aid in respect of such matters as boards of guardians' salaries, expenditure on roads and bridges, national and intermediate schools, cost of medical staff and medicines for workhouses and dispensaries, sanitary officers' salaries and the maintenance of lunatics. *Royal Commission on Local Taxation. Final report of His Majesty's commissioners appointed to inquire into the subject of local taxation. Ireland*, p. 1, H. C . 1902 (Cd 1068), xxxix, 9.
[5] *Criminal injuries (Ireland). A bill to amend the enactments relative to compensation for criminal injuries in Ireland*, p. 1, H. C. 1920 (166), i, 461. The bill was enacted into law on 23 Dec. 1920 as Criminal Injuries (Ireland) Act 1920, 10 & 11 Geo. 5, c. 66.
[6] Cosgrave the deputy for Carlow-Kilkenny was the Minister for Local Government in the provisional government from April 1919 to September 1922 when he became President of the Dáil. He served as President of the Executive Council (Prime Minister) from September 1923 to March 1932. He represented various constituencies in the Dáil until 1944 when he retired from politics.
[7] L. T. Mac Cosgair (William Cosgrave), *Circular no. 51 Local Government Department Dáil Éireann to each county council, county borough council, corporation, urban council and poor law board, the rates and criminal and malicious injuries claims.* 9 Sept. 1921 (MCCA, MCC 3-2-9/10).

submit their accounts to audit and be prepared to conform to the rules and orders … as heretofore'.[8] If the terms of the circular had been complied with, local authorities 'would in fact have bound themselves to pay away in compensation for war damage the money that was needed to maintain vital public services in the country'[9]. The Dáil reacted to this circular by instructing local authorities to sever all connections with the LGB and function thenceforth under the control and supervision of the new Local Government Department, which it had established.[10]

Dublin Corporation, in following the Dáil instructions, by September 1920 found itself in 'a serious and unprecedented financial position' resulting from the withholding of over £200,000 from the local taxation account, monies intended to finance the various services 'inaugurated solely because of this revenue'. As the annual accounts had been adopted on the assumption that this money would be forthcoming and expenditure had proceeded on that basis, the corporation found it necessary to effect severe economies. Among the decisions taken to economise was one to close Crooksling sanatorium, the Charles Street dispensary and the Allan Ryan Home, Pigeon House Road and have all patients discharged by 30 September as 'it would be impracticable to raise sufficient money by public subscription to maintain the institutions'. The decision to close the Allan Ryan Home was made reluctantly it being acknowledged that the patients were in the advanced stages of the disease and a number were actually dying. The discharge of these patients to their homes where they would not get the care and attention they required and were likely to infect other family members posed 'a very serious risk'. 130 patients in Crooksling and seventy-six in the Allan Ryan home were affected by the decision. All staff in the institutions were served with notice of termination of services. A skeleton staff was retained to maintain the premises. All hospitals treating surgical tuberculosis patients under the corporation's tuberculosis scheme were also informed that the corporation would no longer be in a position to fund their treatment.[11]

[8] *Local Government Board, Dublin, circular No. 122M/Miscellaneous, 1920.* 29 July 1920 (MCCA, MCC 3-2-9/10).
[9] Kevin O'Higgins, Dáil debates, vol. 2, no. 28, 1435, 9 Feb. 1923. O'Higgins the Sinn Féin (pro-treaty) deputy for Leix-Offaly was the Minister for Home Affairs in the provisional government from September 1922 until June 1924 when the title home affairs was changed to justice. He was assassinated in July 1927.
[10] L. T. Mac Cosgair, *Circular no. 51*.
[11] *Report of the tuberculosis committee of management relative to the closing of tuberculosis institutions consequent upon order of the municipal council of 6 Sept. 1920*, 22 Sept. 1920, Dublin Corporation reports 1920, vol. 3, report no. 196, pp 193-208.

Some patients discharged from Crooksling found relief in Newcastle. Due to escalating costs the Royal National Hospital for Consumption for Ireland had incurred bank debts of £4,374 by the end of 1919. Despite selling £4,000 of the institution's 'small invested funds', to help balance the books, by mid summer 1920 the 'financial state of the hospital became so serious' that the board was 'reluctantly obliged to close half the beds'. As a result of this action, when Crooksling closed, the hospital was able to re-open 'a very few' of these beds to deal with particularly urgent cases.[12] In November when the Dublin city insurance committee agreed to contribute £900, half the cost of maintaining Charles Street dispensary for the balance of the financial year, it was agreed to keep that institution open.[13]

Subsequent to the decision to close the institutions the LGB informed the corporation's tuberculosis committee that payment of the tuberculosis grant would be made provided the committee undertook to submit their accounts to audit and conform to the rules and regulations of the LGB. On 8 October the committee agreed to provide the undertaking. A grant of £10,861 was received for the half year ended 30 September 1920. Upon becoming aware of the undertaking the corporation issued instructions to all responsible officers 'not to furnish the books or accounts of the Dublin Corporation to the British Local Government Auditor'.[14] Nevertheless as the grant had been received it was decided to immediately apply it to the re-opening of the Allan Ryan Home especially having regard to the large expenditure that was being incurred in paying the staff retained to maintain the hospital and the necessity of isolating 'at the earliest possible moment as many as can be accommodated of the advanced- and consequently highly infectious- cases of pulmonary tuberculosis'.[15] The hospital was re-opened for the treatment of patients on 13 January 1921.[16] Crooksling did not re-open until 3 June 1921.[17]

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[12] RNHCI, *Report and statement of accounts with list of subscriptions for the year ending 31st December, 1920*, p. 10 (NHA).
[13] *Report of committee of the whole house*, 12 Nov. 1920, Dublin Corporation reports 1920, vol. 3, report no. 244, pp 513-9.
[14] *Report of the tuberculosis committee of management relative to the present position in regard to the treatment of tuberculosis*, 19 Jan. 1921, Dublin Corporation reports 1921, vol. 1, report no. 14, pp 39-44.
[15] *Minutes of monthly meeting of the municipal council of the city of Dublin*, 3 Jan. 1921, minute no. 20, pp 14-5 (DCCA).
[16] *Report of the tuberculosis committee, breviate for the quarter ending 31 March 1921and summary for the three months to 31 Dec. 1920*, Dublin Corporation reports 1921, vol. 1, report no. 112, pp 827-50.
[17] *Report of the tuberculosis committee, breviate for the quarter ending 30 June 1921*, Dublin Corporation reports 1921, vol. 2, report no. 165, pp 229-47.

Faced with a budgetary shortfall of approximately £1.5 million, resulting from the withdrawal of British financial support to local government institutions, in June 1920 the newly-formed Dáil established a commission of inquiry into local government, under the chairmanship of Kevin O'Higgins.[18] The commission's report, delivered to the Dáil that September, laid out the main economies considered necessary to ensure the continued functioning of the newly established Department of Local Government as successor to the LGB. To make an annual saving of £50,000 it recommended the abolition and amalgamation of workhouses.[19] In this it was availing of an opportunity to abolish 'the hideous and costly workhouse system, which has been objected to by everybody who […] had any interest in the welfare of the country for a couple of generations at least'.[20] The system, mirroring the English system, had been established against the expert advice of a largely Irish-based royal commission into the state of the poor in Ireland.[21]

It was decided to introduce an amalgamation scheme in each county. Laurence Robbins, the Assistant Minister for Local Government, was charged with the task of overseeing this process. It was envisaged that under the county schemes all boards of guardians would be abolished to be replaced by a single county board of health, operating under the umbrella of the county council and that all workhouses would be closed and replaced in each county by a county home and a county hospital.[22] Dublin was not included in the new system.[23] It was intended that local conferences would take place, attended by the

[18] Richard Haslam, 'The origins of Irish local government' in Mark Callanan and Justin F. Geoghan (eds), *Local government in Ireland inside out* (Dublin, 2003), pp 14-40.
[19] Dáil Éireann Debate Vol. F No. 17, 17 Sept. 1920.
[20] Ernest Blythe, Dáil debates, vol. 2, no. 28, 1423, 9 Feb. 1923. Blyth was the Sinn Féin (pro-treaty) deputy for Monaghan and a member of the executive council occupying the post of Minister for Local Government from December 1922 until his appointment as Minister for Finance in September 1923. He represented Monaghan until his defeat in the 1933 election.
[21] *Third report of the commissioners for inquiring into the condition of the poorer classes in Ireland*, 3 [43], H. C. 1836, xxx, 1.
[22] *L.T.Mac Cosgair, Minister for Local Government to each county council and board of guardians, circular no. 52, Dáil Éireann, Local Government Department*, 27 Sept. 1921 (MCCA, MCC 3-2-9/10).
[23] The Dublin board of guardians had been dissolved in 1923 and the corporation in 1924. Both were replaced by commissioners. Following these dissolutions a Greater Dublin Commission of Inquiry had been appointed to examine the laws and administration affecting the delivery of services in both Dublin city and county and make recommendations as to the desirability of changes in the system. The commission did not report until 1926. Although its recommendations were not accepted by government they did presage the introduction of the city and county management system, which was introduced in Dublin in 1930. As this Commission was sitting during the period when the amalgamation schemes were being introduced the government considered it inadvisable to allow 'fundamental changes in machinery' to come into operation in Dublin in advance of the production of its report. (*Department of Local Government and Public Health second report 1925-1927;* Edward Sheehy, 'City and county management' in Mark Callanan and Justin F. Geoghan (eds), *Local government in Ireland inside out* (Dublin, 2003), pp 123-42; J. Collins, 'The genesis of city and county management' in *Administration*, ii (1954), pp 27-38.

guardians and the county authorities, whereat, with the assistance of the departmental inspectors, voluntary agreement would be reached on the scheme to be implemented in each county. Schemes were subject to ministerial approval. Although subsequently portrayed as voluntary, in reality the schemes were not 'a question of what the county council wanted but a question of what the department would make them do'.[24] In considering its scheme, Wexford County Council had been informed by William T. Cosgrave, the Minister for Local Government, that 'unless the county council were prepared to put the scheme into operation, the government would'.[25] In Kilkenny the department inspector was instructed to inform the Callan Board of Guardians, who had attempted to retain Callan hospital, that if they did not carry out the terms of the approved amalgamation scheme forthwith the board would be abolished by sealed order.[26] In effect Robbins micro-managed every aspect of the process, receiving detailed progress reports from his inspectors and in return issuing comprehensive instructions as to the shaping of schemes in accordance with his wishes. In the event of these wishes not being followed Robbins communicated directly with the councils setting out his requirements.[27] Between 1 May 1921 and 4 April 1922 all the Leinster counties with the exceptions of Carlow and Louth brought schemes forward.

The Local Government (Temporary Provisions) Act was passed in March 1923 to provide statutory approval for what were effectively illegal schemes. The act incorporated the schemes approved by the minister. It made continued provision for the micro-management of the schemes by the minister in providing him with the authority in confirming a scheme to make 'such modifications, omissions and additions as he may deem necessary'. It further allowed him to amend or modify any existing county scheme

[24] Daniel Morrissey, Dáil debates, vol. 2, no. 30, 1557, 21 Feb. 1923. Morrissey was the Labour Party deputy for Tipperary Mid, North and South. He represented different Tipperary constituencies under different political party banners from 1922 until 1957.
[25] Richard Corish, Dáil debates, vol. 2, no. 28, 1432, 9 Feb. 1923. Corish was the Labour Party deputy for Wexford, a constituency he represented from 1921 until his death in 1945.
[26] Report by J. A. Gleeson Department of Local Government inspector on meeting of Callan Guardians 10 Feb. 1922; Letter Daniel Connaughton chief inspector to J. A. Gleeson, 16 Feb. 1922 (NAI, DELG 14/15).
[27] Michael De Lacy inspector to R. J. Keogh secretary Carlow County Council, 31 Jan. 1921; Report of Joseph Boyd Barrett medical inspector to Laurence Robbins on amalgamation scheme for County Carlow, 3/4 Feb. 1922; Reports Daniel Connaughton inspector to Laurence Robbins on Carlow amalgamation scheme, 6 Feb., 1, 21 and 28 Mar. 1922; Laurence Robbins to Secretary Carlow County Council, 16 Mar 1922; Laurence Robbins to Carlow inspector, 16 Mar. 1922 (NAI, DELG 3/6); Laurence Robbins to secretary Kildare County Council, 25 Jan. 1922; Reports Daniel Connaughton inspector to Laurence Robbins on Kildare amalgamation scheme, 7, 21 and 22 Feb. 1922 (NAI, DELG 13/11).

'in any way he may deem necessary'.[28] The Carlow scheme, adopted by the council in October 1922, received ministerial approval in July 1923.[29] The scheme for Louth County Council, which had been adopted by its members in early 1924, received ministerial approval in April 1924.[30] Thomas Johnson criticised the provisions of the act and the arguments advanced from the government benches in their favour as indicative of 'a distinct intention to centralise administration in the country' with 'all the threads of local administration […[run] …] from GHQ through […[a]…] coterie of officials'. In questioning the government's 'desire for bureaucracy' and 'the tendency to that centralisation of authority', thus depriving 'local bodies of the right to control purely local affairs', he accurately predicted the future direction of Irish health administration.[31] Despite the loss of facilities wherein tuberculosis patients were accommodated, none of the Leinster schemes with the exception of County Kilkenny made any specific provision for the treatment of such patients. The Kilkenny scheme provided for the transfer of all tubercular patients, accommodated in the various union hospitals in the county, to the central sanatorium in Kilkenny.[32]

The position of the boards of health was consolidated with the passing of the Local Government Act 1925 which inter alia set out to 'do away with a great deal of confusion and numerous anomalies' which existed by 'placing [...] the administration of the health services in the county, both curative and preventative , under one body'.[33] The act was attempting to address the deficiencies identified by the Irish Public Health Council in its 1920 report. The council had found that there was 'a considerable lack of co-ordination and a certain amount of overlapping, both in the central control and in the local administration of the public health and medical services'. Local health administration had evolved into 'an enormously complicated system' understood by only a few officials

[28] Local Government (Temporary Provisions) Act 1923/9 [Éire] (28 Mar. 1923).
[29] *Minutes of quarterly meeting of Carlow County Council, 12 Dec 1922* (NAI, DELG 3/6); County Scheme Order, Carlow No. 1, 1923 (1923 no. 28,831) (10 July 1923). The approval of the scheme was delayed as Robbins had suggested amendments, which contained errors that would have made the scheme unworkable.
[30] County Scheme Order, Louth No. 1, 1924 (17 Apr. 1924).
[31] Thomas Johnson, Dáil debates, vol. 2, no. 34, 1818-19, 28 Feb. 1923. Johnson was the deputy for County Dublin and leader of the Labour Party. He represented County Dublin from 1922 until his defeat in the 1927 Dáil election.
[32] Local Government (Temporary Provisions) Act 1923/9 [Éire] (28 Mar. 1923).
[33] Seamus Bourke, Dáil debates, vol. 7, no. 10, 942, 20 May 1924. Bourke was the Cumann na nGaedhael deputy for Tipperary and Minister for Local Government and Public Health from October 1923 to June 1927, when he was appointed Parliamentary Secretary to the Minister for Finance, a post he occupied until 1932. He represented Tipperary from 1919 until his defeat in the 1939 Dáil election

directly involved in its implementation. The 'disjointed and unsatisfactory' nature of the system was increased by the proliferation of various institutions functioning as different classes of hospitals in every county, each controlled by different authorities.[34]

This state of affairs was not surprising, having regard to the uncoordinated development of the medical services, over an extended period of time, often as a political response to immediate crises. As these services had developed considerable divergence emerged as to how different counties made services available and administered them. To address these shortcomings the council had recommended the creation of a centralised Ministry of Health, to co-ordinate the medical and public health services in Ireland with local authorities being closely associated with this central authority. It sought to have each county organised under a single board of health, a 'local unit of administration for all matters pertaining to health and medical services' in the county. It envisaged a county medical officer of health being appointed to act as medical advisor to the board of health and being 'generally responsible to the board for the supervision of the public health and medical services in the county'. Having received 'many representations' on the subject the council recommended 'that tuberculosis should be scheduled as an infectious disease and be made compulsorily notifiable throughout Ireland'.[35]

The 1925 act abolished the rural district councils which now joined the boards of guardians as defunct bodies. It established the boards of health as corporate bodies with power to hold land and buildings.[36] A single body was now created in each county, responsible for the institutions through which services to tuberculosis sufferers would be delivered, thus removing many of the obstacles formerly placed in the way of service delivery.

The act obliged every county to appoint, in accordance with qualifications and terms and conditions of office determined by the minister, a county medical officer. Each individual appointment was subject to ministerial approval. The appointed doctor was responsible to the board for the 'effective administration […] of the various powers and duties of such

[34] *Ministry of Health Act 1919.Report of the Irish Public Health Council on the public health and medical services in Ireland*, 1 [Cmd. 761], H. C. 1920, xvii, 1075.
[35] Ibid.
[36] Local Government Act, 1925/5 [Éire] (26 Mar. 1925).

board […] in relation to the safeguarding of the health of the people'.[37] This involved the supervision of tuberculosis officers, dispensary doctors, and doctors occupying positions in the various public institutions in the county. The county medical officer was required to provide the board of health or the county council with expert medical advice on any matter as and when required.[38] This filled a gaping need, as up to that time local authorities, comprised of laymen but charged with medical matters, could make important decisions without recourse to informed medical opinion.

The act applied the compulsory notification provisions of the 1908 tuberculosis act throughout Saorstát Éireann.[39] However, in extending the notification provisions throughout the state, the minister, Seamus Bourke, sought to alleviate public anxieties that with compulsory notification all tuberculosis patients would be subject to 'hard treatment', by explaining that such notification 'only applies in cases where the disease is specially contagious or infectious, notified as being dangerous by the medical practitioner'. He explained that local authorities would only intervene at the patient's 'special request' and that application of the act would 'not submit them to any humiliating investigation or anything of that kind'. He further sought to set aside public fears by declaring that 'greatest care' would be taken to ensure that no publicity would be given to sufferers of the disease nor was there 'any power under the act for the removal of a patient compulsory'.[40]

The 1925 act repealed the prohibition on the use of poor law premises for the provision of sanatorium benefit, set out in the National Insurance Act 1911. This enabled the minister to approve many of the former poor law premises for the treatment of pulmonary and surgical tuberculosis.[41] Following on from the 1923 act the tendency towards centralised control of all aspects of health administration was reinforced by the 1925 Act, with the minister authorised 'to take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people'.[42]

[37] Ibid.
[38] Ibid. Seamus Bourke, Dáil debates, vol. 9, no. 8, 710, 4 Nov. 1924.
[39] Local Government Act, 1925/5 [Éire] (26 Mar. 1925).
[40] Seamus Bourke, Dáil debates, vol. 9, no. 13, 1235-6, 19 Nov. 1924.
[41] Local Government Act, 1925/5 [Éire] (26 Mar. 1925).
[42] Ibid.

Pursuant to the National Health Insurance Act 1929, insurance committees were abolished and sanatorium benefit for insured persons ceased from 1 January 1930.[43] Ostensibly the reason for this was that the burden of providing sanatorium treatment for insured persons was increasingly being thrown onto local authorities. The minister, Richard Mulcahy, pointed out that, due to lack of finance insurance committees have 'to discriminate between the insured persons in their area who will get sanatorium treatment and those who will have to run the gauntlet of having to pay something for it if the local body does not give them assistance under their own schemes'.[44] To compensate local authorities for the withdrawal of funds, which had been available to them under agreements entered into with the insurance committees, an annual subvention in the form of a tuberculosis grant was provided for. The sum to be distributed nationally in 1930 was set at £27,750, the amount which would have been forthcoming from the insurance committees. In return the local authorities were obliged to provide free treatment for insured persons and were not entitled to recover any portion of the cost of their institutional treatment, provided that the cost of administering to them did not exceed three-fifths of the new grant.[45]

New ventures arising from amalgamation schemes 1922-31 - Wexford and Offaly

The amalgamation schemes did present opportunities for the development of tuberculosis treatment facilities, though not all were availed of exactly along the lines first envisaged.

In County Wexford Dr Bowen' the medical officer of the county home, located in the former workhouse premises at Enniscorthy, recommended that the former fever hospital premises located in the same grounds, be used for the accommodation of consumptive patients, pending the provision of a county sanatorium. The premises consisted of four large wards, two smaller wards an isolation hut, up to date food preparation facilities and sanitary accommodation including hot and cold water throughout the building. As the premises was fully equipped and could be managed by the existing staff of the county home, thus involving no extra expenditure in its use, his recommendation was adopted by

[43] National Insurance Act, 1929/42 [Éire] (20 Dec. 1929).
[44] Richard Mulcahy, Dáil debates, vol. 32, no. 2, 235, 24 Oct. 1929. Mulcahy was Cumann na nGaedhael deputy for Dublin North and Minister for Local Government and Public Health from June 1927 to April 1930. He was elected to represent various Dublin and Tipperary constituencies in fourteen of the sixteen elections he contested from 1919 until his retirement from politics in 1961. He also held cabinet posts as Minister for Defence, Minister for Education and Minister for the Gaeltacht.
[45] National Insurance Act, 1929/42 [Éire] (20 Dec. 1929).

the county board of health and sanctioned by the minister in September 1922.[46] Such was the nature of cases referred to the new sanatorium, that by February 1923 it had become 'a kind of hospice for patients in the last stages of tuberculosis'.[47] The fact that mainly terminally ill patients were accommodated there reflected the attitude of the Wexford public to workhouse premises, whereby only as an absolute last resort would patients allow themselves be removed to such premises.

In March 1923 the surgeon attached to the newly-formed county infirmary, located in the former Wexford workhouse premises, complained that cases of tuberculosis, which could be treated at home or in the Enniscorthy sanatorium, were being referred to the infirmary. In response the board of health circulated all doctors in the county asking them to use their discretion in the referral of tuberculosis patients and pointing out that in future their recommendations for admission must contain a statement detailing the complaint from which the patient was suffering.[48] A visit by the departmental inspector to the Enniscorthy facility in April 1923 found the premises 'completely satisfactory' from an isolation point of view, however he expressed the opinion that the treatment provided was inadequate recommending that those cases amenable to treatment should be referred to Newcastle sanatorium.[49] In response to this criticism the secretary informed the board that the Enniscorthy premises 'was more a hospice than a sanatorium' with very few of the patients who were admitted able to 'hope for a cure through sanatorium treatment'.[50] Patients who might benefit from treatment continued to be sent to Newcastle sanatorium in accordance with the agreement entered into with that institution.[51] By 1925 the average number of advanced tuberculosis patients accommodated in the twenty-bed Enniscorthy facility was fourteen.[52]

The opportunities for the development of treatment facilities, which arose in County Offaly from the amalgamation scheme, were eventually thwarted by the tendency of Irish politicians to give primacy to local affiliations over all other considerations.

[46] County Wexford Board of Health minutes, 27 May and 6 Sept 1922 (WCCA).
[47] Ibid., 21 Feb. 1923.
[48] Ibid., 21 Mar. 1923.
[49] Department Local Government to Wexford County Board of Health, 8 May 1923 , incorporating report of medical inspector (WCCA).
[50] County Wexford Board of Health minutes, May 1923.
[51] Report on county tuberculosis scheme for year ending 31 Mar. 1925 (WCCA).
[52] Ibid.; minutes of meeting of County Wexford tuberculosis committee, 5 Oct. 1925.

The County Offaly amalgamation scheme provided inter alia for the closure of Tullamore infirmary and the Birr workhouse.[53] In October 1921 staff were instructed to vacate the Tullamore premises, creating a situation whereby no personnel were available to provide nursing services to the patients then housed in the observation wards attached to the new central dispensary, which by then had assumed the role of a small sanatorium. Dr O'Regan the tuberculosis officer obtained approval to engage a nurse, a matron and a servant to look after the four patients then accommodated in the premises.[54] The following March Dr O'Regan informed the council that he had to decline taking referral cases of pulmonary tuberculosis from the new county hospital, some of whom were in an advanced state of the disease, 'due to the want of sufficient accommodation', there being only six beds available to him. This spurred the committee into deciding to open two wards in the former infirmary to accommodate advanced pulmonary cases.[55] By April an additional nurse and servant were engaged to look after the eight male and two female patients then in the former infirmary.[56]

When made aware that tubercular patients were housed in the premises, the Tullamore UDC objected to its use, due to the proximity of a considerable number of dwellings. The UDC members urged that arrangements be made to transfer the patients 'to a more suitable locality for the treatment of infectious diseases'.[57] Dr O'Regan, wishing to revert the Tullamore premises to its intended use as observation wards, suggested using the former infirmary attached to the Birr workhouse for the treatment of advanced tuberculosis cases. These premises, which could accommodate up to eighty patients with little outlay were 'in every way suitable for the purpose' having good sanitation, water and electricity supplies. The only drawback was that the military were occupying the building.[58] Dr O'Regan's suggestion was accepted and arrangements were made to use the premises as a sanatorium when vacated by the military. The transfer of all tuberculosis cases to Birr was effected by mid-April 1923.[59] Initially eighteen beds were provided in the premises however by mid-May it was found necessary to order a further

[53] Local Government (Temporary Provisions) Act 1923/9 [Éire] (28 Mar. 1923).
[54] Minutes of Offaly hospitals and homes sub-committee, 25 Oct 1921 (OCCA).
[55] Ibid., 14 Mar. 1922.
[56] Ibid., 11 Apr. 1922.
[57] Ibid., 8 Aug. 1922.
[58] Ibid., 11 Apr. and 8 Aug. 1922.
[59] Ibid., 10 Apr. 1923. 'One patient who was in a very precarious condition had to be left in the county infirmary Tullamore'.

twelve. Some of these were used for the staff, which comprised two nurses, two wardsmaids, a cook and a night attendant.[60]

In August 1926 at the instigation of the Department of Local Government, doubtlessly inspired by the wishes of the minister, the Tipperary North Riding Board of Health decided to convert the former workhouse buildings in Roscrea into a sanatorium to serve the counties of Tipperary North Riding, Laois and Offaly.[61] The Offaly Commissioner David O'Keefe, an appointee of the same minister, had confirmed the previous November that Offaly would send its tubercular patients to Roscrea.[62] A letter to the commissioner from Dr O'Regan in September 1927 pointing out that Birr with 'a most competent staff of nurses' and already established as a sanatorium would be in a position to take the Tipperary patients did not alter the decision.[63] In February 1928 the minister armed with O'Keefe's agreement to refer suitable cases to Roscrea informed the Offaly Board of Health that once the Roscrea premises was available, he would withdraw his consent to the continued use of the Birr premises for the treatment of tuberculosis.[64]

Maintaining his previously held position in March 1929 O'Regan attempted to have the now restored council/board of health reverse the decision by pointing out that 'with no power to compel them' Offaly patients would not go to Roscrea preferring instead 'to be near their friends'. This could result in their remaining in their homes thus providing a source of 'grave danger of infection of others'. He mentioned that Laois had been permitted to withdraw from the proposal.[65] The Birr sanatorium patients protested to the board of health against the move pointing out that 'none of the patients want to go to Roscrea' and 'if it was a question of Roscrea or die at home we would prefer to die at home'.[66] The Roscrea premises were ready for the reception of patients in June 1931. The board of health, supporting O'Regan and the patients and being of 'the considered opinion ' that 'these poor people can be better treated in their own county', wrote to the

[60] Minutes of Offaly hospitals and homes sub-committee, 17 May 1923; minutes of Offaly County Board of Health, 26 Aug. 1930 (OCCA). In August 1930 staff occupied five of the beds.
[61] Minutes of Offaly County Board of Health, 24 Aug. 1926.
[62] Ibid., 27 Nov. 1925. O'Keefe had been appointed by the Minister for Local Government, in September 1924, following the dissolution of the council due to financial irregularities.
[63] Minutes of Offaly County Board of Health, 13 Sept 1927.
[64] Ibid., 13 Mar. 1928.
[65] Ibid., 29 Mar. 1929.
[66] Ibid., 27 Jan. 1931.

minister asking him to reconsider the matter.[67] However the minster was not for bending and 'under protest', on 12 September 1931 the board of health moved the patients to Roscrea and closed the Birr facility.[68]

The decision-making process whereby the Offaly sanatorium was relocated to Roscrea provides a good example of Irish 'parish pump' politics whereby local affiliations take precedence over county, regional or national plans. In this case the health needs of Offaly tuberculosis sufferers were placed secondary to the need to maintain facilities and employment in Roscrea, a town represented in the Dáil by Seamus Aloysius Bourke. Bourke, a founder member of the Cumann na nGaedhael political party, was Minister for Local Government and Public Health when the move was initiated and still retained the important post of parliamentary secretary to the Minister for Finance upon its completion.[69] He lived at Rockforest approximately four miles outside the town of Roscrea.[70] He was succeeded as Minister of Local Government by Richard Mulcahy another founder member of Cumann na nGaedhael. Mulcahy a TD for Dublin North, although born in Waterford had spent much of his youth and his early working career in Thurles, County Tipperary where his father, a Tipperary native, was postmaster. His allegiance to Tipperary can be gauged from his subsequent political career as following the loss of his Dublin seat in 1943 he represented Tipperary from 1944 until his retirement from politics in 1961.[71]

The post amalgamation scheme period house developments 1926-42 - Wexford, Kildare, Laois, Louth and Carlow

Following the amalgamation schemes there was a shortage of accommodation in which to treat patients. In seeking to resolve this situation the most frequently adopted remedy was the acquisition of period houses and their adaption as sanatoria. Ostensibly this solution, using existing buildings, would provide the quickest means of increasing bed provision.

[67] Ibid., 23 June 1931.
[68] Ibid., 27 Aug. and 22 Sept. 1931.
[69] 'Dáil Éireann members database' (www.oireachtas.ie/members-hist/) (16 July 2013).
[70] *Nenagh News*, 25 Aug. 1923.
[71] *Irish Times*, 17 Dec. 1971; *Irish Independent*, 17 Dec. 1971; 'Dáil Éireann members database' (www.oireachtas.ie/members-hist/) (16 July 2013).

Having determined that the accommodation in the existing Enniscorthy sanatorium was inadequate to meet the needs of those advanced cases requiring treatment the Wexford Board of Health sought alternative premises. In November 1926 the board forwarded to the minister a proposal to convert Gorey workhouse to such use. However the minister on the advice of his officials rejected the proposal on the grounds that 'the buildings in question are not suitable for use as a tuberculosis hospital'. He suggested that the board consider using the Wexford fever hospital premises. These premises, on a confined site, were considered by the tuberculosis medical officer to be too small. With maximum expansion the premises would accommodate only 30-40 patients. In addition there was no space for patient recreation.[72] Nevertheless plans were drawn up by Gerald Flood to convert the premises into a 30-bed facility at an estimated cost of £3,819. Although too small to meet the needs of the county the plans were forwarded to the minister for approval.[73]

In June 1927 Flood proposed to the board that they consider the acquisition of Brownswood House, located outside Enniscorthy, which was then being marketed together with a farm of 100 acres and six cottages for £8,000.[74] The house, a Victorian reconstruction of an original Georgian house on the site, had been built between 1894 and 1896, at a cost of £4,000.[75] The house was about twice the size of the fever hospital and was 'ideal in every way' for conversion to a sanatorium. Following inspection, the board found the premises suitable and requested the minister to have the premises examined before proceeding with the conversion of the fever hospital.[76] On 6 July the department's medical inspector Dr Boyd Barrett accompanied by the department's architect T. F. Strahan inspected the premises. Strahan advised that similar buildings in the county should also be considered before a decision was arrived at. The board immediately advertised for such buildings.[77]

The advertisement attracted numerous responses. The more obviously unsuitable proposals were rejected and the balance forwarded to the department. Amongst the

[72] County Wexford Board of Health minutes, 15 Nov. and 20 Dec. 1926 (WCCA).
[73] Ibid., 20 June 1927.
[74] Ibid., 21 Mar. 1927.
[75] 'Architectural heritage impact assessment of proposed alterations and change of use to a protected structure at Brownswood House, Enniscorthy County Wexford' (WCC planning application 2009/1111).
[76] County Wexford Board of Health minutes, 20 June 1927.
[77] Ibid., 18 July 1927.

proposals forwarded was a revised offer to sell Brownswood together with *c*. 25 adjoining acres for £6,500. This offer was elicited by Strahan following a further inspection of the premises by him on 18 November 1927.[78] A detailed report on the five most suitable propositions was prepared for the minister. The report concluded that the only two alternatives to the fever hospital were 'to build a new hospital on up-to-date lines in a convenient and healthy position in pleasant surroundings' or to acquire Brownswood and 'carry out the additions and alterations necessary'.[79] Influenced by the ability of a renovated Brownswood to take in hands more quickly the nursing of advanced cases, despite the minister's reservations that 'these premises would be too costly for one county and their upkeep would be expensive', the acquisition of the premises was recommended.[80] As Lady Gray the owner, 'having regard to the object, which the board have in view, namely, the establishment of a sanatorium', agreed to further reduce the price to £5,000 the board decided to proceed with its acquisition.[81] The total estimated cost of acquiring, altering and equipping the new premises was estimated at £6,399 which was to be met by way of a sanatorium grant of £3,347 with the balance funded by means of a loan of £3,052.[82]

The board decided that Dr William O'Connor, the tuberculosis officer, should perform the duties of resident medical officer. As recompense for this additional duty he was to be provided with a house on the site free of rent. It was also agreed to recruit a matron, three nurses, two maids, a cook, a laundress, a steward and a labourer to run the facility.[83] From the outset staff problems beset the institution. Problems were experienced by the Local Appointments Commission in recruiting a third nurse, two advertisements failing to attract any qualified candidate.[84] In its early years of operation there was a constant turnover of staff especially cooks and wardsmaids, with many advertisements for vacancies eliciting no response or producing only one candidate. The board acknowledged in 1934 that 'it was difficult to get wardsmaids to remain in the sanatorium'.[85] On two occasions in 1932 with cooks leaving the sanatorium without

[78] Ibid., 21 Nov. 1927.
[79] Ibid., 20 Feb. 1928.
[80] Ibid., 19 Sept. 1927 and 20 Feb. 1928.
[81] Ibid., 16 Jan. and 20 Feb. 1928.
[82] Ibid, 18 June 1928 and 10 Jan. 1929.
[83] Ibid., 15 Oct. 1928.
[84] Ibid., 21 May 1929.
[85] Ibid., 29 May 1934.

notice the cooking duties had to be performed by the laundress.[86] Difficulties were also experienced in retaining nurses for night duty. 'Several came and remained only a short time', attributed to them finding the duty very lonely. As an attempted solution to this problem the engagement of a night attendant was approved in April 1931.[87]

All works to the premises required ministerial approval. His dictates even extended to detailing which rooms were to be used as pantries and matron's apartments.[88] The formal opening of the new facility, 'Grianán Charmain' (Plate 7.1), took place on 13 May 1930.[89] It had accommodation for eighteen male and nineteen female patients.[90] However neither a laundry or sputum incinerator were provided, both essential elements in a properly run sanatorium.[91] The process of moving patients from the old sanatorium commenced on 1 July and was completed on 8 August when six male and twelve female patients were in occupation.[92]

From the outset religion played an important role in the sanatorium. Amongst the first appointments made with ministerial approval were those of Catholic and Protestant chaplains at annual salaries of £78 and £10 respectively.[93] The Catholic chaplain was required 'to celebrate mass on Sundays and holy days and to attend the institution when required' whereas the Protestant chaplain was required 'to visit from time to time the Protestant patients who may be in the sanatorium'.[94] Patient rules subsequently adopted with ministerial consent obliged all patients not confined to bed to attend mass at 9 o'clock on Sundays and holidays, although this rule was subsequently amended to apply only to Catholic patients.[95] In June 1929 in reviewing the board's plans for alterations to Brownswood the minister pointed out that 'there is no provision for a chapel in the sanatorium'.[96] To remedy this situation the minister sanctioned the board's proposal to provide a wooden altar in the billiard room, a room intended for men's recreation, at a

[86] Ibid., 18 Jan. and 21 Mar. 1932.
[87] Ibid., 20 Apr. 1931.
[88] Ibid., 15 July 1929.
[89] Ibid., 19 May 1930.
[90] Ibid., 20 Apr. 1931.
[91] Ibid., 16 June 1930.
[92] Ibid., 18 Aug. 1930.
[93] Ibid., 18 Feb. and 25 Mar. 1929.
[94] Ibid., 15 Oct. 1928 and 25 Mar. 1929.
[95] Ibid., 1 July 1935 and 15 May 1939.
[96] Ibid., 15 July 1929.

cost of £25. It was proposed to screen off the altar when not in use. He also approved of the purchase of vestments, sacred vessels and other altar furnishings costing £45-17-11.[97]

The Rev. Michael Rossiter, the Catholic chaplain, on becoming aware of the proposals for the billiard room, objected to its use as a day-room, declaring his intention of leaving the Blessed Sacrament permanently in the sanatorium chapel which necessitated the room bring permanently reserved for this purpose. Dr O'Connor suggested using the green house as the men's dayroom. This entailed glazing and painting the roof and fixing the leaks. The board accepted this suggestion further directing that 'a couple of lights be installed'.[98] Despite repairing the roof it still leaked badly resulting in the patients having nowhere to go on wet days.[99] In winter due to lack of heating this facility could not be used nor could it be used at other times after dark due to the absence of proper lighting.[100] In this instance the religious wellbeing of the patients took precedence over their mental and physical needs.

In his 1931 annual report, Dr O'Connor suggested making alterations to the sanatorium to increase its capacity, to provide separate staff accommodation and to generally improve patient and staff comforts.[101] Architects were appointed to draw up plans for the works in consultation with the board's engineering and medical advisors and the department. The medical advisors reported that it was 'not easy with a building such as the present sanatorium to incorporate modern medical requirements with modern architectural necessities' and while the architects stated that on 'account of the orientation of the present building' it did 'not permit of economic alteration in order to convert it into a suitable sanatorium'.[102] Having regard to these comments the architects were instructed to prepare plans for a separate sanatorium to house 100 beds, later downsized to 65-70 beds on the minister's instructions, retaining the existing house for staff accommodation and administrative purposes.[103] Further intervention by the minister

[97] Ibid., 19 Aug. and 21 Oct. 1929.
[98] Ibid., 18 Aug. 1930.
[99] Ibid., 20 Oct. 1930.
[100] Ibid., 19 Jan. and 16 Feb. 1931.
[101] Ibid., 18 May 1932.
[102] Ibid., 17 Oct. 1932.
[103] Ibid., 16 Jan. 1933.

Plate 7.1 Brownswood House, Enniscorthy, County Wexford, acquired for conversion into the county tuberculosis sanatorium in 1928. It is currently in use as a secondary school (Alan Carthy, 2013)

Plate 7.2 Firmount House, Clane, County Kildare, acquired in 1929 for conversion into the county tuberculosis sanatorium. It is currently being restored as a private house (REA Brophy Farrell, sales brochure, 2010)

determined that separate staff accommodation should be provided and the house retained for patient use.[104]

In July 1934 a tender for £31,740 was accepted to carry out the works.[105] When the cost of furnishings, heating, lighting, improvement of water supply and sewerage, connection to the Shannon electricity scheme and professional fees were included the costs escalated to an estimated £54,590, which sum was to be met from the hospital's sweepstakes fund.[106] A contract inclusion, in accordance with government policy, that certain specified materials 'be of Saorstát Éireann manufacture' caused severe difficulties for the contractor and subsequent delays. Initially the supplier of Courtown bricks could not meet the demand. When this difficulty was resolved a fire at the brickworks further disrupted supplies.[107] Similar problems were encountered in securing Irish slates with quarries from Donegal, Wicklow, Cork and Dublin unable to fulfil orders. This problem was only resolved in October 1936 when the minister consented to the use of Bangor slates.[108] The impossibility of running an institution while works were ongoing together with the contractor's employees' refusal 'to work within an area occupied by TB patients' led to the closure of the sanatorium in November 1936 with seven patients being sent home and placed under domiciliary treatment, three being referred to other sanatoria and eight female patients being accommodated in the doctor's residence.[109] The staff home was ready for occupation on 25 June 1937.[110] However it was not until March 1939 that the seventy-bed three-storey new sanatorium was ready for occupation when the process of moving the patients into it commenced.[111]

The process of acquiring and adapting a period house in Kildare mirrored the Wexford experience. Following the Kildare amalgamation scheme a small numbers of advanced tuberculosis cases were accepted in the county home in Athy.[112] The minister had approved of the premises for such cases only on a temporary basis, 'pending the provision of special accommodation for the purpose' as his officials were of opinion that

[104] Ibid., 15 May 1933.
[105] Ibid., 30 July 1934.
[106] Ibid., 3 Feb. 1936.
[107] Ibid., 17 Feb. 1936.
[108] Ibid., 20 Jan., 7 Sept. and 5 Oct. 1936.The Bangor slates came from quarries in north Wales.
[109] County Wexford Board of Health minutes, 2 Nov. 1936.
[110] Ibid., 19 July 1937.
[111] Ibid., 20 Mar. 1939.
[112] Application for approval, 28 Feb. 1927 (NAI, Health D 111/17).

it was unsuitable on account of the 'number of inmates of delicate constitution…likely subjects for infection'.[113] Arrangements had been made with Peamount sanatorium to reserve sixteen beds for early curable cases.[114] Cases of surgical tuberculosis were treated in the county hospital in Naas and the county infirmary in Kildare.[115]

In February 1928 the county medical officer James Harbison recommended to the board of health that premises, 'which would be suitable for conversion into a tuberculosis hospital', be sought.[116] Following advertisement, Harbison, accompanied by the department's medical inspector J. Boyd Barrett inspected the eight premises offered. He recommended acquiring Firmount House, Clane. The premises had been used as a military hospital during the First World War.[117] The house together with twenty-six adjoining acres was purchased by the council in early 1929 for £2,500 (Plate 7.2).[118]

Plans drawn up to adapt the premises and provide a house for the resident medical officer were rejected by the department. Amongst the shortcomings identified in the plans were the absence of space for a priest to vest, the lack of a patients dining room, inadequate heating arrangements, it being proposed to use the existing open fireplaces. The design of the doctor's residence being the conversion of outbuildings was found to be totally inadequate.[119] Works, carried out in accordance with revised plans to meet departmental requirements, were financed by a sanatorium grant of £1,047 and borrowings of £7,853.[120] Complying with the department's requirements meant that costs had escalated to double the expenditure contemplated when the scheme was originally devised.[121]

With ministerial approval it was decided to recruit staff consisting of a matron, two nurses, two wardsmaids, a cook, a gardener and a labourer. The respective annual salary

[113] Ar son Rúnaidhe to the Secretary, National Insurance Audit Department, 2 Jan. 1928; File notes 14 and 16 Dec. 1927 (NAI, Health D 111/17).
[114] Annual report of the county medical officer of health, County Kildare, 1929 (KCCA).
[115] Applications for approval, 24 Mar. 1926 and 7 May 1927; Ar son Rúnaidhe to the Secretary, Kildare County Council 20 May 1926; Ar son Rúnaidhe to the Secretary, National Insurance Audit Department, 13 May 1927 (NAI, Health D 111/17).
[116] *Kildare Observer*, 3 Mar. 1928. Harbison's appointment as county medical officer in Kildare in 1928 was the first such appointment in the state under the Local Government Act 1925. He was later appointed County Dublin medical officer of health in 1931 and to the same post in Dublin city in 1948, a post he held until his retirement in 1956. His son Dr John Harbison served as state pathologist from 1974 to 2003.
[117] *Kildare Observer*, 5 May, 21 July and 20 Oct 1928.
[118] Ibid., 23 Feb. 1929.
[119] Ibid., 25 Oct. 1930.
[120] Ibid., 8 June 1929 and 26 Dec. 1931.
[121] Undated draft letter, probably Nov. 1930 (NAI, Health 13/28).

scales for the posts were £100x£5-£150, £75x£5-100, £40, and £30 together with board and rations. The gardener was to be paid £2 weekly and the labourer £1-10-0 per week. The religious needs of patients were to be overseen by a Catholic and a Protestant chaplain, paid respectively £70 and £20 per annum.[122] The relative weightings of the salaries of the full time nursing staff and the part-time chaplains demonstrate the importance placed on religious matters, even allowing for the fact that as men they automatically held the right to a higher salary.

In August 1933 the minister took the board to task as the sanatorium had not opened. On the recommendation of the Local Appointments Commission the matron had been appointed on 16 January 1933. 'It was not however until the 12th April that the matron was called on to carry out any duties and this referred merely to the selection of equipment for the sanatorium'. She had not received any salary since her appointment not even recompense for time spent in selecting equipment despite having 'to hold herself at the disposal of the board for a period of seven months since her appointment'. In the minister's view this was a contributory factor in 'the whole history of the institute', which did 'not reflect any credit on the administration of the board'. He threatened an investigation into whether the delay in opening the institution was 'attributable to neglect or default on the part of any officers of the board'.[123] The board's current financial position was advanced as the reason for this situation as the opening of the facility would 'be a serious addition' to its expenditure. Nevertheless as the department was 'getting the hammer at us now' and the board had 'no back door' through which to escape, it decided 'to open Firmount sanatorium as soon as possible and to inform the matron to be ready to take up duty from the 1st October'.[124]

The Kildare sanatorium was formally opened by Dr E. P. McCarron the secretary of the department on 2 February 1934. It was named St Conleth's and contained a chapel dedicated to the saint. It had accommodation for thirty patients in three ten-bed wards. The building was heated throughout with radiator central heating and equipped with 'the most modern appliances'. McCarron admitted that 'ordinarily he was opposed to converting private houses for use as sanatoria. But in this case he had to remind himself

[122] *Kildare Observer*, 25 Oct. 1930.
[123] *Letter 22 August from Local Government Department* quoted in *Kildare Observer*, 22 Sept. 1933.
[124] *Kildare Observer*, 22 Sept. 1933.

constantly that this was a converted building so admirably was it suited for its purpose'.[125]

The necessary accommodation in Laois was also provided by the acquisition, adaption and extension of a period house. However in this instance the initial involvement of the department was not as prominent as in other counties.

Following the Laois amalgamation scheme small numbers of advance cases were accommodated in the district hospital in Abbeyleix and the county home in Mountmellick.[126] Surgical cases were treated in the county hospital Portlaoise and the district hospital Abbeyleix.[127]

In November 1927 the board of health established a sub-committee 'to inspect the county institutions and other sites …in connection with the board's proposal to provide adequate and suitable institutional accommodation for the treatment of advanced cases of tuberculosis'. Following inspection of the existing institutions and other available properties, the committee recommended the acquisition of Shaen House (Plate 7.3). Situated outside Portlaoise and midway between the county hospital and the county home, they considered it 'ideally situated from a standpoint of isolation'. It was on offer to the board for £2,100.[128] The department took no part in this selection process as it was the official intention that, as in the case of Offaly, the Laois sanatorium requirements would be met in Roscrea. However suggestions as to the use of Roscrea were rejected by the board of health, seemingly without demur from the department.[129] Having renegotiated the purchase of the property to include sixty-seven acres of adjoining land the department approved of the acquisition for £2,800 in October 1928.[130]

Conversion works together with the acquisition of the premises were to be financed from the sanatorium fund and borrowings of £8,300.[131] In August 1929 the department

[125] Ibid., 10 Feb. 1934.
[126] Applications for approval, 26 May 1926; Ar son Rúnaidhe to the Secretary Laoighis County Council, 22 June and 6 July 1926 (NAI, Health D 111/22).
[127] Applications for approval, 10 Apr. and 26 May 1926. Ar son Rúnaidhe to the Secretary Laoighis County Council, 7 May and 6 July 1926 (NAI, Health D 111/22).
[128] *Kilkenny People*, 7 Jan. 1928.
[129] Ibid., 14 Jan. 1928.
[130] *Irish Independent*, 10 Oct. 1928.
[131] *Kilkenny People*, 18 Aug. 1928.

approved of plans to convert outbuildings into a Catholic chapel.[132] The thirty-bed facility was completed, equipped and ready for the reception of patients in March 1930.[133] This provision for tuberculosis patients was to prove inadequate, as at the behest of the department in March 1933 the architect Thomas J. Cullen was appointed to develop plans to extend the capacity of the hospital.[134] In July 1935 a tender in the sum of £12,801 was accepted, to provide new wards and a nurses' home at the institution.[135] When completed in 1936 these works extended the capacity of the sanatorium to forty-two beds.[136] The full works designed by Cullen, which brought the bed complement of the sanatorium to forty-nine, were not completed until 1941/42 (Plate 7.4).[137]

In Louth the use of a period house as a sanatorium was the eventual solution arrived at. However its genesis was quite different. Although not specifically acquired for sanatorium use**,** circumstances forced the Louth authority into adapting the house for tuberculosis accommodation.

In 1922 the Rushton estate on the outskirts of Ardee was purchased for £9,540 'in connection with the County Louth asylum scheme'. In June that year the Ardee workhouse was taken over to accommodate refugees from Belfast and patients moved from the workhouse hospital into Ardee House (Plate 7.5) on the Rushton estate.[138] In 1925, four male patients suffering from advanced tuberculosis were accommodated in the house and work was underway on providing a wing for female sufferers.[139] That year Dundalk and Drogheda district hospitals provided accommodation for twelve and eleven advanced sufferers respectively.[140] Surgical cases were treated in the Louth county infirmary in Dundalk a building dating from 1834.[141] By the end of 1925 the completion of the female ward at Ardee and the addition of a pavilion for male patients increased the

[132] Ibid., 17 Aug. and 16 Nov. 1929
[133] Ibid., 15 Feb. 1930; Application for approval, 20 July 1930 (NAI, Health D 111/22).
[134] Extract from minutes of proceedings of Laoighis board of health, 14 Mar. 1933 (NAI, Health H 15/6/3).
[135] *Irish Press*, 22 June 1935; *Irish Independent*, 19 July 1935.
[136] Annie Power, Catherine McCann, Margaret Doherty and Mary J. Bourke to Laoighis County Council, 10 Dec. 1943 (NAI, Health D15/45).
[137] Secretary, Laoighis County Council to Secretary, Department of Health, 26 June 1952 (NAI, Health H 15/6/3); Power, McCann, Doherty and Bourke to Laoighis County Council, 10 Dec. 1943.
[138] Harold O'Sullivan, *History of local government in the County of Louth* (Dublin, 2000), pp 79-80.
[139] Application for approval, 9 July 1925 (NAI, Health D 111/20).
[140] Applications for approval, 9 July 1925; Ar son Rúnaidhe to the Secretary, National Health Insurance Commission, 24 July 1925 (NAI, Health D 111/20).
[141] Application for approval, 10 Dec. 1925 (NAI, Health D 111/20); *The Argus*, 21 July 2000.

Plate 7.3 Shaen House, County Laois, *c*. 1928, acquired in 1929 for conversion into the county tuberculosis sanatorium (http://lordbelmontinnorthernireland.blogspot.ie)

Plate 7.4 Shaen House, County Laois, showing additions completed in 1941/42 to extend the capacity of the sanatorium (St Bridgid's Hospital Shaen, advertising brochure, 2010)

provision for tuberculosis sufferers to fourteen beds.[142] Reallocation of space within Ardee House provided accommodation for twenty-four pulmonary and four surgical cases by January 1930.[143] This allocation subsumed 50% of the total space in the hospital. Most of the fourteen male patients were housed in shelters erected in the hospital grounds. For the avoidance of infection of other inmates the department's medical inspector had arranged with the matron 'to have one pantry kept entirely for the use of TB patients and to have utensils washed there'. He also arranged to 'have a bath and lavatory on each floor set apart for their use'.[144] Further relocation of available beds provided accommodation for thirty-five tubercular patients by 1937.[145] To cater for the religious needs of patients St Joseph's chapel was built adjacent to the hospital in 1929 (Plate 7.6).[146]

In 1933/4 it was 'generally agreed that the existing system of TB hospitalization (in Louth) is not satisfactory, even when the services of local hospitals are augmented by larger sanatoria situated outside the county'.[147] Accordingly during 1933 the board of health had advertised for a country mansion 'suitable for conversion into a county sanatorium'. Ten replies were received and the three most suitable forwarded to the department for deliberation.[148] When these premises were rejected as unsuitable, following inspection by the department's medical and engineering inspectors, advertisements were placed for sites 'suitable for the erection of a county sanatorium'. This advertisement also elicited ten responses with the three most favourable being referred to the department for consideration.[149] However any progress along these lines was effectively stymied when the Hospitals Commission recommended using Ardee House as the county sanatorium.[150]

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[142] Application for approval, 12 Jan. 1926 (NAI, Health D 111/20). .
[143] Ibid., 9 Jan. 1930.
[144] Report on visit to Ardee hospital, 22 Jan. 1930 (NAI, Health D 111/20).
[145] Secretary, Louth County Board of Health and Public Assistance to Secretary, Department of Local Government and Public Health, 14 May 1937 (NAI, Health D 111/20).
[146] 'Ardee District Hospital, Ardee, County Louth' (http://buildingsofireland.ie) (29 Apr. 2014).
[147] *County of Louth, seventh annual report upon the health and sanitary conditions of the county and districts, 1934*, p. 27 (LCCA).
[148] *County of Louth, sixth annual report upon the health and sanitary conditions of the county and districts, 1933*, p. 19 (LCCA).
[149] *County of Louth, seventh annual report*, p. 27.
[150] *The Hospitals Commission, first general report, 1933-34*, P 1976 (Dublin, 1935), p. 41; *The Hospitals Commission, second general report, 1935 & 1936* (Dublin, 1937), pp 266-7.

Plate 7.5 Ardee House, County Louth, acquired by the local authority in 1922 and used to house tuberculosis patients from 1925 onwards. Photograph taken *c.* 1997 (www.buildingsofireland.ie)

Plate 7.6 St Joseph's chapel Ardee, County Louth, built adjacent to Ardee House Hospital in 1929 to cater for the religious needs of patients. Photograph taken *c.* 1997 (www.buildingsofireland.ie)

In 1923 the Carlow Board of Health were forced by the military authorities to vacate the former Carlow workhouse, which was being used to house patients, and to transfer them to the cavalry barracks, which was converted into a county home.[151] Eleven beds were reserved in this new facility for the treatment of four male and seven female cases of advanced tuberculosis. Surgical tuberculosis cases were treated in the district hospitals at Carlow, Muinebeag and Tullow.[152] This situation was to pertain until after the Second World War.

The board of health had attempted to provide a tuberculosis hospital when they purchased Upton House in 1937.[153] The house dating from *c*. 1840, located in a rural setting *c*.4 miles east of Muinebeag, together with forty-eight acres of land was purchased for £2,500. A further £560 compensation was paid to the leasehold owner.[154] Acquisition costs totalling £3,613 were funded in full from the Hospitals Trust Fund. However in 1943 the house was considered unsuitable for conversion to a hospital following adverse reports from the medical and architectural officers in the department on plans submitted by the council.[155] It was eventually sold in 1947 for £2,000. After deduction for the costs of disposal the net loss incurred was £1,733 which was bourn by the Hospitals Trust Fund.[156]

New build 1930-6 - Meath and Wicklow

In providing specifically designed new accommodation for the treatment of tuberculosis on sites adjoining existing institutions, authorities were able to derive economic benefits from utilising the facilities and staff of those institutions.

[151] *Annual report of the county medical officer of health, County of Carlow, 1931*, p. 13 (H.S.E. library Kilkenny).
[152] *Annual report of the county medical officer of health, County of Carlow, 1929*, pp 7, 15; Robert Condy, *Report on the operation of the tuberculosis scheme for the county over the period of six months ending the financial year 31 March 1928*, 21 May 1928 (H.S.E. library Kilkenny).
[153] File note, 25 Sept. 1954 (NAI, Health AD 1/41); *Irish Independent*, 25 Mar. 1937.
[154] File note, 4 Oct. 1954 (NAI, Health AD 1/41); 'Upton House, County Carlow' (http://www.buildingsofireland.ie) (11 Nov. 2013).
[155] File note, 25 Sept. 1954 (NAI, Health AD 1/41); Report on operation of Carlow tuberculosis scheme, 12 July 1948 (NAI, Health D112/361).
[156] File notes, 25 Sept. 1954 and 4 Oct. 1954 (NAI, Health AD 1/41).

Although Meath County Council on the recommendation of the board of health adopted a tuberculosis scheme in November 1926 it was not inaugurated until 1930.[157] In adopting the scheme the board of health had recommended that 'a suitable institution be established in the county for the treatment of advanced pulmonary cases'.[158] On 29 January 1930 it was decided to draw up plans to provide for offices for the county medical officer, a central dispensary and a small hospital for advanced tuberculosis cases in the grounds of the county home in Trim.[159] Having amended the plans (Plate 7.7) in accordance with departmental instructions, a tender for £2,042 was accepted to construct the building. This was to be financed by a sanatorium grant of £431 and borrowings of £1,611. [160] With overruns the cost of the project eventually reached £2,163 with £1,488 of this sum being attributed to the hospital. The works were completed by mid-December 1930.[161] The hospital contained two six-bed wards separated by a nurse's duty room. It was staffed by two nurses and two wardsmaids under the direction of the matron of the county home, which institution provided it with all its facilities.[162] However delays were experienced in launching the hospital. To facilitate its opening in September 1931 the tuberculosis officer was authorised to equip it with furnishings borrowed from the county home and the county hospital.[163] Most curable cases of pulmonary tuberculosis in the county were referred to Peamount where fifteen beds had been reserved. Some overflow patients were accommodated in Newcastle. Although the county hospital in Navan was used for cases of surgical tuberculosis, this was only a staging-post until the patients could be referred for treatment elsewhere, as the much needed 'beds therein cannot be allowed to glutted with' such cases.[164]

Throughout the 1920s Wicklow had no tuberculosis scheme. Despite the urgings of the minister, who pointed out the 'inadequacy of the existing arrangements', the council

[157] *Meath Chronicle*, 1 Jan. 1927; Extract from annual report of Meath county medical officer 1934 (NAI, Health D 22/4).
[158] *Meath Chronicle*, 1 Jan. 1927.
[159] Extract from County Meath Board of Health minutes, 29 Jan. 1930 (NAI, Health D 22/4).
[160] Ar son Rúnaidhe to the Secretary, Board of Health and Public Assistance, 8 Mar. and 26 May 1930; Secretary, An Bord Sláinte, Conndae na Mide to the Minister Department of Local Government, 22 May 1930; Extract from minutes of the County Meath Board of Health, 21 May 1930 (NAI, Health D 22/4).
[161] T. H. Leech to Meath County Board of Health, 22 November 1930 (NAI, Health D 22/4).
[162] *Tenth annual report of Meath county medical officer of health, 1939*, p. 14 (MCCA); Plans for proposed hospital at county home Apr. 1930 (NAI, Health D 22/4).
[163] Extract from County Meath Board of Health minutes, 23 Sept 1931.
[164] *Seventh annual report of Meath county medical officer of health, 1936*, pp 39-40 (MCCA).

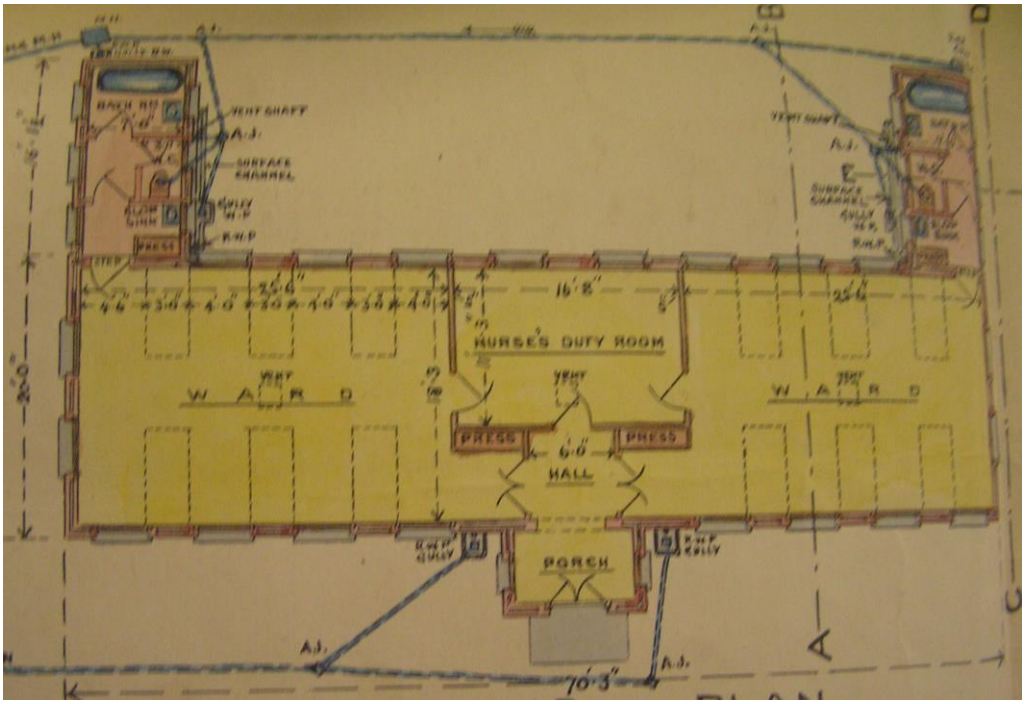

Plate 7.7 Architectural plans for Trim Hospital, County Meath, 1930. The twelve-bed hospital was opened in September 1931 to treat advanced cases of tuberculosis (NAI, Health D22/4)

refused to adopt one.[165] The standard reason advanced for such refusal was that 'the large expenditure involved in carrying out such a scheme should not be undertaken in the coming financial year'.[166] Under the 'existing arrangements', occasionally patients were referred for sanatorium treatment while others were treated in the county home and the county hospital. As the board had declared in 1925 that there were no institutions under its control for the treatment of tuberculosis, it would appear that tuberculosis patients in the county hospital had not been referred there for treatment but rather been diagnosed as suffering from the disease subsequent to admission, although certain advanced cases were referred to the county home.[167] In 1927, two uninsured patients had received sanatorium treatment, fourteen were treated in the county home and seven in the county hospital. The county insurance committee provided institutional or domiciliary treatment for insured patients. In 1927, thirty-four insured patients had received institutional treatment and twenty-six domiciliary treatment.[168]

In 1929 the board of health and the council adopted a scheme prepared by the department's inspectors Dr W. Sterling Berry and Dr Boyd Barrett. The scheme, which became operational on 1 April 1930, proposed inter alia referring cases of surgical tuberculosis to the Countess of Wicklow Memorial Hospital in Arklow and investigating the suitability of Shillelagh workhouse for the treatment of advanced cases.[169] The Countess of Wicklow voluntary hospital had opened as a three-ward facility in 1921 adding a fever wing in the summer of 1928. Further extensions in 1931/2 provided a forty-two bed facility with thirty-two beds reserved for the treatment of surgical tuberculosis.[170]

[165] L.S. Smith ar son Rúnaidhe to the Secretary, Wicklow County Council, 17 Dec. 1925 quoted in minutes Wicklow County Board of Health, 21 Dec. 1925; Minutes Wicklow County Board of Health, 28 Nov. 1927, 23 Jan., 18 June, and 26 Nov. 1928 (WWCCA).
[166] Minutes Wicklow County Board of Health, 15 Jan. 1926.
[167] Ibid., 21 Dec. 1925 and 24 Feb. 1930.
[168] Ibid., 27 Feb. 1928 and 21 May 1929.
[169] *Minutes Wicklow county council,* 27 May 1929*;* Minutes Wicklow County Board of Health, 21 May and 8 July 1929 (WWCCA).
[170] L. Myres, secretary, The Countess of Wicklow Memorial Hospital to the Secretary, Department of Local Government and Public Health, 8 June 1937 (NAI, Health D 111/38); Irish Architectural Archive, Dictionary of Irish Architects 1720-1940 'Countess of Wicklow Memorial Hospital, Arklow' (www.dia.ie) (2 Nov. 2013).

In February 1930 Dr. G. P. G. Beckett, the county medical officer, objected to sending advanced cases of tuberculosis to the county home in Rathdrum, as it posed a danger to other patients, there being 'no provision for their isolation from other cases'. He suggested purchasing a suitable house within the county in which to accommodate them.[171] However having inspected the disused fever hospital at Shillelagh, part of the former workhouse premises, he felt that these were suitable for adoption and offered a more economical solution that purchasing a premises.[172] It was estimated that refurbishing and extending the fever hospital, which was 'in an advanced state of dilapidation' would cost £7,000-£8,000. The minister rejected the proposal, as the cost incurred would be prohibitive. He suggested inspecting 'large country mansions in good repair...with well laid out grounds attached', which might be acquired at a lesser cost than bringing the fever hospital up to standard.[173]

Advertisements were placed seeking suitable premises, to which nineteen replies were received.[174] The twelve most suitable of these were inspected by Dr Beckett accompanied by Boyd Barrett. They determined that the most suitable of those was the former private sanatorium 'Altidore'.[175] However the estimated cost of its acquisition and refurbishment £10,000 proved a significant barrier.[176]

Under threat of the loss of government funding for the project Dr Beckett devised an alternative scheme, which was approved by the board in February 1932. This involved the acquisition of a field of *c.* 10 acres located immediately south of the existing county home and constructing thereon a hospital with a verandah capable of accommodating 20-25 patients. As all the facilities of the county home including management would be available to the proposed institution only a small increase in staff would be required. He estimated the project would cost £8,000.[177] The field was acquired for £1,000.[178] Plans were drawn up in consultation with the department which provided for six four-bed wards, a day room and nurses quarters.[179] Cost were increased by decisions to use

[171] Minutes Wicklow County Board of Health, 24 Feb. 1930.
[172] Ibid., 24 Mar. 1930.
[173] Ibid., 18 Aug. 1930.
[174] Ibid., 27 Oct. and 24 Nov. 1930.
[175] Ibid., 15 Dec. 1930 and 28 Sept. 1931.
[176] Ibid., 26 Oct. 1931.
[177] Ibid., 22 Feb. 1932.
[178] Ibid., 9 May 1932.
[179] Ibid., 21 Mar. and 9 May 1932.

Wicklow granite for the walls and Wicklow slate for the roof and further added to by the withdrawal of the lowest tender due to delays by the department in issuing approval. The new successful tender was for £10,220. Other approved tenders were for electrical works £324, plumbing £973, heating £605, boundary wall and gate piers £2,640, additional works and equipment £6,037, paths and walks £844 and a gate lodge, to provide security for the institution, £785. Several of the works experienced considerable overruns before completion.[180] The cost of the project now of the order of £24,000 considerably exceeded the 'prohibitive 'costs of the rejected proposals. However no undue financial strain was placed on the board as the minister had agreed to the funding of the project from the sanatorium grant and from hospital's sweepstakes funds.[181]

Negotiations were entered into with the Poor Servants of the Mother of God, the order of nuns running the county home, regarding nursing services in the new institution. The order was founded in London in 1869 by Frances Taylor (Mother Magdalen) who had gained considerable practical nursing experience during the Crimean war.[182] Based on the ideas developed by the Little Servants of Mary in the Duchy of Posen in Poland and with the aid of Lady Georgiana Fullerton, 'girls who had a call to serve god in religion' were accepted into the new congregation 'without having the necessary dower'.[183] The shortfall in funds was made up by the order engaging in industrial works such as laundry and printing.[184] Initially involved in visitations to the poor in their dwellings, at the request of the Jesuits they opened a hospital in 1882 in their convent at St Helens Lancashire, which had been established the previous year. By 1900 having moved to larger premises the now titled Providence Hospital had seven wards and accommodation for sixty-two patients.[185] In 1875, at the invitation of the local priest Fr Seymore, who promised a site for a convent and a contribution towards building costs, the sisters arrived in Carrigtwohill, County Cork. Shortly thereafter they undertook the teaching duties at the local national school before founding a girl's secondary boarding school in

[180] Ibid., 9 May 1932, 6 Mar., 6 June, 24 July 1933, 26 Mar., 8 Aug. 1934 and 27 May 1935.
[181] Ibid., 6 June 1933.
[182] 'The life of Frances Taylor' (www.poorservants.org) (6 Feb. 2015). Fanny Taylor, *Eastern hospitals and English nurses* (London, 1857).
[183] Henry James Coleridge, *Life of Lady Georgians Fullerton* (London, 1888), p. 411.
[184] Ibid, pp 411-14.
[185] Carmen M. Mangion, 'Medical philanthropy and civic culture: Protestants and Catholics united by a 'Common Christianity' (www.academia.edu) (17 Feb. 2015).

the 1890s.[186] The sisters came to Dublin in August 1888 to take over St Joseph's Asylum 'for aged single females of unblemished character', which prior to their arrival had been run by lay people.[187] In 1899 Mother Dimas, the superior of the Providence Hospital, together with members of the congregation took over the management of the Rathdown Union workhouse at Loughlinstown, County Dublin.[188]

The order agreed to provide three sisters, who were trained nurses, to provide full twenty-four hour nursing duty, supervised by the matron. The nuns were paid £100 per annum for this service. The matron's services were provided free of charge.[189] As the minister had rejected a proposal to have patients and inmates in the county home perform the duties of wardsmaids, two non-resident wardsmaids were employed at an annual salary of £30.[190] When the local Catholic priest pointed out that no provision had been made 'for spiritual attendance on the inmates', the Catholic and Protestant chaplains of the county home were appointed as chaplains to the new institution at respective salaries of £20 and £10 per annum.[191] This was shortly thereafter increased to £42 and £15.[192] Prior to opening the matron pointed out the necessity of separating 'the male from the female section of the verandah by means of a partition. This was achieved by erecting a low concrete wall with obscure glass over it to a height of seven feet.[193] The sanatorium was officially opened on 6 January 1936.[194]

Adaptation of existing facilities - Kilkenny, Westmeath and Longford

Some authorities adapted existing former poor law premises, although the resultant institutions did not always provide suitable accommodation.

The Kilkenny amalgamation scheme had made provision for the transfer of pulmonary tuberculosis patients to the central sanatorium in Kilkenny city. This was located in the

[186] 'A history of gaelic games in Carrigtwohill' (www.carrigtwohillgaa.com) (14 Feb. 2015). Georgiana Fullerton, 'A village convent at Carrigtwohill' in *The Irish Monthly*, iv (1876), pp 520-2.
[187] M. R., 'The founder of St Joseph's Asylum, Dublin' in *The Irish Monthly*, vol. 25, no. 292 (1897), pp 543-7.
[188] Eva Ó Cathaoir, 'The Rathdown Union workhouse at Loughlinstown , 1838-1923' in *Dublin Historical Record*, vol. 48, no. 2 (1995), pp 111-24.
[189] Ibid., 22 Oct., 26 Nov. 1934, 7 Oct., 28 Oct., and 11 Nov. 1935; *Irish Press*, 7 Jan. 1936.
[190] Minutes Wicklow County Board of Health, 26 Nov. 1934 and 11 Nov. 1935.
[191] Ibid., 27 Jan. 1936.
[192] Ibid., 23 Mar. and 27 Apr. 1936.
[193] Ibid., 10 Dec. 1935.
[194] *Irish Press*, 7 Jan. 1936.

former militia stores and onetime workhouse, which had been acquired for use as a central dispensary. By 1927 it had indoor accommodation for twenty-four patients in addition to housing a further six in chalets in the grounds.[195] Urgent pulmonary cases awaiting transfer to the sanatorium were treated in Castlecomer district hospital and in the former workhouse premises, Kilkenny Central Hospital. The latter institution also treated cases of surgical tuberculosis.[196] Other surgical patients were treated in Aut Even hospital, Kilkenny, which had been founded as a cottage hospital by the Countess of Dessart in 1915.[197] This private facility managed by the Sisters of St John of God had accommodation for fifteen poor patients in wards and five patients of private means in individual bedrooms.[198]

In October 1926 Dr P. Heffernan, the tuberculosis medical officer, announced that provision was been made for additional accommodation in the sanatorium, where 'advanced cases can be treated and isolated'.[199] The following March the board of health provided £372 to cover the works and help reduce the admission waiting list.[200] Work commenced in January 1928. By July the new wards were ready for occupation bringing the capacity of the hospital up to forty-five beds and the transfer of patients from the central hospital had commenced.[201]

By 1934 the sanatorium required 'extensive repairs and equipment'. It was proving impossible to keep advanced patients in the institution, as they continually discharged themselves against medical advice. Dr Heffernan maintained that the acquisition of a house and lands, funded from hospital's sweepstakes funds, would provide a 'more desirable alternative' to redeveloping the existing facility. The department concurred stating that unless works were 'considered urgently necessary' they should not be

[195] Application for approval, 5 May 1927; Ar son Rúnaidhe to the Secretary, National Health Insurance Commission, 13 May 1927 (NAI, Health 111/16).
[196] Applications for approval, 2 June 1926 and 12 May 1927; Ar son Rúnaidhe to the Secretary, Kilkenny County Council, 7 July 1926; Ar son Rúnaidhe to the Secretary, National Health Insurance Commission, 29 June 1927; Ar son Rúnaidhe to the Secretary, Kilkenny Board of Health, 18 May 1927 (NAI, Health 111/16).
[197] National Inventory of Architectural Heritage, 'Aut Even Hospital, County Kilkenny' (www.buildingsofireland.ie/niah) (4 Nov. 2013); Irish Architectural Archive, Dictionary of Irish Architects 1720-1940 'Albert Edward Murray' (www.dia.ie) (4 Nov. 2013).
[198] Application for approval, 7 Mar. 1927; Ar son Rúnaidhe to the Secretary, Kilkenny Board of Health, 31 Mar. 1927; Report J. Boyd Barrett, 16 Dec. 1925 (NAI, Health 111/16); Aut Even Hospital 'Proud of our history open to change' (http://autevenhospital.ie) (4 Nov. 2013).
[199] *Kilkenny People*, 16 Oct. 1926.
[200] *Irish Times*, 1 Apr. 1927.
[201] *Kilkenny People*, 21 Jan., 9 June and 21July 1928.

undertaken as 'the site of the existing sanatorium is not considered an ideal one'. It suggested advertising for site of at least twenty-five acres on which an alternative proposal could be developed. Following advertisement proposals were submitted to the department. [202]

However on 8 May 1937 the department informed the board of health that 'this matter was being deferred pending the issue of a decision as to the general policy concerning institutional treatment of cases of tuberculosis'.[203] The Hospitals Commission, which was established pursuant to the Public Hospitals Act 1933, was asked to examine what provision should be made for the treatment of tuberculosis.[204] The government had under consideration the commission's second report, which recommended the provision of regional centres for the treatment of tuberculosis.[205] The Commission had pointed out that the governments financial position was 'palpably inadequate' to finance the recommended schemes of hospital development and as money 'required to finance the various schemes for local authority hospital development […] will not be forthcoming for a considerable time […] care will have to be exercised in regard to allowing a large number of these schemes to proceed until there is a reasonable assurance that the necessary monies can be made available'.[206]

In Westmeath, during the early 1920s, the Mullingar fever hospital was entirely used for chronic tuberculosis cases, a purpose it 'served […] fairly well'. However an outbreak of fever led to its restoration to its former use.[207] Arising from this situation in March 1925 Boyd Barrett reported that 'no satisfactory arrangements have been made for advanced cases' in Westmeath. Some patients were housed in various wards in the county home and county hospital in Mullingar, although no special wards were available for them, while others were accommodated in the lower wards of the fever hospital while the upper wards contained fever cases, a situation which according to Boyd Barrett 'cannot be

[202] Extracts from annual report of county medical officer for Kilkenny, 1937 (NAI, Health D14/3); *Kilkenny People*, 6 Apr. 1935.
[203] Extracts from annual report of county medical officer for Kilkenny, 1937.
[204] Public Hospitals Act, 1933/18 [Éire] (27 July 1933); Dr Francis Constantine (Con) Ward, Dáil debates, vol. 65, no. 7, 1027, 25 Feb. 1937. Ward was Fianna Fáil deputy for Monaghan and Parliamentary Secretary to the Minister for Local Government and Public Health from March 1932 to July 1946.
[205] *The Hospitals Commission, second general report*, pp 16-25.
[206] Ibid., pp 34-5.
[207] File note J. Boyd Barrett, Aug. 1925 (NAI, Health D 111/34).

considered suitable'.[208] Surgical cases were referred to the county infirmary in Mullingar, where seven beds were available for their treatment.[209] In 1926 the minister approved of the use of four wards containing twenty beds in the county hospital for the treatment of all forms of tuberculosis.[210] In issuing this approval he had regard to the recommendation of Boyd Barrett that early cases of the disease be accommodated in this hospital, where the medical officer, with the aid of x-ray equipment, was 'doing numerous operations of pneumothorax with very good results'.[211] He also approved of the district hospital in Athlone, where two wards containing eleven beds were available, for the treatment of surgical and advanced cases.[212]

In 1932 the board of health decided to seek grant aid to build a hospital for the treatment of pulmonary tuberculosis.[213] In pursuance of this decision newspaper advertisements were placed seeking sites. In response numerous site were offered in various parts of the county.[214] Because of the number of sites involved, the department requested that a selection be made of the best three or four and forwarded to the department for technical assessment. An inspection of the existing county hospital, which would become available when the new county hospital then under construction was completed, suggested to board members that the premises 'might possibly suffice if adapted as a tuberculosis hospital'. This could be achieved for 'a comparatively small sum'. The board directed that any engineering report forwarded to the department should include this possibility.[215] It was probably the inclusion of this financially beneficial alternative to site acquisition that caused the department to reject all three sites suggested.[216] With no other alternative, when patients were transferred from the old county hospital to the new hospital in 1935, the old hospital was reorganised as a sanatorium providing accommodation for forty-eight tuberculosis patients.[217] In September 1937 the county infirmary in Mullingar was closed and the surgical tuberculosis patients therein transferred to two two-bed wards

[208] Report on County Westmeath tuberculosis scheme, 12 Mar. 1925 (NAI, Health D 111/34).
[209] Ibid: Application for approval, 24 Apr. 1926 (NAI, Health D 111/34).
[210] Application for approval, 1 June 1926; Ar son Rúnaidhe to the Secretary, National Health Insurance Commission, 9 July 1926 (NAI, Health D 111/34).
[211] File note recommendation of J. Boyd Barrett, 14 June 1926 (NAI, Health D 111/34).
[212] Application for approval, 1 June 1926; Ar son Rúnaidhe to the Secretary, Westmeath County Council, 28 July 1926. (NAI, Health D 111/34).
[213] *County Westmeath, fourth annual report of the county medical officer of health, 1932*, p. 17 (WMCCA).
[214] *County Westmeath, fifth annual report of the county medical officer of health, 1933*, p. 17.
[215] *Westmeath Examiner*, 7 Oct 1933.
[216] *County Westmeath sixth annual report of the county medical officer of health, 1934*, p. 14.
[217] *County Westmeath, eighth annual report of the county medical officer of health, 1936*, p. 17.

complete with sun balconies which had been reserved for such treatment in the new county hospital.[218] In December 1937 it was decided to transfer all tuberculosis patients from Athlone district hospital to the sanatorium.[219]

Longford Board of Health was the most reticent of the Leinster authorities in making provision for the treatment of tubercular patients. In 1926 the minister approved of the use of the county hospital in Longford for the treatment of cases of surgical tuberculosis.[220] However as no tuberculosis scheme had been adopted or no county medical officer appointed there was no co-ordination regarding the overall treatment of tuberculosis in the county. From 1926 to 1934, the department continuously urged the council to adopt a scheme and appoint a medical officer. However the council engaged in the political subterfuge of marking departmental correspondence on the subject as 'read' or deferring consideration of it for 6 months, while at the same time refusing to take any action thereon.[221] The attitude of the council is typified by a motion, passed unanimously in August 1930 in response to a departmental letter urging the appointment of a county medical officer, 'that we do not consider the appointment of a medical officer of health necessary, as we are satisfied the machinery for carrying out the medical services in the county at present are quite sufficient for a rural district'.[222] To further pressurise the council the department's inspector was dispatched to attend the November 1934 council meeting, where he elicited an agreement to adopt a tuberculosis scheme and appoint a county medical officer.[223] However it was not until the following November that Dr Anthony Doherty was appointed to the post.[224] He took up duty on 1 January 1936.[225]

At his first board of health meeting, on 21 January 1936, Doherty tabled a tuberculosis scheme which was unanimously adopted. The scheme provided inter alia for the erection of two verandahs, one for the female ward and one for the male ward at the county home 'to afford open air treatment to the cases being treated there'.[226] The inclusion of this

[218] Ibid., p. 19.
[219] Extract from the Westmeath Board of Health minutes, 10 Dec. 1937 (NAI, Health D 111/34).
[220] Minutes of quarterly meeting of county council, 18 Aug. 1926 (LDCCA).
[221] Ibid., 17 Nov. 1926, 16 Feb. 1927, 21 Aug. 1929 and 22 Aug. 1934; Minutes of special meetings of county council 2 May 1928 and 10 Oct. 1934 (LDCCA).
[222] Minutes of quarterly meeting of county council, 20 Aug. 1930 (LDCCA).
[223] Ibid., 21 Nov. 1934.
[224] Ibid., 20 Nov. 1935.
[225] Minutes of meeting of County Longford Board of Health and Public Assistance, 21 Jan. 1936 (LDCCA).
[226] Ibid.

provision is evidence that this institution was being used to accommodate some tuberculosis cases. A report on this institution the following July by the Hospital Commission found it to be in a 'deplorable condition'. It was totally overcrowded ninety patients occupying a space intended for seventy-five. The sanitary arrangements were 'very bad, though there is a bath and two w.cs, there is an insufficient water supply to operate these and a septic tank overflows into a field right beside the building'. The premises were not connected to the town water supply. The Commission found that the Longford health authorities had failed 'to provide even moderately improved County Home accommodation' thus failing 'to do their duty' and showed little evidence 'of an earnest desire […] to discharge their obligations'.[227] In February 1936, eight cases of pulmonary tuberculosis and ten cases of surgical tuberculosis were undergoing treatment.[228] In April the board agreed to purchase six chalets at a cost of £20 each for the immediate use of tubercular patients at the county home.[229] In a subsequent report in 1948, James Deeney, the department's chief medical advisor, commented on the county home, which then had eighteen beds reserved for advanced cases, 'feeding is reasonably good but there are none of the proper amenities of a tuberculosis institution […] this accommodation is the worst of its kind in Ireland'.[230]

Dispensaries

The consolidation of tuberculosis services under one county health authority and the appointment of county medical officers facilitated the geographical expansion of county tuberculosis dispensaries (see appendix 17). Most of this expansion occurred by the making available of the facilities of poor law dispensaries when required. The abolition of the boards of guardians and the rural district councils had removed two potential bodies of objectors to the location of tuberculosis facilities in these premises. Yet objections did arise from other sources.

In 1923 the Offaly branch of the Irish medical association objected to the use of public dispensaries to treat tuberculosis believing the practice to be 'injurious' to ordinary patients. The belief was based on the knowledge 'that the germ of tuberculosis lives in the walls and in the air of buildings where phthistical people congregate'. As the patients

[227] *The Hospitals Commission, second general report*, pp 321-3.
[228] Minutes of meeting of County Longford Board of Health and Public Assistance, 24 Mar. 1936.
[229] Ibid., 21 Apr. 1936.
[230] Report on operation of Longford tuberculosis scheme, 12 July 1948 (NAI, Health D112/361).

attending the dispensaries were of 'lowered vitality these [germs] constitute serious danger'.[231]

In Gorey, County Wexford, when the tuberculosis dispensary in the former workhouse was taken over for the redevelopment of the site in 1936 the board of health decided to relocate the facility in the poor law dispensary in the town. However Dr E. G. Connolly in whose residential premises the dispensary was located objected to the proposal.[232] His objection stressed the dangers associated with bringing a group of tuberculosis patients into contact with ordinary dispensary users. Such contact would have a psychological effect on his patients 'even if it were possible to assure them that no tubercule bacilli were hanging around'. He viewed the existing premises as too small for existing users. The installation of facilities for the tuberculosis officer would further reduce space. As the dispensary lacked sanitary facilities, tuberculosis patients would wander over his premises including his 'garden and private grounds making use of these as sanitary conveniences' a matter he 'had previous experience of'. He also considered it 'unfair to my children and my staff to expose them to the risks'. Although the county medical officer considered Dr Connolly's objections as 'public advocacy of the unenlightened medieval policy of treating tuberculosis patients as pariahs or lepers' Connolly's objections were upheld by the board.[233] The dispensary was temporarily relocated to the district hospital. When the hospital was being redeveloped, in 1939, the dispensary was closed and the patients referred to the Enniscorthy dispensary some twenty miles away.[234] When an adjoining caretaker's house was acquired for the redeveloped hospital, a tuberculosis dispensary was constructed to the side of the premises accessed via the side and rear passages of the house.[235]

In 1938, at the department's behest, the Kilkenny county medical officer approached the Graiguenamanagh dispensary medical officer with a view to providing a tuberculosis dispensary in his premises.[236] However his response reflected his Gorey colleague as 'under no circumstances' would he agree to have a tuberculosis dispensary held on the

[231] Minutes of meeting of Offaly County Council, hospitals and homes committee, 10 July 1923.
[232] County Wexford Board of Health minutes, 17 Feb. 1936.
[233] Ibid, 2 and 16 Mar. 1936.
[234] Ibid., 17 Apr. and 17 July 1939.
[235] Ibid., 19 June 1939; plans prepared by J. W. O'Sullivan, architect, Oct. 1941 (NAI, Health D 31/35).
[236] Ar son Rúnaí to Dr K. McColgan, county medical officer of health, Kilkenny, 10 Aug. 1938 (NAI, Health D 14/11).

premises which enjoyed no separate entrance. Since there would be 'no provision for having premises and surroundings disinfected' as the father of very young children he intended 'taking no risks whatever'.[237]

Some of the premises in which the dispensaries were held drew criticisms. The department inspectors found the Offaly public assistance dispensary premises to be mostly 'unsuitable and dingy'.[238] They considered the central clinic in Longford to be 'inadequate and unsuitable, a dusty shabby room […] with no examination couch'. Patients had to 'wait in a small hall without seating or heating with only room for four patients'. The Longford branch dispensaries were 'of a poor type'.[239] The central dispensary in Kilkenny was held in a room in the hall of the county sanatorium, 'inadequate in size even for ordinary examinations'. As there was no waiting room, patients had to 'wait in a draughty hall'. The branch dispensaries here were also described as being 'mostly of a poor type'.[240] The Maynooth dispensary was held in a house in 'very bad repair', the walls were 'damp […] cracked and crumbling'. There was no sanitary accommodation.[241] The Kildare premises had no waiting room and 'patients have to wait in the open air in all weathers'.[242] The Carlow central dispensary was held at Monacurra about one mile from Carlow town, a distance considered too far by the department's inspector. The premises were also deemed 'unsatisfactory' having no electricity or water.[243] The Wexford central dispensary situated about ¾ mile from the town was approached by a long steep gradient which in the inspector's opinion would 'impose a strain on a dyspnoeic patient'.[244] The dispensary at Tyrellspass was described by Dr McWeeney as 'rather decrepit and dirty'.[245]

[237] K. McColgan to the Secretary, Department of Local Government and Public Health, 11 Aug. 1938 (NAI, Health D 14/11).
[238] Report on operation of Offaly tuberculosis scheme, 12 July 1948 (NAI, Health D112/361).
[239] Report on operation of Longford tuberculosis scheme, 12 July 1948 (NAI, Health D112/361).
[240] Report on operation of Kilkenny tuberculosis scheme, 12 July 1948 (NAI, Health D112/361).
[241] Dr McCarthy to the Secretary, Department of Local Government and Public Health, 17 Feb. 1938 (NAI, Health D 13/35).
[242] Ibid., 5 Dec. 1945.
[243] Report on operation of Carlow tuberculosis scheme, 12 July 1948 (NAI, Health D112/361).
[244] Report on operation of Wexford tuberculosis scheme, 12 July 1948 (NAI, Health D112/361). Dyspnoea is a medical term for difficulty in breathing, a condition from which many pulmonary tuberculosis patients suffered.
[245] Report by Dr McWeeney on operation of County Westmeath tuberculosis scheme, 15 Mar. 1938 (NAI, Health D 30/7)

Although, because of the paucity of available statistics, it is not possible to accurately portray the impact of the dispensaries on the public, nevertheless available figures can indicate the important role they played. Offaly recorded 2,493 patient attendances at tuberculosis dispensaries for the year 1927-28 rising to 3,294 in 1928/29 and 3,835 in 1930.[246] Louth recorded 2,616 attendances in 1928 rising to 2,916 in 1929 and 3,344 in 1930 but in subsequent years they declined to 3,147 in 1931, 2,848 in 1932 and 2,493 in 1933.[247] The initial attendance increases in this county were declared by the county medical officer to be 'evidence of a tendency on the part of patients to at last pay attention to the many warnings issued *re* the necessity of regular attendance'.[248] Wexford recorded 3,325 attendances for the year 1929/30, rising to 3,770 in 1930 yet thereafter generally declining to 3,592 in 1932 and 2,357 in 1938.[249] Westmeath recorded 961 attendances in 1937 rising to 1,331 in 1938 and 1,578 in 1939 but falling to 1,416 in 1940.[250] Meath recorded 812 attendances in 1938 falling to 631 in 1939 and 606 in 1940.[251]

The figures do show some anomalies. Louth and Meath with similar populations and three dispensaries each display startling differences in attendance. This may be explained by the size of the relative counties. As Meath is almost three times the size of Louth, its small number of dispensaries may have proved inaccessible to large numbers of the population.

The dispensaries played a key role in the identification of tuberculosis sufferers, the follow-up of their contacts to detect the presence of the disease, the provision of

[246] Minutes of Offaly County Board of Health, 10 Apr. 1928, 23 Apr. 1929 and 24 Mar. 1931.
[247] *County of Louth, second annual report upon the health and sanitary conditions of the county and districts, 1929*, p. 18; *County of Louth, third annual report upon the health and sanitary conditions of the county and districts, 1930*, p. 19; *County of Louth, fourth annual report upon the health and sanitary conditions of the county and districts, 1931*, p. 24; *County of Louth, fifth annual report upon the health and sanitary conditions of the county and districts, 1932*, p. 23; *County of Louth, sixth annual report upon the health and sanitary conditions of the county and districts, 1933*, p. 26 (LCCA).
[248] *County of Louth, third annual report upon the health*, p. 19.
[249] Minutes of Wexford Board of Health and Public Assistance, 16 June 1930, 20 Apr. 1931, 18 May 1932 and 16 Jan. 1939 (WCCA).
[250] *County Westmeath, ninth annual report of the county medical officer of health, 1937*, p. 19; *County Westmeath, tenth annual report of the county medical officer of health, 1938*, p. 18; *County Westmeath, eleventh annual report of the county medical officer of health, 1939*, p. 17; *County Westmeath, twelfth annual report of the county medical officer of health, 1940*, p. 17 (WMCCA).
[251] *County of Meath, ninth annual report upon the health and sanitary conditions of the county, 1938*, p. 82; *County of Meath, tenth annual report upon the health and sanitary conditions of the county, 1939*, p. 104; *County of Meath, eleventh annual report upon the health and sanitary conditions of the county, 1940*, p. 80 (MCCA).

medicines and treatment, educating sufferers regarding all aspects of the disease and the supervision of domiciliary care. This work would not have been possible without the assistance of the many jubilee nurses (see appendix 17) who facilitated the operation of the clinics. In addition they visited the homes of sufferers to provide nursing care, reported on home conditions, persuaded contacts to attend the dispensary and educated 'patients and their families in the methods of prevention and the necessity for treatment'.[252]

Although the dispensaries did increase considerably the availability of diagnostic and treatment facilities, they did not gain the confidence of all members of the public. This is evidenced by the declaration of the TD James Everett in 1945 that 'the people are ashamed and afraid to be seen going near these dispensaries. It is only the advanced case that will go to the dispensaries and they go there because they think there is some hope of getting into a sanatorium to die there.'[253]

Conclusions

In the post First World War period the newly established national government sought to dismantle the health system it had inherited. It set up new structures to deliver tuberculosis services. These structures facilitated the expansion of the tuberculosis dispensaries, making available diagnostic and treatment facilities to large numbers of sufferers. The new regime subjected local heath authorities to micro-management by central government. This often resulted in the escalation of costs and delays in the provision of services, frequently to the detriment of patients.

The Department of Local Government and Public Health's preferred solution to the provision of sanatorium facilities appeared to be the acquisition and adaptation of period houses. Most authorities attempted to secure such premises. However this process frequently proved costly often requiring substantial additional construction to provide adequate facilities. Some authorities sought to avail of the economic benefits to be derived from co-locating facilities. In Meath this resulted in limited new accommodation

[252] Annual report of the county medical officer of health, County Kildare 1929, pp 18-9 (KCCA); *County of Meath, seventh annual report upon the health and sanitary conditions of the county, 1936*, pp 52-3 (MCCA).
[253] James Everett, Dáil Debates Vol. 95, No.14, 1953-4, 31 Jan. 1945. Everett, a trade union employee, was the Labour Party TD for County Wicklow from 1922 to 1969.

being provided for small capital outlay and with low operational overheads. However in Wicklow the capital costs of the project escalated, although lower operational costs were achieved. In some counties the lower cost of adapting existing premises forced this solution on financially constrained authorities over more expensive alternatives. Invariably this provided a less than ideal solution.

Concern with religion and the provision for religious practice, occasionally instigated by chaplains and local clergy, shaped decisions both within the department and by local authorities. The continued involvement of religious orders of nuns facilitated the maintenance and expansion of services as had hitherto been the case. As in previous decades the extent to which resources for the treatment of tuberculosis had been developed would not have been achieved in the absence of the extensive facilities and inexpensive labour provided by female religious congregations. The impact of the religious comfort provided by nursing nuns on both patients and their families continued to provide an important psychological boost to such persons.

Chapter 8

Filling the void—the role of religious organizations and philanthropy in the treatment of children 1874-1969

In 1873 the year immediately preceding the opening of the first institution to treat tubercular children in Ireland, in an estimated population of 5,337,261, the number of deaths occurring was 97,537. The registrar general attributed 14,005 of these to tuberculosis. Of the tubercular deaths 3,999 were in children under 15 years of age 2,434 of those occurring in infants under 5 years of age.[1] By 1911 the year preceding the opening of the second such institution the estimated population had declined to 4,374,584. That year 72,475 deaths occurred, 9,623 of these being attributed to tuberculosis. Children under 15 years of age accounted for 1,815 of the tuberculosis deaths with 920 of them occurring in infants under 5 years of age.[2]

When it came to the treatment of tubercular children, the state relied almost totally on voluntary hospitals founded by religious congregations and private individuals. These institutions adopted the most up to date medical practices, whilst also addressing the children's educational and religious needs. Relying chiefly on private philanthropy to meet their funding needs, chronic underfunding was a persistent problem requiring constant fundraising initiatives to address it. Subsequent state involvement in funding brought with it micro-management by central authorities without addressing the real monetary needs of the institutions. This chapter will examine the evolution and development of these institutions in Leinster in chronological order from the date of their first involvement in the treatment of tubercular children.

The Cripples Home Bray 1874-1968

The Cripples Home in Bray was the first institution in Ireland to provide for the nursing, educational and training needs of crippled children, mainly sufferers of various forms of non-pulmonary tuberculosis. Established by a religious inspired benefactress it relied largely on private philanthropy for its funding needs. Although expressed to be non-denominational the institution had a marked Protestant ethos. It was amongst the earliest

[1] *Tenth detailed annual report of the registrar-general of marriages, births, and deaths in Ireland 1873*, p. 3, [C. 1376], H. C. 1876, xviii, 387.
[2] *Forty-eighth detailed annual report of the registrar general for Ireland containing a general abstract of the numbers or marriages, births, and deaths registered in Ireland during the year 1911*, p. 3, [Cd 6313], H. C. 1912-13, xiv, 1.

Irish institutions to introduce heliotherapy as developed by Auguste Rollier as a method of treatment for surgical tuberculosis.

According to her own account, in the mid 1870s Lucinda Sullivan travelled continental Europe spending time in various hospitals learning 'how best to nurse the sick'. Upon her return to Ireland she took up a residency in the Adelaide Hospital, Dublin, where she witnessed children suffering from spinal and joint diseases being shuffled from one hospital to another or released to the care of a mother in a dismal damp abode only to return some months later 'thinner and more suffering…with feebler prospects of recovery than before'.[3] This experience made her aware of the great need in Ireland for a cripples' home wherein hospital care, schooling and training for future industrial occupation could be combined. Sullivan borrowed the empty Bray Auxiliary to the Hospital for Incurables in which to establish her cripples' home.[4] She had a letter published in the *Daily Express* on 26 October 1874, setting out her proposals for establishing a home for crippled children from all parts of Ireland regardless of creed, but subject to the fundamental principle that 'every inmate must receive religious instruction direct from the Word of God'. Within five days of the appearance of the letter Sullivan had received £300, sufficient funds to enable the project to proceed. By the end of the year contributions of £1,000 had been received.[5] The home opened in late 1874 with accommodation for fourteen children, suffering mainly from surgical tuberculosis and rickets.[6]

Recruiting members of the aristocracy as supporters of the home increased the profile of the endeavour and assisted in fundraising. One of the prominent early supporters of the home was Lady Louisa Abercorn wife of the viceroy. Her assistance both financial and in kind ensured that sufficient funds (almost £2,000) had been accumulated by February 1875 to enable her daughters lay the foundation stone for an extension to the home.[7] The facility, which accepted patients from March 1878, was not completed until April 1880

[3] Lucinda Sullivan, *Cripples' Home, Bray, County Dublin. An address by Mrs. Lucinda Sullivan delivered before the British Association for the Advancement of Science on Thursday, the 22nd of August, 1878, being the occasion of their visit to the Cripples' Home Bray* (Dublin, 1878) pp 3-8.
[4] Ibid., pp 5-8.
[5] Ibid., pp 5-9.
[6] *Freeman's Journal*, 8 Feb. 1875. Loghhrey from an examination of early admission forms has identified Pott's Disease (tuberculosis of the spine), tubercular meningitis, rickets and tubercular peritonitis as the most common diseases afflicting early admissions (Francis Loughrey, *Sunbeam House Bray* (Bray, 1996), p. 25.).
[7] Sullivan, *Cripples' Home, Bray*, pp 10-11; *Freeman's Journal*, 8 Feb. 1875 and 1 Nov. 1880. Illness prevented Lady Abercorn laying the foundation-stone, her daughters performed the ceremony in her absence.

when Lady Frances Marlborough wife of the new viceroy and a leading benefactress of the home performed the opening ceremony. The extension which brought the capacity of the home up to forty beds had been provided at a cost of £3,000 (see Plate 8.1).[8] The institution relied entirely on charitable donations and bequests together with the proceeds of an annual two-day sale-of-work, collections at charitable sermons and occasional concerts to meet its funding needs. In March 1926 the financial position of the home was improved when it was approved by the minister pursuant to the provisions of the National Insurance Act 1911 as an institution for the treatment of children suffering from non-pulmonary tuberculosis.[9]

In 1927 plans to increase the capacity of the institution and to introduce the treatment methods developed by Auguste Rollier were developed. Ministerial sanction was sought for the proposal which involved 'curing tubercular [...] children in an early stage, before the crippling deformities have become permanent' by the provision of heliotherapy. The department's inspectors while finding 'the site and buildings as admirable for the purpose' advised the construction of a sun gallery from the first floor dormitory and the provision of a room for violet ray treatment.[10] In April an appeal for funds was launched, addressed to 'the members of Protestant churches in Ireland to lighten the burden of the Roman Catholic homes by establishing an institution worked on similar lines to that of Cappagh, for their own children […] whose parents cannot afford to send them to foreign sanatoria'.[11] By the end of the year £1,400 had been raised which enabled work to commence on the construction of an open-sided sun-balcony roofed with vita glass. Special surgical beds manufactured in Rollier's factory at Leysin were ordered at a cost of £200. An additional nurse fully trained in the Protestant Adelaide Hospital was recruited to assist with the new facility. She was immediately dispatched to Leysin to. receive additional training from Dr Rollier.[12] An ultra-violet light apparatus was installed to assist in the treatment

The new facility was opened in February 1928, equipped to accommodate nine patients. It was intended to accept male patients from three to thirteen years of age and females from three years upwards. Although Protestant children were preferred no religious

[8] Sullivan, *Cripples' Home, Bray*, pp 11-13; *Freeman's Journal*, 27 Apr. 1880.
[9] Leas Rúnaidhe to Secretary Cripples Home Bray, 6 Mar. 1926 (NAI, Health D 111/38).
[10] *Home for crippled children, report 1927* (NAI, Health D 111/38); *Irish Times,* 2 Apr. 1927.
[11] *Irish Times*, 2 Apr. 1927.
[12] *Home for crippled children, report 1927*; *Irish Times*, 12 Dec. 1927.

Plate 8.1 Cripples' Home Bray, County Wicklow 1927. The premises opened as a hospital to treat 14 children suffering mainly from surgical tuberculosis in 1874. Its capacity was extended in 1880 to 40 beds (NAI, Health D111/38)

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Plate 8.2 Peamount Sanatorium, County Dublin, official opening of children's pavilion in 1914 by Herbert Asquith prime minister of the United Kingdom, flanked by children. Lady Aberdeen is front right (NAI, Priv1212/wnha/7/162)

distinctions were made.[13] As was accepted medical practice the children undergoing treatment for tuberculosis received a particularly nutritious diet with breakfast consisting of porridge and egg or rasher, roast or stewed beef, roast or boiled mutton and fish and rabbit in season was provided for dinner, for tea bread and butter, jam and tea or milk was served while for supper bread and butter together with milk or cocoa was supplied. In addition these patients were provided with fruit once or twice a week.[14]

As an approved institution the home was the subject of regular department inspections. A 1933 visit by Boyd Barrett revealed 'several quite remarkable cures' amongst the twelve patients then accommodated on the balcony.[15] In 1935 Boyd Barrett found nine Protestant children sent by various local authorities accommodated on the balcony. He found the home to be mainly a home for Protestant children but that when convalescent Catholic patients were admitted no attempt was made to interfere with their religion and they were sent to mass if well enough. Nevertheless, displaying the then religious sensitivities of the department, he considered that Catholic children should not be sent there except in an emergency or when sufficiently convalescent to attend their own place of worship.[16]

As with all Irish voluntary hospitals continuing difficulties were experienced in raising adequate finances. During the 1930s declining income from investments, subscriptions and donations forced the now titled Sunbeam Home[17] to make serious inroads into its capital balances and rely on bank overdrafts to continue to fund its activities. [18] A public plea for funds was made in 1946 by Canon E. H. F. Campbell, the Protestant rector of Bray, the home being heavily in debt at that stage. In his plea Campbell pointed out that the home admitted children from all over the country 'without reference to creed'.[19] However the home in ensuring that its Protestant ethos was retained required that all staff recruited be of the Protestant faith.[20] Further difficulties were experienced in 1948 when

[13] Application for approval, 29 Feb. 1928; A. F. Scott Honorary Secretary Home for Crippled Children to Secretary Department of Local Government and Public Health, 2 Mar. 1928; J. Boyd Barrett to Dr E. J. Stephenson undated recommendation (NAI, Health D 111/38).
[14] G. E. Manning matron to Secretary Department of Local Government, 2 July 1929 (NAI, Health D 111/38).
[15] Report of J. Boyd Barrett, 22 May 1933 (NAI, Health D 111/38).
[16] Report of J. Boyd Barrett, 1 July 1935 (NAI, Health D 111/38).
[17] By the 1930s mindful of the negative connotations attached to the appellation 'cripples home' the name of the institution was changed to Sunbeam Home. Loughrey, *Sunbeam House Bray* (Bray, 1996), pp 47-8.
[18] *Irish Times*, 3 Mar. 1934.
[19] Ibid., 2 Sept. 1946.
[20] Ibid., 24 July 1945, 10 Sept. 1947 and 10 Apr. 1948; *Irish Independent*, 19 July 1947. The appearance of advertisements for nursing staff from 1948 onwards, which did not require applicants to have any

an out break of mumps caused the postponement of the annual sale resulting in 'serious financial loss' and a bank overdraft 'larger than ever'.[21]

In 1958 the home ceased its involvement with crippled children and reconstituted itself as a residential home and special school for the education of sub-normal Protestant children.[22]

Peamount/Crooksling 1914-56

Immediately following the opening of Peamount Sanatorium, in October 1912, a problem arose regarding the treatment of children and making provision for their educational and religious needs.

In June 1913 Lady Aberdeen announced an allocation of £5,000 from WNHA funds, to provide a special pavilion with separate administration to cater specifically for the needs of the large cohort of children referred by local authorities to Peamount. Construction of the sixty-bed facility, incorporating an open-air school, commenced in early 1914.[23] Herbert Asquith the prime minister officially opened the new facility on 26 September 1914 (see Plate 8.2).[24] By the early 1920s with portion of the new building being allocated for educational purposes its capacity had been reduced to forty-five beds. A staff consisting of a part-time senior sister, a sister–in-charge, two nurses and two maids had been engaged to run this facility. [25] Two teachers, both ex-patients, were employed one for 'ordinary education' and the other to teach the children games and crafts 'so that during their term of treatment their education and mental development is not neglected'.[26] However in November 1923 only twenty-seven of the available beds were

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particular religious affiliation, reflected the general difficulties being experienced at that time by all institutions in recruiting nursing staff. In Ireland in 1949 general trained nurses in state-run hospitals were paid on a scale of £122 x £10 -£142 with £10 additional paid to nurses in tuberculosis institutions together with a further £10 to those with specific tuberculosis nursing qualifications. By comparison in 1950 the scale of pay for staff nurses in English sanatoria was generally £302 10*s.* x £12 10*s.* - £415. This pay disparity caused a drain of nurses from Ireland to England (Letter (day omitted) June 1949 Department of Health to Rúnaí, An Roinn Airgeadais; Extract from *British Journal of Nursing*, Apr. 1950 (NAI, Health D112/109)).

[21] *Irish Times*, 14 and 15 Oct. 1948.

[22] Ibid., 30 June 1960 and 20 Sept. 1963.

[23] Ibid., 21 June 1913; 'Ireland-Women's National Health Association and sanatoriums' in *BMJ*, i, no. 2782 (1914), p. 938; minutes of sixth annual meeting of the general council of the Women's National Health Association of Ireland, 15 Apr. 1913, contained in the supplement to *Sláinte*, v, no. 53 (1913).

[24] *Irish Times*, 27 Sept. 1914.

[25] R. O'Riordan rúnaidhe WNHA to The Secretary, Minister of Local Government, 1 Dec. 1923 (NAI, Health D 110P/9).

[26] Same to same, 15 Nov. 1923; Richard Riordan secretary WNHA to The Secretary, Department of Local Government and Public Health, 14 Dec. 1933 (NAI, Health D 110P/9).

occupied by children, whose ages ranged from 2½ years to eighteen years. Twenty-two of these children had been referred by county councils or tuberculosis committees administering approved schemes. A weekly charge of £2 2*s* was levied in respect of such children. The reason for the vacant beds was that the councils and tuberculosis committees had not allocated sufficient funds to refer any greater number of children for treatment.

In 1923 the department advised Dublin Corporation to consider providing a separate building for the children accommodated in Crooksling.[27] Feeling that the 'cost of securing segregation of child patients at Crooksling sanatorium would be too great' the corporation sought departmental consent to refer all such patients to Cappagh.[28] However this was not feasible, as cases of pulmonary tuberculosis were not admitted to that institution. The department suggested investigating the use of Peamount.[29] Negotiations were entered into with the WNHA and agreement reached to refer twenty children to the sanatorium at the standard weekly charge of £2-2-0.[30] In March 1924 the minister approved of this arrangement.[31] However he consented to a weekly charge of only 37*s.* 6*d.*, ignoring compelling evidence submitted to him justifying a charge of £2-2-0. This left the hospital authorities to cover the weekly deficit of 4*s.* 6*d.* per child.[32]

By August 1924 the children's pavilion reached capacity, under this arrangement. However teething problems were experienced.[33] One problem was the number of parents who removed their children from the hospital, shortly after their arrival, before they became acclimatised to their new surroundings. To resolve this situation the corporation wrote to all parents of new patients informing them that their children could not be

[27] Report on inspection by J. Boyd Barrett of Crooksling sanatorium, 8 Mar. 1923 (NAI, Health D 110P/9).
[28] Ard-Chléirigh Rúnaidhe Corporation of Dublin Tuberculosis Committee to Rúnaidhe Aireacht um Rialtas Áitiúil, 18 Apr. 1923 (N.A.I, Health D 110P/9).
[29] Aire Riaghaltais Aiteamhla to The Clerk, Tuberculosis Committee, Corporation of Dublin, 17 May 1923 (NAI, Health D 110P/9).
[30] Ard-Chléirigh Rúnaidhe Corporation of Dublin Tuberculosis Committee to Rúnaidhe Aireacht um Rialtas Áitiúil, 30 Oct. 1923; WNHA to the Secretary, Ministry of Local Government, 25 Feb. 1924 (NAI, Health D 110P/9).
[31] E. P. McCarron a/s Aire Riaghaltais Aiteamhla to the secretary Peamount Committee of management, 4 Mar. 1924 (NAI, Health D 110P/9).
[32] WNHA to the Secretary, Ministry of Local Government, 15 Nov. 1923; Report of Dr R. P. McDonnell on the treatment of children at Peamount Sanatorium, 4 Jan. 1924; WNHA to Dr McDonnell, 2 Feb. 1924 (NAI, Health D 110P/9).
[33] E. P. McCarron a/s Aire Riaghaltais Aiteamhla to The Secretary Tuberculosis Committee, Corporation of Dublin, 14 Mar. 1924; WNHA to the Secretary, Ministry of Local Government, 8 Nov. 1924 (NAI, Health D 110P/9). .

visited within seven days of their admission.[34] The annual report for 1927 shows that the situation had been somewhat reversed. Such were the efforts being made by the staff to make the children's stay 'as pleasant as possible' that many showed a 'reluctance […] to return home when their term of treatment has expired'.[35]

Religion formed an integral part of the hospital experience. The children's daily routine involved the recitation of prayers or the attendance at church each morning following breakfast. Every evening prior to supper attendance at church or the recital of the rosary was obligatory. The hospital chaplains attended daily to provide the children with religious instruction.[36]

By mid September 1924 a waiting list, containing thirty city based children seeking admission to Peamount, had built up leaving the city authorities with little option but to again consider using Crooksling.[37] By June 1925 this waiting list had increased to thirty-eight, prompting the City Commissioners to make a formal proposal to the minister to treat twenty-two children in Crooksling and to engage the services of an additional probationer nurse 'to afford the necessary care and attention to those children'.[38] The application was made overriding the protests of the resident medical superintendent to the proposal.[39] In September the minister consented to the arrangements as a purely temporary expedient having regard to the paucity of facilities available for children.[40] Despite having no educational facilities eighty-four children were treated in the institution during 1927.[41] That same year 141 children were treated in Peamount.[42]

The waiting lists continued to be a problem. There were fourteen children awaiting institutional admission in August 1928. The corporation suggested that these children be

[34] Extract from Dublin County Borough Tuberculosis Committee minutes, 9 Sept. 1924 (NAI, Health D 110P/9).
[35] WNHA, *Sixteenth annual report of Peamount Sanatorium, 1927-28*, p. 7 (NAI, D 110P/22).
[36] *Twenty- second annual report of the Women's National Health Association of Ireland, 1929-30*, pp 37-8. (NAI, Priv 1212/wnha/6/8). At this stage four chaplains had been appointed to the hospital two Catholic, one Presbyterian and one Church of Ireland.
[37] Extract from Dublin County Borough Tuberculosis Committee minutes, 16 Sept. 1924 (NAI, Health D 110P/9).
[38] M. Russell, medical officer of Health, Corporation of Dublin Tuberculosis Committee to the Secretary department of Local Government and Public Health, 16 June and 10 Sept. 1925 (NAI, Health D 110P/9).
[39] Extract from Dublin County Borough Tuberculosis Committee minutes, 26 Aug. 1925 (NAI, Health D 110P/9).
[40] A/s Rúnaidhe to Dr M. J. Russell, 18 Sept. 1925 (NAI, Health D 110P/9).
[41] M. Russell, medical officer of Health, Corporation of Dublin Tuberculosis Committee to the Secretary department of Local Government and Public Health, 26 Mar. 1929 (NAI, Health D 110P/9).
[42] *Sixteenth annual report of Peamount Sanatorium*, p. 13.

offered places in the South Dublin Union Hospital.[43] However their parents 'in every case […] refused to allow the children to go there'.[44] Clearly the shadow of the workhouse still overhung these premises. By November 1932 the waiting list had grown to forty. The corporation's Medical Officer of Health approached the Sisters of Mercy seeking temporary accommodation in Our Lady of Lourdes Hospital, Dun Laoghaire. 'As it was absolutely necessary to remove them from their homes and they [the corporation] found it impossible to place them elsewhere' the nuns acceded to the request. In December nine male and four female patients were admitted to the institution under this arrangement at a weekly charge of 28*s.* The children were grouped together in large wards and a special hut was erected for their education and recreation, wherein they were provided with lessons and religious instruction daily.[45]

In 1933 the Peamount committee of management made a proposal to Dublin Corporation, that if the corporation guaranteed sending a weekly average of forty children to Peamount for an agreed period of years, the hospital would be prepared to reduce the weekly charge from 37*s.* 6*d.* to 32*s.* 6*d.* per patient. The corporation reacted favourably to the proposal.[46] The Peamount management committee intended to seek Department of Education approval for an enlarged school which would result in teacher's salaries and school requisites grants being paid by the educational authorities.[47] The education savings made together with economies of scale would enable the operation of the children's facilities to be covered by the reduced fees. The construction costs of the additional facilities would be covered by grant aid from sweepstake monies provided by the Hospitals Trust Fund.

However shortcomings in the existing educational arrangements were identified. Neither of the two teachers then employed possessed any qualifications for recognition as a national teacher. Formal recognition by the Department of Education would necessitate

[43] Extract from Dublin County Borough Tuberculosis Committee minutes, 10 Aug. 1928 (NAI, Health D 110P/9).
[44] T. Scanlon for medical officer of Health, Corporation of Dublin Tuberculosis Committee to the Secretary department of Local Government and Public Health, 4 Sept 1928 (NAI, Health D 110P/9).
[45] Extract from Dublin County Borough Tuberculosis Committee minutes, 13 Jan. 1933; a/s Rúnaidhe Department of Local Government and Public Health to The Superioress, Our Lady of Lourdes Hospital, Dun Laoghaire, 13 Mar. 1933; Sr Patrick to The Secretary, Local Government Board, 16 Mar. 1933; a/s Banisteoir na Cathrach agus Ard-Cléireach to An Rúnaidhe, Roinn Rialtais Áitiúla agus Sláinte Publí, 11 Dec. 1933 (NAI, Health D 110P/9).
[46] *Twenty- sixth annual report of the Women's National Health Association of Ireland, 1933-1934*, p. 25 (NAI, Priv 1212/wnha/6/12); M. J. Russell, Medical Officer of Health to Gerald J. Sherlock, City manager and Town Clerk, 30 Nov. 1933 (NAI, Health D 110P/9).
[47] R. Riordan, secretary WNHA to The Secretary, Department of Education, 6 Mar. 1934 (NAI, Health D 110P/9).

the appointment of teachers 'fully qualified in accordance with the regulations'. In May 1934 the department informed the hospital that in the absence of such an appointment 'the question of continuing to allow local authorities to send children to Peamount for treatment would have to be considered afresh'.[48] Nor was the department standard of the provision of a minimum of four hours education per day being adhered to, with only 2½ hours being provided for males and 3½ hours for females, the hours having been determined by Dr Alice Barry the resident medical superintendent, to facilitate an hours rest in the morning and a similar rest period in the afternoon, an essential element in the treatment of children suffering from tuberculosis.[49] In July having being informed that the application for construction grant aid was successful the Peamount authorities made arrangements for the appointment of a qualified teacher.[50] This paved the way for the corporation to enter into a contract to treat between forty and fifty children per week in the institute for a five year period.[51]

A contract was placed with the newly-formed on-campus Peamount Industries to construct the extensions, consisting of two sixteen bed wards and an open air classroom.[52] The construction cost of £4,054 was met by the Hospital's Trust Fund.[53] With the works completed, by November 1935 children referred by Dublin Corporation were occupying fifty beds.[54] As the usual long school holiday periods 'were unsuitable for children whose attendance could not be regular owing to ill-health', a qualified assistant teacher was appointed in August 1938 'so as to enable the school to be kept open all the year round'.[55]

[48] Summary of meeting held in May 1934 between R. Riordan and officials of the Department of Local Government (NAI, Health D 110P/9).
[49] *Twenty- second annual report of the Women's National Health Association of Ireland, 1929-30*, pp 37-8. (NAI, Priv 1212/wnha/6/8); P. Breathnach, Office of National Education to R. Riordan, 24 Apr. 1934 (NAI, Health D 110P/9).
[50] R. Riordan to The Secretary Department of Local Government and Public Health, 24 July 1934 (NAI, Health D 110P/9).
[51] Extract from Dublin Corporation Public Health (Tuberculosis Section) minutes, 13 July 1934; Contract 20 May 1935 between the Women's National Health Association (Incorporated) and the Right Honourable the Lord Mayor, Aldermen and Burgesses of Dublin (NAI, Health D 110P/9).
[52] *Peamount annual report 1935-36*, p. 5 (NAI, D 110P/22).
[53] E. P. McCarron, Secretary Department of Local Government and Public Health to the Secretary Women's National Health Association, 17 July 1935 (NAI, Priv 1212/wnha/1/3).
[54] Richard Riordan to The Secretary Department of Local Government and Public Health, 9 Dec. 1935 (NAI, Health D 110P/9). This number was regularly exceeded in the early months of 1936 with 51 city child patients in occupation of beds on 11 January and 29 February rising to 56 on 7 March.
[55] *Peamount annual report 1938-39*, p. 33 (NAI, D 110P/22).

The increased number of beds available lead to an immediate increase in the through-flow of patients. In 1935 176 children were treated in the enhanced facilities.[56] This number increased to 227 in 1938 and 230 in 1940, dropping marginally to 225 in 1943.[57] However by the latter year the waiting list demonstrated the lack of treatment facilities for children containing the names of 112 boys and 113 girls. [58] The following year the number of children treated dropped to 207, the waiting list also experienced a decline in numbers with only 137 children represented.[59] However the arrangements made with the corporation appeared to enhance the prospects of treatment for Dublin city based children over those from other areas as in May 1945 they comprised only fifty of those on the waiting list.[60]

The refusal of the department to adequately fund the cost of children's treatment continued to pose fiscal problems for Peamount. Having regard to general inflation, when its children's contract fell for renewal in 1940, the corporation was prepared to reinstate the 37*s.* 6*d.* weekly charge.[61] However the minister was only prepared to sanction a rate of 35*s.* per week.[62] In 1942 he sought a reduction in the adult rate of £2-2-0 payable in respect of children over fifteen years of age.[63] Peamount agreed to treat children between fourteen and eighteen years of age at a weekly rate of £2.[64] When the agreement again fell for renewal in 1945 the minister refused to allow any increase in the payments.[65] However following representations from the hospital in 1947 wherein they demonstrated that the treatment of children in terms of the provision of food, facilities and medical treatment was as costly on a per capita basis as that of adults, with lower children's fees contributing to the hospital's anticipated deficit of £4,116 for that year, the minister relented somewhat allowing the still inadequate charge of £2 12*s.* 6*d.* per week.[66]

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[56] *Peamount annual report 1935-36*, p. 11 (NAI, D 110P/22).
[57] *Peamount annual report 1938-39*, p. 7; *Peamount annual report 1940*, p. 5; *Peamount annual report 1943*, p. 3 (NAI, D 110P/22).
[58] *Peamount annual report 1943*, p. 3.
[59] *Peamount annual report 1944*, pp 3, 16 (NAI, D 110P/22).
[60] Margaret Dancey, secretary, Peamount Sanatorium to The Secretary Department of Local Government and Public Health, 26 May 1945 (NAI, Health D 110P/9).
[61] M. J. Russell, Medical Officer of Health to P. J. Hernon City Manager and Town Clerk, 3 June 1940; for City Manager and Town Clerk to The Secretary Department of Local Government and Public Health, 12 June 1940 (NAI, Health D 110P/9).
[62] Rúnaí to City Manager Dublin, 3 Aug. 1940 (NAI, Health D 110P/9).
[63] Rúnaí to City Manager Dublin, 21 May 1942 (NAI, Health D 110P/9).
[64] for City Manager and Town Clerk to The Secretary Department of Local Government and Public Health, 20 July 1942 (NAI, Health D 110P/9).
[65] Rúnaí to City Manager Dublin, 17 Nov. 1945 (NAI, Health D 110P/9).
[66] Margaret Dancey, secretary, Peamount Sanatorium to The Secretary Department of Local Government and Public Health, 18 Apr. 1947; T. J. Brady to Secretary, Peamount Sanatorium, 23 June 1947 (NAI, Health D 110P/9).

It was only after the intervention of the Hospitals Commission, who pointed out 'that the cost of treatment of patients in children's general hospitals can be as expensive as the treatment of adults in general hospitals' and expressed the opinion 'that the weekly maintenance rates to be paid by local authorities in respect of patients treated in these hospitals should be identical with those paid for adults', that the minister finally relented approving a weekly rate of £3 13*s.* 6*d.* for all local authority patients treated in Peamount from 1 July 1947.[67]

In mid 1950 the consent of the Department of Education was sought to convert the existing school into children's bed accommodation. No objections were raised to this proposal as it was intended to relocate the school to the vacant Everard Hostel formerly used by workers in Peamount Industries.[68] The adapted facility provided at a cost of £250 accommodated eighteen male children.[69] This brought the total provision of children's beds to 100 all of which were occupied on 31 Dec 1951.[70] It also impacted on the waiting list reducing the number of children awaiting accommodation from sixty-nine at the end of 1950 to fifty-five at the end of 1951.[71] The waiting list experienced a dramatic reduction in 1952 with only nine children on it at the end of the year.[72] By the end of December 1956 no waiting lists existed.[73]

St Joseph's Coole 1916-81

Catholic philanthropy and a chance approach to an experienced order of nuns led to the founding of St Joseph's Home for crippled boys in Coole, County Westmeath, which operated on similar lines to the Cripples' Home in Bray albeit on a larger scale.

In 1866 Charlotte Dease, a member of a prominent Westmeath Catholic family established a trust fund, containing over £4,000 for the purpose of founding a convent in

[67] *The Hospitals Commission seventh annual report, 1945-47*, pp 219-220; Rúnaidhe to Margaret Dancey, 23 July 1947(NAI, Health D 110P/9).
[68] Extract from minute 9 Aug. 1950 sent to Mr Murray, Department of Health (NAI, Health D 110P/39). Following the example set by Dr P. C. Varrier-Jones who had established a village settlement scheme in conjunction with his sanatorium at Papworth Hall, Cambridgeshire, which incorporated factories to provide employment for tubercular residents, Peamount industries was established in January 1930 to provide similar employment. Due to serious financial deficits from 1937 onwards Peamount industries closed in December 1940. (Peamount settlement and industries, undated (NAI, Priv/1212/wnha/3/50); *Peamount annual report 1940*, p. 7 (NAI, Health D 110P/45)).
[69] A. E. Johnston to Secretary, Peamount Sanatorium, 9 Sept. 1950 (NAI, Health D 110P/39).
[70] Margaret Dancey, secretary, Peamount Sanatorium to The Secretary Department of Health, undated Jan. 1952 (NAI, Health D 110P/12 vol. 2).
[71] Same to same, 29 Jan. 1951 and undated Jan. 1952. (NAI, Health D 110P/12 vol. 2).
[72] Same to same, 29 Jan. 1953 (NAI, Health D 110P/12 vol. 2).
[73] *Forty-ninth annual report of the Women's National Health Association of Ireland, 1956*, p. 16 (NAI, Priv 1212/wnha/6/28).

the area.[74] In 1896 the Dease family leased a five-acre site at Coole, on which Theresa Dease, a great-niece of Charlotte Dease, established the Turbotstown technical school, which operated on the site until about 1905.[75]

In 1916 Theresa Dease ascertained that 'there was no exclusively Catholic home in Ireland in which boys suffering from defective or tubercular limbs could be treated or taught trades, which would enable them to become self-supporting'. She felt that the wishes of her great-aunt Charlotte could 'be more fully realised by the establishment of [such] a home' on the site.[76] She approached a cousin Sister Langdale a member of a French order, the Sisters of Charity of St Vincent de Paul, with her suggestion.[77]

The Sisters of Charity of St Vincent de Paul had since 1863 been involved in managing the St Louis de Gonzagain orphanage for destitute Catholic boys in Liverpool. The work involved supervising craftsmen teaching trades such as tailoring, carpentry and shoemaking to the boys. By 1900 the sisters were involved in running eight similar establishments in Britain. The experience gained in these institutions had 'shaped a growing realisation that working with boys and young men could be an important part of their mission in Britain'.[78] Having obtained the consent of Dr Laurence Gaughran, the Bishop of Meath, it was agreed to send four sisters to manage the new establishment.[79] All of the four nuns were trained nurses and one, a trained teacher, held a certificate from the Board of Education. The former technical school was adapted as their residence and contained a laundry and an oratory.[80]

Funded from the trust a new shelter attached to the residence was erected. It was fronted by a verandah where the patients could enjoy the 'beautiful scenery and fresh air on the wettest days'. This verandah was funded by a gift of over £100 from a Miss Fanny Adams of Rathmines (see Plate 8.3). The premises named 'St Joseph's Home, Hospital and School for Crippled Boys' were formally opened on 19 July 1916 with solemn benediction following the opening addresses. It had thirteen patients.

[74] *Westmeath Examiner*, 10 Nov. 1917, 30 Nov. 1957 and 18 July 1970.
[75] Ibid., 22 July 1916, 7 Sept. 1918 and 30 Nov. 1957.
[76] Ibid., 10 Nov. 1917.
[77] Ibid., 27 Sept. 1924 and 20 Aug. 1977.
[78] Susan O'Brien, 'The Daughters of Charity and Vincentian charity in Victorian Britain' (www.academia.edu/2010068) (17 July 2013).
[79] *Westmeath Examiner*, 10 Nov. 1917.
[80] Ibid., 22 July 1916 and 11 Nov. 1916.

Education and religion were core considerations of the institution. A decision had been made to admit boys only between the ages of six to twelve years. The reasons for this were twofold. Firstly such boys could be taught together. Because of the nature of their infirmities many of the boys had not even rudimentary education, some of the older boys having failed to 'grapple successfully with the alphabet'. Secondly boys of this age were too young to learn a trade. No funds had at that stage been raised to erect a workshop and employ craftsmen to teach the boys. [81] All of the boys were Catholics, as the trustees nominated by the Catholic Dease family and the Bishop of Meath had determined that 'admissions should be confined to Catholic children'.[82] As was standard practice in all Catholic establishments dealing with the education and care of children, primacy was given to the Catholic ethos. St Joseph's first aim was 'to teach their religion to the boys and give them an opportunity of going to mass and of frequenting the sacraments'.[83]

Although philanthropic in its nature, the funds available to the home did not extend to maintaining the patients undergoing treatment, thus it proved necessary to restrict admissions to those boys who were supported by boards of guardians making an annual subscription of £25 for their upkeep. [84] However it was also found necessary to resort to alternative funding mechanisms. An annual fête was inaugurated in 1917. It was supported by Lord and Lady Longford who provided tents and marquees and by local businessmen who facilitated attendance by providing a half-day holiday for staff. The last fête took place in 1925.[85] The demise of the fête could probably be attributed to the death of the chief organiser Theresa Dease in September 1924.[86] In 1968 the fête in the form of an annual horse show was reinstated.[87] Other fund raising activities resorted to by the nuns included whist drives, St Anthony's bread poor box collections, pound days, clothing appeals, concerts, carol singing and an annual Christmas appeal for funds started in 1928 with press advertisements and transferred to appeals on Radio Éireann from December 1944.[88]

[81] Ibid., 22 July and 11 Nov. 1916.
[82] Ibid., 30 Nov. 1957.
[83] Ibid., 11 Nov. 1916.
[84] Ibid., 11 Nov. 1916.
[85] Ibid., 23 June, 30 June and 14 July 1917, 28 May and 9 July 1921, 6 June and 18 July 1925.
[86] Ibid., 20 and 27 Sept. 1924.
[87] Ibid., 18 July 1970.
[88] Ibid., 11 Nov. 1916; 24 Mar. 1917; 13 Mar. 1920; 10 Nov. 1921; 10 Mar. 1923; 18 Feb., 20 Oct. and 15 Dec. 1928, 13 Apr. 1929, 8 Mar. and 13 Dec. 1930, 7 Mar. 1931,12 Dec. 1942, 16 Dec. 1944; 2 Dec. 1950; 23 Dec. 1961; 6 Jan. 1962 and 30 Oct. 1965.

Plate 8.3 Boys receiving school lessons at St Joseph's Home, Hospital and School for Crippled Boys, Coole, County Westmeath, *c.* 1929.The premises had been converted to hospital use in 1916 (NAI, Health D110/9)

Plate 8.4 Cappagh House, County Dublin, undated probably early 1900s. Used as a children's convalescent home from 1908 it was converted into a surgical tuberculosis hospital for children in 1920 (Religious Sisters of Charity archive)

By the end of its first year of operation the number of patients had reached twenty-eight. During that year, when the number in school reached twenty-five, the Board of National Education provided a grant to cover the educational needs of the children.[89] Through fund raising, sufficient money was available in 1918 to acquire the former polo pavilion at Lediston. This was transported to Coole and adapted for use as a workshop. When leather supplies had been secured courses in bootmaking for the older boys were instituted.[90] As the home was placed on the approved list of institutions for the treatment of tuberculosis by the Minister for Local Government in 1926, the County Westmeath Board of Health agreed to refer all children under sixteen years of age suffering from tuberculosis to the home at an annual charge of £25.[91] Thus some certainty with regard to patient numbers was secured. It was probably this security that encouraged the nuns to add a new wing to the hospital in 1927 bringing the capacity of the institution up to seventy-six patients.[92]

The financial pressures on the home were eased by legislation providing access to sweepstake funding. In 1930 the Dáil passed an act authorising sweepstakes to be run for the purpose of raising funds to support certain public charitable hospitals and sanatoria in the state.[93] The passing of amending legislation the following year provided further financial support, when at the behest of the local TD Patrick Shaw, St Joseph's was added to the list of hospitals entitled to benefit from the sweepstakes proceeds.[94] Commencing with the Manchester November Handicap in 1930, six initial sweepstakes were held, concluding with the Epsom Derby in June 1931.[95] In total £2,762,501 of an available surplus from these sweepstakes was distributed amongst the participating hospitals.[96] St Joseph's received £39,771 from this sum.[97] Up to the end of 1955, seventy-nine further sweeps were held.[98] However amending legislation in 1933 meant

[89] Ibid., 10 Nov. 1917.
[90] Ibid., 23 Nov. 1918.
[91] Ibid., 10 Apr. and 8 May 1926; *Department of Local Government and Public Health second report 1925-27*.
[92] *Westmeath Examiner*, 29 Oct. 1927 and 20 Oct. 1928.
[93] Public Charitable Hospitals (Temporary Provisions) Act 1930/12 [Éire] (4 June 1930).
[94] Public Charitable Hospitals (Amendment) Act 1931/24 [Éire] (17 July 1931); James Dolan, Dáil debates, vol. 38, no. 18, 2172, 29 May 1931. As Patrick Shaw was absent from the floor of the house on 29 May 1931 during the debate on the legislation an amendment in his name adding St Joseph's to the list of benefitting institutions was moved by his party colleague James Dolan and accepted by the Dáil.
[95] Marie Coleman, *The Irish Sweep* (Dublin, 2009), p. 227.
[96] J. O'Sheehan and E. de Barra (eds), *Oispidéil na hÉireann Ireland's hospitals 1930-1955* (Dublin, 1956), p. 19.
[97] O'Sheehan and de Barra, *Oispidéil na hÉireann*, p. 60.
[98] Coleman, *The Irish Sweep*, pp 227-30.

that from that date on all public hospitals would benefit from the funds.[99] Nevertheless from 1933 to 1955 St Joseph's received £8,848 in maintenance payments and £62,081 in capital grants from the funds provided by these additional sweepstakes.[100]

The sweepstake monies together with the hospital's own fundraising enabled the capacity to be increased to 133 patients by 1933. Of these 133 patients, 123 had been referred by local authorities or boards of health, ten were accommodated free by the nuns and one was a paying patient. Girls were admitted to the hospital for the first time in 1940.[101] These increased facilities required a corresponding increase in staff. By 1952 there were sixteen sisters, twenty-four nurses and twenty maids employed. Many of these staff members were housed in an old farmhouse some distance away.[102] To remedy this situation in 1954-5 a new nurses' home was constructed with the aid of sweepstakes funding augmented by a bank overdraft.[103] Earlier in 1954 a new wing was added to the hospital housing an operating theatre, x-ray facilities and a physiotherapy department.[104] The educational facilities were also improved with the construction of a two-room school in 1948.[105] By the 1950s, for children who had recovered from the disease and though physically disabled were no longer in need of medical treatment, two-year apprenticeships in cobbling and tailoring were available for boys and a dressmaking course was taught to the girls. Authorities who supported such children were charged 7*s.* 6*d.* per day for their full board and the supply of materials. No wages were paid to these trainees.[106]

Due to a decline in the number of patients and the more urgent needs for their services in other areas, in November 1980 the Sisters of Charity announced that they were withdrawing the remaining nuns from the hospital. Resulting from this decision the hospital trustees determined that it would not be possible to continue operating the

[99] Public Hospitals Act 1933/18 [Éire] (27 July 1933).
[100] O'Sheehan and de Barra, *Oispidéil na hÉireann*, p. 60.
[101] *Westmeath Examiner*, 20 Aug. 1977.
[102] Ibid., 20 Dec. 1952.
[103] Ibid., 30 Nov. 1957.
[104] Ibid., 20 Aug. 1977.
[105] Ibid., 27 Nov. 1948.
[106] Ibid., 30 Nov. 1957; A. E Johnston to Secretary Meath County Council 21 Sept. and 9 Dec. 1955; Secretary Meath County Council to Secretary Department of Health, 26 Aug., 23 Sept. and 5 Dec. 1955 (NAI, Health D 22/45).

premises as a viable orthopaedic hospital and ceased admitting children.[107] The hospital closed in mid 1981.[108]

St Mary's Hospital Cappagh 1921-*c.*1955

A philanthropic bequest provided the Sisters of Charity with the premises which became Cappagh Hospital. In adapting these premises for the treatment of surgical tuberculosis in children they imported the treatment methods developed by Auguste Rollier.

In 1873 St Josephs Infirmary was established at Upper Buckingham Street Dublin, and placed under the care of the Religious Sisters of Charity in 1876. Upon the expiration of the lease on the premises in 1879 the hospital relocated to Temple Street and was renamed the Children's Hospital.[109] In 1907 Lady Mary Martin[110] bequeathed Cappagh House (see Plate 8.4), her father's former residence, standing on a site of 131 acres, to the Religious Sisters of Charity, 'to there establish some good institutions for the poor and schools for the poor'.[111] However as the surrounding district was sparsely populated, there being 'few houses in the neighbourhood with the exception of two small cottages at the crossroads', it was not considered feasible to set up a school.[112] However the work of Temple Street Children's Hospital had been steadily increasing with pressure being brought on the hospital accommodation, owing to the limited space available for intern patients. To relieve this pressure, it was decided to convert the newly-acquired premises to a convalescent home.[113] Remodelling the house cost £2,000.[114] On 8 September 1908 St Mary's Convalescent Home for Children opened to accept the twelve patients who were transferred there from Temple Street.[115]

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[107] Dr Michael Woods, Dáil debates vol. 325, no. 6, 1101, 11 Dec. 1980. Woods the Fianna Fáil deputy for Dublin (Clontarf) (subsequently Dublin North-East) was Minister for Health from December 1979 to December 1982. He represented the constituency from 1977 until his retirement from politics in 2011, serving as a member of the cabinet in various ministries from December 1979 to June 2002.
[108] *Westmeath Examiner*, 28 Nov. 1981.
[109] Katherine Butler, 'Catherine Cummins and her hospital 1920-1938' in *Dublin Historical Record*, xlv, 2 (1992), pp 81-90; 'Mrs. Ellen Woodlock: an admirable Irishwoman of the last century' in *The Irish Monthly*, xxxvi, 417 (1908) pp 171-6; Deirdre Bryan, 'Ellen Woodlock' in *Dictionary of Irish biography* (www.dib.cambridge.org) (14 Aug. 2013).
[110] Lady Martin was the widow of the prominent Dublin philanthropist and businessman Sir Richard Martin and daughter of the physician Sir Dominick Corrigan. *Weekly Irish Times*, 26 Oct. 1901.
[111] 'The Sisters of Charity Cappagh' (RSCA, RSCG/H34/1/62(a)); *St Mary's Hospital, Cappagh, Finglas, County Dublin first report for the years 1921, 1922, 1923* (RSCA, H34/1/6(3)), p. 4; *Irish Times*, 17 Dec. 1907.
[112] 'The Sisters of Charity Cappagh'; Annals of Cappagh (RSCA,).
[113] *Irish Times*, 29 Feb. 1908; *Irish Independent*, 29 Feb. 1908.
[114] *St Mary's Hospital, first report*, p. 4.
[115] Annals of Cappagh.

Because of the 'crying need' for an institution to provide for children suffering from surgical tuberculosis and having regard to the ideal nature of the site at Cappagh owing to its elevated and secluded location 'while at the same time it was sufficiently accessible to the city to allow parents visit their children with as little inconvenience as possible' in 1920 it was decided to convert the convalescent home to a hospital to meet this need.[116] Three old army huts were acquired. When the home was vacated for Christmas, work commenced on converting the existing building into a convent and reassembling the huts.[117] The design of the new facility was based on that created by Dr Auguste Rollier at Leysin in Switzerland.[118] Two huts were refurbished to form a boys' ward and a girls' ward separated by a play-room. The unit thus created was fronted by a concrete floored verandah (see Plate 8.5). The centrally-heated wards were used to acclimatise newly-arrived patients. Once acclimatised, patients were expected to spend their entire hospital stay, day and night, winter and summer, in the open air mainly on the verandah, which although roofed was fully exposed to the elements on three sides.[119] Comfort blankets were provided to wrap around patients' heads to ward off the worst of the night-time chill. Staff were treated in a similar manner, with nurses permitted to wear protective cardigans only during darkness. Only when storm conditions persisted were beds withdrawn into the wards, until the weather abated.[120] The third hut was converted into a 'well equipped operating theatre' where 'radical' surgery was performed on patients who required such intervention. The sixty-bed facility opened for the reception of patients in March 1921, accepting girls up to twelve years of age and boys up to the age of ten years.[121]

The treatment regime followed was that developed by Dr Rollier.[122] For heliotherapy, during the summer months, beds were wheeled from the verandah and placed in the fields (see Plate 8.6).[123] To shield patients' eyes, sun blinds were developed which could be attached to the beds' headrests.[124] During winter months, staff were trained 'to pounce on every sunray and to expose […] at least the actual lesion and surrounding skin to its

[116] *St Mary's Hospital, first report*, p. 4.
[117] Annals of Cappagh.
[118] 'Cappagh Orthopaedic Hospital' (RSCA, RSCG/H34/1/62(J)).
[119] *St Mary's Hospital, first report*, p. 6.
[120] Rosemary Conry, *Flowers of the fairest* (Dingle, 2002), pp 8, 27-8, 34.
[121] Annals of Cappagh; *St Mary's Hospital, first report*, pp 6, 20.
[122] *St Mary's Hospital, first report*, p. 8; *St Mary's Hospital, Cappagh, Finglas, County Dublin second report for the period 1st January 1924 to 31st July 1926*, pp 19-20 (RSCA, H34/1/6(4)).
[123] *St Mary's Hospital, first report*, p. 6.
[124] Ibid., p. 15.

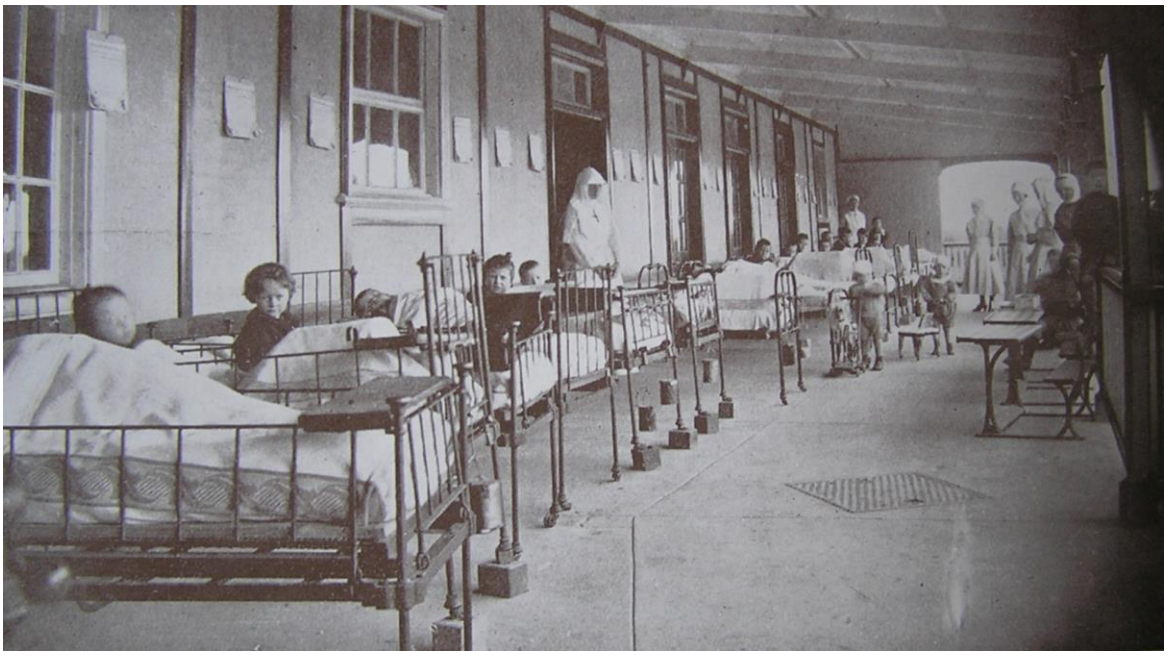

Plate 8.5 Concrete floored verandah at Cappagh children's hospital County Dublin, *c.* 1923 (Religious Sisters of Charity archive)

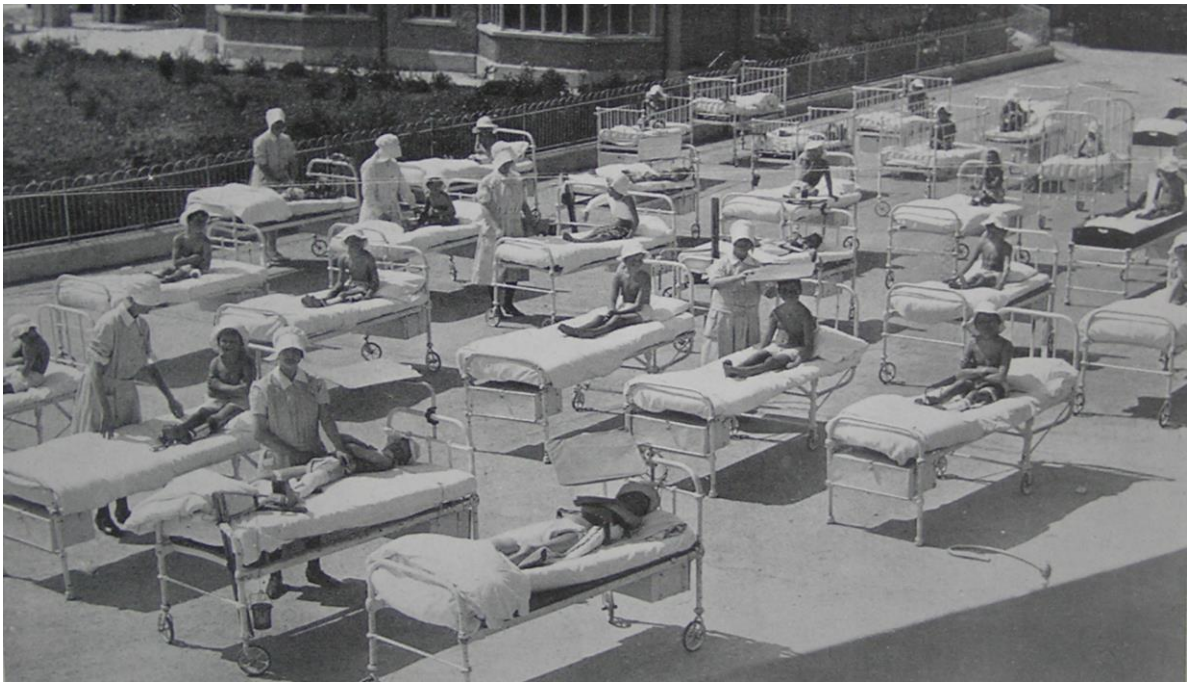

Plate 8.6 Patients undergoing 'Rollier's' sun cure at Cappagh children's hospital, County Dublin, *c.* 1927 (Religious Sisters of Charity archive)

favourable influence', by wheeling beds to an unroofed totally-exposed part of the verandah.[125]

From the opening of the hospital until December 1923, 173 cases of surgical tuberculosis were treated. In addition 156 cases of non-tubercular lesions were treated, although from the nature of these complaints many required only short-term hospital stays.[126] These figures were achieved without proper support from local boards of health, with in many cases poor children being treated by the nuns for periods in excess of a year without any financial recompense from the authorities.[127] Because of the difficulties faced by Dublin Corporation following the withdrawal of LGB support in 1920 it had not been in a position to pay for city children in the institution and proposed as an alternative to have them transferred for treatment to Crooksling. However 'in all cases the children's parents declined to have them removed'. Although it was decided to review the situation in November 1922 it was not until the following March that it was resolved to send as many patients as possible to Cappagh at a weekly cost of one guinea per patient.[128] Pursuant to this decision twenty-five city children were undergoing paid treatment by December 1923 with the number increasing to thirty-five by mid 1925.[129]

From the outset, due to limited accommodation, the hospital was 'overtaxed' with verandahs 'full beyond their complement'. The hospital had to refuse admissions and place patients on a waiting list. The problem was exacerbated by patients presenting with the disease in an advanced stage, partly attributable to the delay in treatment occasioned by a lack of facilities. The cure of surgical tuberculosis required prolonged treatment. Cases of early tuberculosis of the hip required hospital bed treatment for at least one year. However the treatment of advanced cases could extend to three to four years. With the number of advanced cases undergoing treatment in Cappagh, there was no prospect of beds being freed up at an early date. It quickly became apparent that there was 'a crying necessity for more accommodation'.[130]

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[125] *St Mary's Hospital, second report*, p. 20.
[126] *St Mary's Hospital, first report*, p. 11.
[127] Ibid., p. 14.
[128] *Report of the tuberculosis committee of management relative to the question of payment for the treatment of tuberculosis children in Cappagh Convalescent Home and Tubercular Hospital, 27 Jan. 1923*, Dublin Corporation reports 1923, report no. 35, pp 181-2; *Minutes of adjourned meeting of municipal council*, 12 Mar. 1923, minute 192, p. 122 (DCCA).
[129] Local Government Department file note, 18 Mar. 1924; M. J. Russell medical officer of health to the Secretary Department of Local Government and Public Health 3 June 1925 (NAI, Health D 110P-9).
[130] *St Mary's Hospital, first report*, p. 12.

The expansion of the facilities was contingent on receiving funds mainly from private sources. Encouraged by the proceeds of a fête held in the grounds of Temple Street Hospital in 1922, which raised £3,300 for Cappagh, the sisters embarked on a fundraising campaign securing in excess of £2,000.[131] Having received a bequest of £1,000 from Mrs D. E. Williams of Tullamore, they negotiated a loan of £4,000.[132] With this £11,000 they commenced building operations to extend St Mary's in 1924.[133] Despite an extensive fundraising campaign,[134] sufficient funds to enable the works to continue failed to materialise, resulting in the abandonment of the works, which had reached roof level, and the dismissal of the workmen in late 1924.[135]

During the following two years more successful fund raising ventures enabled building works to recommence in 1926. The works were completed in July 1927 at a total cost of almost £60,000.[136] To help defray the costs, the sisters entered into an agreement with Dublin County Council whereby £4,000 from the council's grant allocation under the Finance Act 1911 was handed over to them. In return eight beds were reserved in perpetuity for the council, with the council having the right to nominate patients for those beds. Nominated patients were maintained in the hospital at one-half the ordinary weekly charge approved by the minister. This charge covered all medical, surgical and nursing attendance and any extra medicine or dressings required.[137] Despite this innovative funding exercise the nuns faced bank debts of £14,563 following completion of the building works.[138]

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[131] Annals of Cappagh; *Irish Independent*, 19 Dec. 1924; *St Mary's Hospital, second report*, p. 35.
[132] *Irish Independent*, 19 Dec. 1924; *St Mary's Hospital, first report*, p. 18.
[133] *St Mary's Hospital, Cappagh, Finglas, County Dublin third report for the period 1st August 1926 to 31st December1927*, p. 8 (RSCA, H34/1/6(5)).
[134] The campaign included concerts, newspaper appeals, a sweep and the organisation of a hurling match in Croke Park between the then Leinster champions Dublin and Laois. The sweep demonstrated the difficulties experienced in raising funds by this method. It was decided to run a sweep on the Manchester November Handicap, the last major handicap of the flat horse-racing season. However competition was forthcoming from the Mater Hospital who, also in need of funds, decided to run a sweep on the same race. The total prize-fund offered by the Cappagh organisers was £1,720. However their projected ticket sales fell short by over £1,000, attributed at the time to unemployment. As a result of this the guarantors of the sweep had to make good the prize-fund from their personal resources. The hospital received no revenue from the project. *Irish Independent*, 8 and 25 Nov. 1922.
[135] *Irish Independent*, 8 Nov. 1922, 29 Aug., 27 Oct., 10 Nov., 12 Nov. and 19 Dec. 1924.
[136] 'The Sisters of Charity Cappagh'; *St Mary's Hospital, third report*, p. 8; Sr M. Polycarp to Mr Smith Department of Local Government and Public Health 12 Mar. 1929 (NAI, Health D 110P-9).
[137] Agreement and mortgage between Alice Chamberlaine and Dublin County Council, 21 Sept. 1927 (FCCA/DD/La/14); Rúnaidhe Department of Local Government and Public Health to T. Early Solicitor, 15 Aug. 1927 (NAI, Health D113/2).
[138] *St Mary's Hospital, third report*, p. 32.

The newly-constructed hospital extension consisted of two separate blocks. A two storey block contained nurses' quarters at first floor level wherein all the nurses were allocated separate bedrooms. To provide for the nurses' recreation, a sitting room furnished with a piano and wireless set together with a library were located at this level. The nurses' dining room was located on the ground floor together with operating theatres, x-ray and splint rooms, a laboratory, a pharmacy and administrative offices. The other block was a single storey structure containing two girls' wards separated by a large play-room. These wards were fronted by a 261 foot long glass roofed verandah.[139] This new facility brought the capacity of the hospital up to 120 beds.[140] It also enabled an extension of the admission ages to sixteen for girls and twelve for boys.[141] A visit by the British Orthopaedic Association to the hospital in April 1930 found the site 'ideal' and the hospital 'one of the most modern of its kind' where the treatment 'left nothing to be desired'.[142]

The passing of legislation providing access to sweepstake funds proved a financial boon to the nuns, enabling them to complete their building programme. As the 1931 Public Hospitals (Amendment) Act had added St Mary's to the list of hospitals entitled to benefit from sweepstakes draws, the nuns received £48,946 in respect of the first six draws to set against their accumulated debt and to help finance the new boys' wing then under construction.[143] The nuns received an additional £11,501 towards this new ward, from the surplus of £470,000 available for distribution following the 1932 Grand National sweepstake.[144] This wing was completed in 1932 increasing the overall number of beds to 210.[145] Further extensions followed, another boys' ward in 1935 and an infants' ward in 1939. These additions brought the capacity of the hospital to 260 beds.[146] A staff of ninety-seven persons including forty-four nurses was engaged to look after the needs of the patients.[147]

The hospital provided a complete treatment regime covering both in-hospital and post-discharge care. The hospital 'endeavoured to investigate the home conditions' of patients

[139] Ibid., pp 8-9.
[140] 'The Sisters of Charity Cappagh'.
[141] *St Mary's Hospital, third report*, p. 35.
[142] 'Ireland-Dublin meeting of the British Orthopaedic Association' in *BMJ*, i, no. 3616 (1930), p. 794.
[143] O'Sheehan and de Barra, *Oispidéil na hÉireann*, p. 60.
[144] *Irish Press*, 21 Dec. 1932.
[145] 'The Sisters of Charity Cappagh'; *Irish Press*, 23 Dec. 1932; *Irish Independent*, 26 June 1933.
[146] 'Cappagh Orthopaedic Hospital'; 'The Sisters of Charity Cappagh'.
[147] *Irish Press*, 29 May 1935.

and retain 'those cases longest which have the most unsuitable homes'. Following discharge periodic reports were obtained to ensure that appliances were properly used and that relapsed cases were readmitted.[148] By 1927 this after-care had evolved into the production of six-monthly reports, produced with the assistance of local branches of the St Vincent de Paul Society 'whose members visit the home of every patient, make a minute investigation of every case and report accordingly'.[149]

Dealing with children's education and training featured high on the hospital's agenda. On account of the nature of their illness the education of many of the children had been 'sadly neglected'. To remedy this situation sanction was received from the National Board of Education in 1923 to establish a school with teachers drawn from the ranks of the sisters who had received specific teacher training. Lessons were delivered to the children in situ on the verandahs. As a form of occupational therapy and to enhance the future earning capacity of the children, the educational remit was extended to include the teaching of special crafts.[150] When the admission age for patients was extended, arrangements were entered into with the County Dublin Vocational Committee[151] to supply the hospital with qualified teachers, to teach handicrafts to the older children. Under their guidance many of the patients became particularly adept at Celtic scroll design, basket making and the production of purses, wallets and artistic lamp shades many of which were exhibited at the well attended Dublin Spring Shows held in the Royal Dublin society grounds at Ballsbridge, a show which was attracting crowds in excess of 160,000 during the 1940s and 1950s.[152]

Run by a congregation of nuns, as elsewhere religion played a central role in the life of the hospital. As no chapel had been provided in the hospital the archbishop gave permission for mass to be celebrated on the verandah each Tuesday and a general communion to be provided each Friday. Priests from Dublin's Pro Cathedral, the parish in which the parent hospital was situated, attended to hear patients' confessions.[153] In 1927 Sr Mary Polycarp Cummins the superioress established an annual Corpus Christi procession through the grounds both preceded and followed by solemn benediction. In its

[148] *St Mary's Hospital, first report*, p. 14.
[149] *St Mary's Hospital, third report*, p. 12.
[150] Annals of Cappagh; *St Mary's Hospital, third report*, pp 6-8.
[151] The committee had been established under the 1930 Vocational Education Act to make provision with regard to technical education. Vocational Education Act 1930/29 [Éire] (21 July 1930).
[152] Annals of Cappagh; *St Mary's open air orthopaedic hospital souvenir book 1952* (RSCA,); *Irish Times*, 5 May 1953.
[153] Annals of Cappagh.

inaugural year 1,000 people took part in the procession, with special buses being laid on by the Dublin United Tramways Company to facilitate the event. The procession was witnessed by the young patients from their verandah beds.[154] Attendance at the procession rapidly grew with 3,000 attending in 1928, the numbers swelling to 9,000 by 1933.[155] By this stage Sr Polycarp had acquired the altar, which had been erected on O'Connell Bridge in Dublin for the papal legate to give the final benediction at the 1932 Eucharistic Congress and had it reassembled in the grounds, surmounted with a golden tabernacle, in an elevated position so as to be visible from all the verandahs.[156] Mass was celebrated each Sunday on this altar. In keeping with the religious ethos the children were awoken each morning to utter responses in unison with the nurses to the rosary intoned by the sister-in-charge. They were also required to similarly respond to the evening recital of prayers. The sisters also ensured that the children were properly prepared for the sacraments of first communion and confirmation.[157]

Public transport providers co-operated to provide access to the hospital. In 1932 the Dublin United Tramways Company had inaugurated the number 40A bus service to link Finglas village to the city centre. The Finglas terminus for the route was extended to the hospital as required to accommodate staff and visitors.[158] Initially such visitors were permitted only on Sunday between 1 p.m. and 3 p.m., with all visitors being excluded during epidemics in the city.[159] These visiting hours were further restricted from 1924 with visitors allowed only on alternative Sundays for one hour.[160] By 1940 relaxation of the rules permitted visiting on Wednesday and Sunday afternoons.[161]

With the decline in the numbers of children suffering from tuberculosis, from the mid 1950s the hospital developed as a general orthopaedic hospital and began to treat adult patients who make up 90% of current admissions.[162]

[154] *Irish Independent*, 28 June 1927.
[155] Annals of Cappagh; *Irish Press*, 26 June 1933.
[156] *Irish Press*, 26 Dec. 1932.
[157] Conry, *Flowers of the fairest*, pp 28-32, 43, 167-8.
[158] P. J. Flanagan and C. B. Mac an tSaoir, *Dublin's buses* (Dublin, 1968), p. 41.
[159] *St Mary's Hospital, first report*, p. 20.
[160] *St Mary's Hospital, second report*, p. 39.
[161] Conry, *Flowers of the fairest*, p. 7.
[162] Cappagh National Orthopaedic Hospital, *Annual Report 2011*, p. 4.

St Ultan's 1919-69

Initially established as a voluntary institution for poor Dublin infants, from the early 1930s St Ultan's hospital began to focus on tuberculosis. The hospital grew to become a major provider of tuberculosis treatment for infants on both an in-patient and out-patient basis.

As a 'practical effort to stem the abnormal death-rate of infants' in Dublin city, early in 1918 a group of women decided to open a hospital solely for infants.[163] A house in Charlemont Street was purchased by a benefactress and provided rent free to them until they could purchase the premises at its original price.[164] The house was pressed into emergency service as a hospital during the flu epidemic of 1918 receiving donations of a 'good deal of useful furniture'. With the benefit of these fittings the hospital opened on 29 May 1919 with two cots in the house annex, pending the carrying out of repairs to the main building. By the following April sufficient works had been carried out in the main building to enable eight cots to be accommodated therein.[165] The promoters restricted admissions to infants under one year old, suffering from non-infectious diseases.[166] In September 1919 the hospital opened an outpatients department in the former laundry in the main house.[167] Children up to five years of age were treated in this department.[168]

The workload of the hospital grew quickly. In its first year the hospital admitted fifty-three patients and treated 214 children in the outpatients department.[169] The following year, with further repairs to the house increasing capacity to eighteen cots, although sufficient funds were not available to fully utilise them, seventy-nine infants were treated and 562 seen in the outpatients department.[170] The capacity of the hospital continued to grow by 1923, twenty cots were available increasing to twenty-four the following year.[171] In 1924, 187 infants were admitted to the hospital. That year the first tuberculosis deaths occurred, with two of the seventy-four deaths recorded attributed to the disease.[172] The

[163] *Teach Naoimh Ultuin report for the year 1919-20*, p. 1; *Teach Ultáin sixth annual report 1924-25*, p. 5 (RCPI, SU/1/1). The title of the hospital is formatted differently in the various annual reports.
[164] *Teach Naoimh Ultuin report for the year 1919-20*, p. 1; *Teach Ultain Inc. sixteenth annual report 1934*, p. 6 (RCPI, SU/1/1).
[165] *Teach Naoimh Ultuin report for the year 1919-20*, p. 2 .
[166] *Teach Ultáin second annual report 1920-21*, p. 5 (RCPI, SU/1/1).
[167] Ibid., p. 3.
[168] Ibid., p. 6.
[169] *Teach Naoimh Ultuin report for the year 1919-20*, p. 3.
[170] *Teach Ultáin second annual report*, pp 4-6.
[171] *Teach Ultáin fourth annual report 1922-23*, p. 1; *Teach Ultáin fifth annual report 1923-24*, p. 5 (RCPI, SU/1/1).
[172] *Teach Ultáin fifth annual report*, pp 6-7.

number of patients treated in the outpatients department grew to 901.[173] Although the outpatients department was 'little better than a shed, confined cold and draughty' it proved a success amongst Dublin mothers. Its patients' visits continued to grow from 1,936 in 1924-5 to 2,071 in 1925-6 and 4,507 in 1926-7.[174] To improve conditions, the hospital authorities commissioned a new two storey wing to provide a new outpatients department and increased accommodation for patients. It was officially opening on 15 December 1928.[175]

The new wing, which brought the cot capacity of the hospital to forty-five, was funded largely from funds raised by the hospital authorities in America. [176] The annual running costs of the expanded facility amounted to approximately £2,000 only £750 of which was met from state sources.[177] However as only non-infectious cases were admitted, tuberculosis cases formed a very small cohort of the admissions. Between 1925-26 and 1931 only twenty-one tuberculosis deaths were recorded out of a total of 435 deaths.[178] The work of the outpatients department continued to grow with 6,192 patient visits made in 1929-30, 6,502 made in 1931 and 10,766 in 1932.[179] Having been approved to benefit from the proceeds of sweepstakes under the 1930 act, the hospital authorities commissioned a further extension to provide enhanced nurses accommodation and further wards.[180] The completion of the four new wards at first floor level together with some reorganisation of the existing wards provided the hospital with fifty cots.[181]

In about 1932, the tuberculin skin test was introduced in the outpatients department. As a result of this, in 1933 the hospital filled a ward with children 'who have been infected by mothers who are suffering from pulmonary tuberculosis'.[182] The priority for the hospital was to remove the children from the source of infection and provide them with treatment,

[173] *Teach Ultain Inc. seventeenth annual report 1935*, p. 13 (RCPI, SU/1/2).
[174] *Teach Ultáin sixth annual report*, p. 9; *Teach Ultáin seventh annual report 1925-26*, p. 8; *Teach Ultáin eight annual report 1926-27*, p. 10 (RCPI, SU/1/1).
[175] *Irish Times*, 16 Dec. 1917 and 19 Dec. 1928.
[176] *Teach Ultáin ninth annual report 1927-28*, p. 5; *Teach Ultain Inc. twelfth annual report 1930*, pp 5-6 (RCPI, SU/1/1).
[177] *Teach Ultain Inc. eleventh annual report 1929-30*, p. 6 (RCPI, SU/1/1). The £750 consisted of annual grants from Dublin Corporation and Rathmines Urban District Council amounting to £250 and a rebate of approved expenditure under the Maternity and Child Welfare Act of about £500.
[178] *Teach Ultáin annual reports 1925-26 to 1931* (RCPI, SU/1/1 and SU1/2).
[179] *Teach Ultain Inc. eleventh annual report*, p. 12; *Teach Ultain Inc. thirteenth annual report 1931*, p. 13; *Teach Ultain Inc. fourteenth annual report 1932*, p. 13 (RCPI, SU/1/2).
[180] *Teach Ultain Inc. twelfth annual report*, pp 6-7.
[181] *Irish Times*, 28 May 1931; *Teach Ultain Inc. fourteenth annual report*, p. 7.
[182] *Teach Ultain Inc. fifteenth annual report 1933*, p. 9 (RCPI, SU/1/2).

which lasted a year or more, consisting mainly of rest.[183] They were not allowed return home until cured and then only provided the home was free from infection, the parent the source of the infection having undergone treatment in a sanatorium or otherwise.[184] To accommodate these children, the hospital changed its procedures admitting infants up to two years of age as tuberculosis patients.[185] In 1932 it was decided to fit out an x-ray room and engage an honorary radiologist.[186] The equipment was delivered and erected in September 1933 and staff training commenced.[187] The x-ray service, which became operational in early 1934, provided another diagnostic tool to the hospital for the detection of tuberculosis.[188]

The hospitals 1933 annual report identified the prevalence of tuberculosis amongst outpatients.[189] To address this situation in 1934 a weekly tuberculosis clinic was established at which 'a more thorough investigation is made into definite cases, treatment and follow-up pursued and suspects are referred for diagnosis'.[190] This resulted in 'a greater demand for in-patient accommodation for these cases'. As the disease required isolation facilities a new ten bed tuberculosis unit was erected on the flat roofed annex to the hospital in 1936.[191] This unit proved extremely successful reducing the mortality rate amongst the 103 patients treated between 1937 and 1941 to 25% from a rate of 76% amongst the seventy-nine patients treated from 1933 to 1936.[192] However the prolonged treatment administered often resulted in children remaining in the unit until three years of age. To deal with the early educational needs of such children a Montessori teacher was engaged in 1938 for one hour per day.[193] On the advice of the medical practitioners, in order to provide more effective treatment the capacity of this new unit was subsequently reduced to eight beds.[194]

[183] Dorothy Price, 'Tuberculosis in infants' in *BMJ*, i, no. 4022 (1938), pp 275-7.
[184] *Teach Ultain Inc. fifteenth annual report*, p. 9.
[185] *Teach Ultain Inc. sixteenth annual report 1934*, p. 10 (RCPI, SU/1/2).
[186] *Teach Ultain Inc. fourteenth annual report*, pp 7, 9.
[187] Minutes of medical committee, 13 Sept. 1933 and 10 Jan. 1934 (RCPI, SU/3/2/1).
[188] Minutes of medical committee, 9 May 1934 (RCPI, SU/3/2/1).
[189] *Teach Ultain Inc. fifteenth annual report*, p. 14.
[190] *Teach Ultain Inc. sixteenth annual report*, p. 13; *Teach Ultain Inc. seventeenth annual report 1935*, p. 11 (RCPI, SU/1/2).
[191] *Teach Ultain Inc. eighteenth annual report 1936*, pp 7-8 (RCPI, SU/1/2); Irish Architectural Archive, Dictionary of Irish Architects 1720-1940 'James Hardress de Warenne Waller' (www.dia.ie) (15 Oct. 2013).
[192] *Teach Ultain Inc. twenty-third annual report 1941*, p. 9 (RCPI, SU/1/3).
[193] *Teach Ultain Inc. twentieth annual report 1934*, pp 7-8 (RCPI, SU/1/2).
[194] *Teach Ultain Inc. twenty-second annual report 1940*, p. 8 (RCPI, SU/1/3).

Due to lack of bed spaces treatment of patients in the early stages of tuberculosis was most frequently carried out in their own home under the supervision of the clinic.[195] 'Valuable assistance' was provided by the Jubilee Nurses in the delivery of this service.[196] Parents 'without exception' co-operated in the home treatment as they appeared 'to grasp the whole nature of the scheme to save the children from this much-dreaded disease'. With the co-operation of the Charles Street dispensary the family members of infants found to be suffering from tuberculosis were x-rayed and 'in this way other cases were discovered and lives saved'.[197]

To remedy the lack of bed spaces, eliminate waiting lists and meet a desired objective of the hospital to increase the admission age of tuberculosis patients to five years, in December 1941, the sanction of the department was sought to extend the existing tuberculosis facility.[198] In January 1942 the architect Michael Scott was instructed to prepare an outline scheme for an extension to the tuberculosis block to provide for twenty extra beds, subsequently increased to thirty beds at the behest of the department. Micro-management by the department of the design and tendering process delayed the start of the works until June 1943 and increased costs from an estimated £5,500 to £7,462. The works were funded from the proceeds of sweepstakes. In conjunction with the work on the new extension it was also decided to convert adjoining premises, in Charlemont Street, which had been acquired by the hospital authorities, into a nurses' home.[199] Although basic building works were completed by about September 1944, due to war-time restrictions, delays were experienced in fitting out the new facility.[200] It eventually opened on 7 May 1945.[201]

During 1946 the thirty new beds were fully occupied. However the nature of the patient changed, being now mainly the 'more difficult and advanced cases'. Consequently it was not possible to reduce the death rate below 20%. This change was brought about by the facilities provided in both Fairy Hill and Ballyroan for dealing with the less serious cases

[195] *Teach Ultain Inc. twenty-fourth annual report 1942*, pp 5-6 (RCPI, SU/1/3).
[196] *Teach Ultain Inc. twenty-second annual report*, p. 12.
[197] *Teach Ultain Inc. twenty-fourth annual report*, p. 6.
[198] M. Ffrench-Mullen, secretary Teach Ultain to Sean McEntee, Minister for Local Government and Public Health, 17 Dec. 1941 (NAI, Health H10/4/20).
[199] File note 'Extension to Teach Ultain and provision of accommodation for nursing staff', 10 Jan. 1945 (NAI, Health H10/4/2).
[200] M. Gilmartin, secretary Teach Ultain to The Secretary, Department of Local Government and Public Health, 11 Oct. 1944; D. Monaghan, Department of Supplies to Secretary, Department of Local Government and Public Health, 31 Oct. 1944 (NAI, Health H10/4/2).
[201] *Irish Press*, 8 May 1945.

of primary tuberculosis. [202] In November 1947 the hospital used for the first time the new drug streptomycin, administering it to a four month old patient suffering from tuberculous meningitis secondary to miliary disease. 'In pre-streptomycin days her chances of recovery were nil', yet four months after the treatment she appeared 'to be doing well'.[203]

The work of the clinic continued with 632 visits being made by patients in 1946. Amongst the duties now been undertaken was the supervision of all cases discharged from the tuberculosis unit for a two or three year period.[204] In 1948 the number of visits reached 898. A figure attributed to the greater awareness amongst doctors and parents of the benefits to be obtained from tuberculin testing and x-ray in the early diagnosis of the disease 'and consequently early treatment and more rapid and complete healing'.[205]

Throughout the 1960s the decrease in the incidence of tuberculosis amongst infants resulted in a continuous fall in both the number of admissions to the tuberculosis unit and visits to the tuberculosis clinic. Admissions fell from twenty-six in 1960 to one in 1969 while the number of patients visiting the tuberculosis clinic dropped from seventy-seven to four over the corresponding period (see appendix 18). The hospital attributed the decrease in the incidence of tuberculosis in this age group mainly to 'the full scale BCG vaccination of babies'. However they acknowledged that there were also other contributory factors, namely 'the lower incidence of tuberculosis in the country generally' thus there were less sources of infection; the impact of mass-radiography leading to 'early diagnosis of cases of the disease' thus making treatment more effective; the ability to cure the disease made possible by 'anti-tuberculosis chemotherapy' and 'better housing and a higher standard of living'.[206]

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[202] *Teach Ultain Inc. 28th annual report 1946*, pp 13-14; *Teach Ultain Inc. 29th annual report 1947*, p. 17. (RCPI, SU/1/3).
[203] *Teach Ultain Inc. 29th annual report*, p. 12. Miliary tuberculosis is the disseminated spread of the disease through blood and the lymph systems. In addition to the lung it normally affects several organs at the same time, such as the liver, spleen and brain. It is invariably fatal if not treated. It is characterised by very small lesions which resemble millet seeds, hence its name. *Harrison's principles of internal medicine*, Eugene Braunwald, Stephen L. Hauser, Anthony S. Fauci, Dan L. Lango, Dennis Kasper and J. Larry Jameson (eds) (15th ed., 2 vols, New York, 2001), i, p. 1029.
[204] *Teach Ultain Inc. 28th annual report*, p. 14.
[205] *Teach Ultain Inc. 30th annual report 1948*, pp 13-14 (RCPI, SU/1/3).
[206] *Teach Ultain Inc. forty-ninth annual report 1967*, p. 14 (RCPI, SU/1/5).

Fairy Hill Howth 1941-61

Fairy Hill was founded by local philanthropists in Howth and by fortuitous circumstances adapted for the treatment of tuberculosis in children.

In early 1941, two Howth residents purchased a cottage at Baily Howth for £2,000, intending to use the premises to receive children from bombed out English towns.[207] However failing in that objective they determined to use the premises as a hospital for pauper infants from two to five years of age, referred from children's hospitals, convalescing from general debility and malnutrition, healed primary tuberculosis and coeliac disease. This would free up beds in those hospitals for acute cases, for which there had been a large and increasing demand. The hospital, named 'Fairy Hill', opened in June 1941.[208] Two nurses, a part-time cleaner and a part-time porter were engaged to staff the institution. Nursing assistance, cooking, and laundry services were supplied by local volunteers. Dr W. Chapman a local physician attended as required on a voluntary basis. Dr Robert Collis the consultant paediatrician and Dr C. J. McSweeney the consultant physician at Cork Street fever hospital attended weekly or more often as the needs of special cases demanded, also on a voluntary basis.[209] Resulting from these volunteers' contributions, first year operating costs were only 10*s.* per patient per week.[210]

The establishment of a Samaritan fund by Dr Collis led to the expansion of the hospital's facilities and services. In late 1939 a play written by Dr Collis, 'Marrowbone Lane', had a successful run in the Gate Theatre.[211] The play depicted life in the Dublin slums and highlighted the difficulties faced in obtaining hospital accommodation for sick tenement children.[212] Addressing members of the Rotary club in Dublin on 3 March 1941, on the question of malnutrition amongst Dublin's poor, Dr Collis announced his intention of forming the 'Marrowbone Lane Samaritan Fund' to feed hungry children with the support of hospital social services.[213] By mid May, with the aid of a benefit performance of the play and a radio appeal, over £1,700 was subscribed to the fund.[214] In 1942 Collis

[207] Memorandum for Parliamentary Secretary to the Minister for Local Government and Public Health, undated (either June or July 1945) (NAI, Health D 111/11); *Irish Press*, 16 Dec. 1949.
[208] Memorandum (either June or July 1945).
[209] Note of telephone conversation 24 July 1945 with Arthur Cox; Undated letter Arthur Cox to Secretary Department of Local Government and Public Health (NAI, Health D 111/11).
[210] Memorandum (either June or July 1945).
[211] *Irish Times*, 6 Oct. and 8 Dec. 1939.
[212] *Weekly Irish Times*, 13 Jan. 1940.
[213] *Irish Times*, 4 Mar. 1941.
[214] Ibid., 25 Mar., 5 May and 9 May 1941.

decided to use some of the fund's proceeds to maintain and develop Fairy Hill.[215] With the assistance of the fund the hospital extended its facilities to include a modern kitchen, sanitary annexes, open-air wards, isolation wards, staff quarters, a laundry and bathrooms, bringing the capacity to twenty beds. It also enabled the hospital to extend its remit to include the admission of active cases of primary tuberculosis. However the cost of maintaining the enlarged facility and providing treatment for patients increased the weekly patient cost to 18*s*.[216]

In July 1943 application was made to the minister to approve the institute for the treatment of primary tuberculosis.[217] Ministerial approval enabled the hospital to charge one guinea per week in respect of patients referred by the Dublin authorities.[218] However this applied to only 33% of the patients. The balance of the Dublin patients, 50% of the total, either did not suffer from tuberculosis or had not been referred by the appropriate authorities. 17% of the patients came from outside Dublin and no attempt appears to have been made to have the authorities from their counties of origin make the appropriate referrals, which would have enabled the hospital levy charges.[219] During its first four years of operation the hospital treated 500 children 164 of whom were cases of primary tuberculosis.[220]

In 1942 a new anti-tuberculosis campaign was launched firstly under the aegis of the Anti-Tuberculosis League established in the Royal College of Physicians and following the intervention of the Catholic archbishop of Dublin John McQuaid by the Red Cross, an organisation 'almost entirely in Catholic hands', into which the League was subsumed.[221] In November 1943 Collis announced that the fund was 'preparing to throw the full weight of our support behind the new anti-tuberculosis campaign by….building an extension to Fairy Hill for curable cases'.[222] The following April the Irish Red Cross

[215] Ibid., 18 Nov. 1942.
[216] Memorandum (either June or July 1945).
[217] Application for approval of institution, 21 July 1943 (NAI, Health D 111/11).
[218] Secretary Department of Local Government and Public Health to Sascha Kenny, 26 Aug. 1943; Assistant Secretary Department of Local Government and Public Health to the city manager, 15 Dec. 1943 (NAI, Health D 111/11).
[219] Note of telephone conversation 24 July 1945 with Arthur Cox.
[220] Memorandum (either June or July 1945).
[221] Greta Jones, *Captain of all these men of death* (Amsterdam, 2001), pp 196-9. The claim that the Red Cross was 'almost entirely in Catholic hands' was made by Archbishop Walsh of Tuam in a letter , 26 Feb. 1942, to Archbishop McQuaid of Dublin quoted in John Cooney, *John Charles McQuaid ruler of Catholic Ireland* (Dublin, 1999), pp 163-5.
[222] *Irish Times*, 10 Nov. 1943.

Society provided a grant of £1,500 for the project.[223] The new wing, which added ten beds to the hospital, was officially opened in September 1945. It had been provided at a cost of between £7,000 and £8,000, the vast majority of the funds being subscribed by the Marrowbone Lane Samaritan Fund.[224] This wing was dedicated to the treatment of infants suffering from primary tuberculosis.[225] A full time nurse was engaged to cater for the additional patients, but costs were minimised by allocating some of the increased workload to seven girls in training for nursery child-care.[226] However the number of patients did not increase significantly, with 120 treated in the first year of the increased capacity and 131 in the second year.[227] This can be attributed to the longer hospital stay required by tubercular patients.

In December 1947 the Marrowbone Lane Fund launched an appeal to raise £5,000 to provide a final wing to Fairy Hill.[228] The need for this extra accommodation arose from the hospital's success in treating cases of miliary tuberculosis. However this necessitated keeping the children in the hospital for a number of years. In addition many of the cases of primary tuberculosis referred to the hospital were 'more severe than the average', requiring treatment with streptomycin over a long period before 'the spread of the germ' could be arrested.[229] Having secured the necessary finance the new wing comprising a children's playroom and a four-bed isolation unit was opened in June 1950.[230]

By 1961 with tuberculosis in children no longer a major complaint, the hospital was dealing mainly with convalescent children many of whom came from 'broken homes'. The management committee felt that the premises at Fairy Hill were outdated for the cohort of children then being dealt with. Accordingly they sold the premises and relocated to Terenure.[231]

[223] *Irish Press*, 7 Apr. 1944.
[224] *Irish Press*, 24 Sept. 1945; *Irish Times*, 24 Sept. 1945.
[225] *Irish Times*, 25 Oct. 1947.
[226] *Irish Press*, 16 Dec. 1949.
[227] *Irish Times*, 6 Jan. and 9 Dec. 1947.
[228] Ibid., 16 Dec. 1947.
[229] Ibid., 20 May 1950. The hospital was one of the voluntary hospitals in which the use of streptomycin had been sanctioned by the Medical Research Council. (Streptomycin sanctioned by the Medical Research Council, 28 Apr. 1948 (NAI, Health D112/432)).
[230] *Irish Times*, 5 June 1950.
[231] *Irish Independent*, 28 Sept. 1961; *Irish Press*, 7 Oct. 1961.

Baldoyle 1943-56

The length of their waiting lists caused the Cappagh hospital authorities to seek alternative accommodation. The solution was found in Baldoyle.

In August 1942 Sister Baptist the superior of Cappagh Hospital wrote to the minister pointing out that long lists of patients awaiting admission were developing, often leading to delays exceeding three months before vacancies could be secured. During this waiting period 'the (tubercular) lesions from which the patient is suffering progresses actively, with the result the period of treatment necessary in Cappagh is greatly prolonged'. These extended periods of treatment resulted in even lesser availability of beds. To resolve this problem she suggested adapting part of her congregation's convent at Baldoyle for use as an auxiliary hospital. This would provide forty beds for the treatment of ambulatory cases. The children's educational needs could be met in the local national school which was under the nuns' control.[232] However the department's technical officers considered the premises, which consisted of two of the first-world –war army huts, formerly used at Cappagh, unsuitable for the intended purpose.[233]

An accommodation crisis for infants affected by disease outbreak forced the authorities to reconsider. During the latter half of 1942 an outbreak of infant paralysis (poliomyelitis) occurred in the country affecting 360 children sixty-four of whom died.[234] Approximately forty-eight of these cases occurred in Dublin where ten deaths were recorded.[235] Affected children required 'a lengthy period of specialised care and after treatment' in a 'centre specially staffed and equipped for the purpose' without which complete recovery was not possible. As departmental officials failed to source suitable premises, approaches were made to Sister Baptist with a view to accommodating them in Cappagh and opening Baldoyle for orthopaedic cases. She acceded to the request seeking a payment of 35*s*. per week in respect of each patient transferred from Cappagh to Baldoyle to cover staff costs and 'the initial expense for alterations, fittings and equipment'.[236] As the Cappagh waiting lists had grown to seventy-two tuberculosis and

[232] Sr Baptist to The Secretary Department of Local Government and Public Health, 11 Aug. 1942 (NAI, Health D 100/44).
[233] Rúnaí to Mother Superior, St Mary's Open Air Orthopaedic Hospital, 11 Nov. 1942 (NAI, Health D 100/44); *Irish Independent*, 5 July 1956.
[234] Cabinet briefing paper, report of Department of Local Government and Public Health on condition of the public health, especially in Dublin, 6 Jan. 1943 (NAI, Health D 100/44).
[235] *Irish Times*, 16 Dec. 1942. The national statistics covered the period 1 July to 31 Dec. whereas the Dublin figures were for the period 1 Aug. to 12 Dec.
[236] Cabinet briefing paper, 6 Jan. 1943; Sr Mary Peter to Mr Hurson, Secretary, Department of Local Government and Public Health, 28 Jan 1943 (NAI, Health D 100/44).

infant paralysis cases by early March 1943, the minister consented to use the premises until 31 December. The consent was subject to the engagement of experienced orthopaedic staff, under the supervision of Cappagh medical staff and the carrying out of necessary adaptation works.[237] Following the completion of building alterations the premises opened in April, treating 100 patients by the end of October of whom sixty-three were discharged.[238] Dublin Corporation refused to pay the new rate only contributing 29*s.* 6*d.* per week the same charge as applied to their patients in Cappagh, a rate which had been fixed on 1 April 1938.[239]

The lack of forward planning by the department was evidenced by the fact that the minister's approval ran only until the end of the year. This caused particular problems for the hospital authorities. They considered that the management of the hospital would be improved by the appointment of a visiting physician and a matron 'with considerable orthopaedic training and wide experience in the management of children'. However suitable staff could not be recruited until there was 'some certainty of the post being permanent'.[240] Nor were they prepared to carry out other essential alterations 'until sanction, to the institution being permanently used as a hospital, had been obtained'.[241] Recognising these problems the minister extended, by a further two years, the use of the hospital subject to the additional alterations being carried out.[242] Plans for the works were submitted to the minister in May 1944.[243] In issuing approval the department stated that 'it would suffice if the architect could obtain any three competitive tenders […] without incurring the expense and delay of public advertisement'.[244]

The department micro-managed the construction process, yet failed to provide adequate finances. The department approved of the lowest tender for the works, £1,102, in August

[237] Sr Mary Peter to Mr Hurson, 28 Jan 1943; Rúnaí to Sr Mary Peter, 26 Mar. 1943 (NAI, Health D 100/44).
[238] Sr Mary Vincent to J. Hurson, 4 Nov 1943; Sr Mary Peter to The Secretary, Department of Local Government and Public Health, 15 Dec. 1943 (NAI, Health D 100/44).
[239] For City Manager and Town Clerk to The Secretary, Department of Local Government and Public Health, 6 May 1943; File note c. June 1943 'Charges for children sent from St Mary's Open Air Orthopaedic Hospital Cappagh to the recently opened auxiliary institution at Baldoyle (NAI, Health D 111/10).
[240] Dr H. MacAuley to An Rúnaidhe, Department of Local Government and Public Health, 11 Dec 1943 (NAI, Health D 100/44).
[241] Extract from report on inspection of Baldoyle auxiliary hospital on 2 Feb. 1944 (NAI, Health D 100/44).
[242] Rúnaí to Mother Superior, St Mary's Open Air Orthopaedic Hospital, 29 Feb. 1944 (NAI, Health D 100/44).
[243] William H. Byrne to The Secretary, Department of Local Government and Public Health, 25 May 1944 (NAI, Health D 100/44).
[244] Rúnaí to Mother Superior, St Mary's Open Air Orthopaedic Hospital, 23 June 1944 (NAI, Health D 100/44).

1944.[245] During the course of construction further necessary works were identified costing £785 which the department duly approved of.[246] However when the hospital authorities applied for grant aid from the Hospital's Trust Fund to cover these costs, it was refused. The department cited as the reasons for refusal the condition attached to its original approval of the institution, which required rendering the premises suitable for use as a hospital and the justification advanced by the nuns for the fee of 35*s.* that 'the initial expense for alterations, fittings and equipment will be considerable'.[247] Some recompense was provided when the minister increased the weekly rate in respect of patients referred by local authorities to the institution to £2 12*s.* 6*d.* in the late 1940s increasing the rate further to £3 3*s.* from 1 January 1951.[248]

By the early 1950s the converted huts were considered quite unsuitable as hospital accommodation, the visiting surgeon Dr E. P. Stanley expressing the view that if winter weather proved severe it would be necessary to remove the children.[249] Application to the minister in 1951 for a grant of £30,000 to enable the rebuilding of the hospital although given 'very sympathetic consideration' was unsuccessful as the only source of such finance available to the minister the Hospital's Trust Fund was inadequate to meet existing commitments and probable short term accretions.[250] In February 1952 a fund raising committee was formed under the patronage of Andrew Clerkin the Lord Mayor of Dublin to raise the estimated £36,000 to build the new hospital.[251] The fund was subsequently named 'The Little Willie Fund' after a patient in the hospital, whose image of a young crippled child supporting himself on crutches elicited much public sympathy. Having raised £11,000, the foundation stone was laid in January 1954, for a building now estimated to cost £73,500.[252]

[245] Same to same, undated August 1944 (NAI, Health D 100/44).
[246] William H. Byrne to The Secretary, Department of Local Government and Public Health, 19 Feb. 1945; Rúnaí to Rev. Mother Superior, St Mary's Open Air Orthopaedic Hospital, undated 1945 (NAI, Health D 100/44).
[247] Rúnaí to Rev. Mother Superior, St Mary's Open Air Orthopaedic Hospital, 18 Apr. 1945 (NAI, Health D 100/44).
[248] Secretary of Public Health Department, Corporation of Limerick to Secretary, Department of Health, 14 Feb. 1951; Department of Health to City Manager, Limerick, 28 Feb. 1951 (NAI, Health D 100/44).
[249] *Irish Independent*, 10 Oct. 1953.
[250] Dr James Ryan, Dáil debates, vol. 128, no. 7, 1019-1020, 13 Dec. 1951. Ryan was Fianna Fáil deputy for Wexford and Minister for Health from June 1951 to June 1954. He represented the constituency from 1919 to 1965 when he retired (he did not stand for the third Dáil which sat from August 1922 to August 1923). From March 1932 whenever his party was in power he was a member of the cabinet holding various ministries.
[251] *Irish Press*, 29 Feb. 1952.
[252] *Irish Independent*, 23 Jan. 1954.

The building was officially opened on 4 July 1956. It had cost £80,000. However a fresh application for grant aid had been successful and £40,000 was provided from this source. £33,000 had been raised by the 'Little Willie Fund', leaving a balance of £7,000 to be funded by way of bank borrowings. The three-storey building had accommodation for 114 patients and thirty-six staff. However by the time the new hospital was ready for occupation the focus had changed away from tuberculosis with cases of poliomyelitis, cerebral palsy and spastic paralysis accounting for the bulk of the patients.[253]

Ballyroan Preventorium 1943-60

The possession of Ballyroan House by the Sisters of Mercy enabled Archbishop John McQuaid to secure its development as a preventorium, an extension of the concept originated by Lady Aberdeen at Sutton.

In the early 1930s the ownership of Ballyroan, a nineteenth-century house, together with sixty-two adjoining acres had devolved to Annette and Rita McCabe. Unable to maintain or sell the premises they bequeathed them to the Sisters of Mercy, a congregation their sister Mona had joined in 1919.[254] The nuns converted the house into a convent, St Mary's, which opened on 26 July 1932. They converted the out-offices into a holiday home for working girls with accommodation for twenty-three persons. The home opened in September 1933, receiving guests during the summer months and at Christmas. It continued in this use until 1941 when due to war difficulties it was forced to close.[255]

On 25 May 1943 Archbishop John McQuaid of Dublin requested the sisters to make Ballyroan available to the anti-tuberculosis section of the Red Cross, for use as a preventorium for children up to five years of age. Such an approach from the archbishop was akin to a command. McQuaid dispatched his emissary Monsignor Daniel Moloney, the parish priest of Donnybrook, who found the site and surroundings ideal for the proposed use and the buildings capable of adaption with some small alterations.[256] The offer of the premises was conveyed to the Red Cross who at a meeting on 31 May decided to accept it.[257]

[253] *Irish Times*, 5 July 1956; *Irish Independent*, 5 July 1956; *Irish Press*, 5 July 1956.
[254] Ballyroan tells its story (CSMA, C8/1/5).
[255] St Mary's, Ballyroan, Rathfarnham (CSMA, C8/1/3).
[256] Ibid.
[257] Irish Red Cross Society report on Irish Red Cross preventorium for the treatment of young children with primary tuberculosis, 9 May 1978 (CSMA, C8/1/3).

The Red Cross sanctioned a grant of £500 to facilitate the alterations.[258] This was added to by a gift of £1,000 from Archbishop McQuaid.[259] The recreation and dining rooms were converted into wards to accommodate twenty-five infants and the dormitories adapted as accommodation for nursing staff.[260] The Red Cross accepted responsibility for the payment of this nursing staff in addition to underwriting the undertaking.[261] This required the Red Cross to make up the deficit in respect of patients referred by local authorities to the institution, as the one guinea per week paid by the local authorities did not meet the cost of their maintenance and treatment.[262] On 9 September 1943, sixteen children were conveyed to Ballyroan by a fleet of six Red Cross ambulances from Temple Street, the Richmond and St Ultan's hospitals. The children fell into three categories, those who reacted positively to a tuberculin skin test, indicating the presence of the disease, children showing signs of the initial stages of the disease and children whose environmental surroundings had placed them in danger of contracting the disease.[263] The preventorium was officially opened by Archbishop McQuaid on 12 September. Although the Catholic clergy was well represented at the ceremony the press did not list any politicians as being amongst the attendance.[264]

At the official opening Justice Conor Maguire the chairman of the Irish Red Cross announced his organisation's intention of unfolding 'very shortly larger plans, which we have in view' for Ballyroan.[265] By the following January architects were instructed to draw up plans for a new forty-bed pavilion.[266] As an interim measure a ten-bed extension to the existing ward was commissioned at a cost of £1,100. This extension was completed in August 1944, funded entirely by the Red Cross.[267] The provision of these extra beds contributed to the preventorium successfully treating fifty-one children suffering from primary tuberculosis in its first eighteen months of existence.[268]

Contracts were signed in September 1945 for the new extension consisting of one large ward, two small wards and an isolation ward. The wards were surrounded by a large

[258] *Irish Press*, 1 June 1943.
[259] Ibid., 14 June 1943.
[260] St Mary's, Ballyroan, Rathfarnham; *Irish Press*, 13 Sept 1943.
[261] *Irish Press*, 13 Sept 1943.
[262] Irish Red Cross Society report, 9 May 1978.
[263] *Irish Press*, 9 Sept 1943; *Irish Independent*, 10 Sept 1943; *Irish Times*, 10 Sept 1943.
[264] *Irish Press*, 13 Sept. 1943; *Irish Independent*, 13 Sept. 1943.
[265] *Irish Press*, 13 Sept. 1943.
[266] Ibid., 3 Jan. 1944.
[267] Irish Red Cross Society report, 9 May 1978; *Irish Times*, 17 Aug. 1944; *Irish Press*, 17 Aug. 1944.
[268] *Irish Press*, 17 Feb. 1945.

concrete path which facilitated wheeling the beds outside to enable patients benefit from heliotherapy. In addition new nurses' accommodation was constructed providing each nurse with a separate single bedroom and providing them with new communal dining and sitting rooms. The former nurses' accommodation was divided into cubicles for the maids who were provided with their own separate dining room. To facilitate the new extensions connections to the public sewers and water supply were made and a thirty-six foot high water tower erected. These works, funded by the Red Cross cost £24,627.[269] The new extension was officially opened on 22 Aug. 1947.[270] At the opening it was revealed that up to the end of the previous May 140 children had passed through Ballyroan. It was 'estimated that at least 50% of these children might have died in the absence of the treatment they received there'.[271]

The new facilities enabled both the number and age range of children being treated to be increased. This created the need to provide educational facilities and additional staff accommodation. It was decided to accept patients up to twelve years of age, later extended to fourteen.[272] To cope with the now seventy-five patients the congregation assigned eleven additional sisters to the institution and recruited more highly qualified lay staff.[273] This enabled the institution to increase its annual throughput of patients to over 200. At the end of March 1955 the Red Cross withdrew entirely from the institution leaving its running entirely to the Sisters of Mercy.[274] The following year the Department of Education sanctioned a two roomed school in the hospital.[275] Two sisters trained in the congregation's teacher training college in Carysfort were assigned to this new school.[276] In mid 1957 a new wing containing a new nurses' home and wards was built at an estimated cost of £6,000.[277] This work increased the patient accommodation to eighty-nine beds. The modern nursing accommodation may have been necessary to attract nurses to work in the rather isolated institution, as only four of the nursing staff of twelve were members of the congregation, the balance being lay nurses.[278]

[269] Irish Red Cross Society report, 9 May 1978; 'Ballyroan' (CSMA, C8/1/3).
[270] *Irish Times*, 23 Aug. 1947; *Irish Press*, 23 Aug. 1947.
[271] *Irish Times*, 23 Aug. 1947.
[272] Ballyroan tells its story; 'Ballyroan'.
[273] Ballyroan tells its story.
[274] Irish Red Cross Society report, 9 May 1978.
[275] 'Ballyroan'.
[276] Ballyroan tells its story.
[277] Hugh O'Neill to Rev. Mother Therese Joseph, 18 July 1957 (CSMA, C8/1/2); 'Ballyroan'.
[278] A. MacNamara to The Superioress, St Mary's Preventorium, 26 July 1958 (CSMA, C8/1/1).

In the 1950s new methods available for the treatment of tuberculosis in children caused a rapid decline in the demand for the hospital's services. Eighty-nine patients were resident in the hospital at the end of December 1958 by the end of June 1959 this number had dropped to sixty-two falling further to thirty-nine by the end of December 1959.[279] Although thirteen new patients were admitted in early 1960 by the middle of that year the preventorium had closed.[280]

Wicklow Preventorium 1955-56

The closing of Wicklow fever hospital provided Wicklow County Council with a vacant premises. An Attempt to establish a preventorium therein provides a startling example of waste of public funds officially encouraged and sanctioned by the department.

By the early 1950s, a diminution in the incidence of infectious diseases had reduced the demand for the services provided by Wicklow fever hospital.[281] The last serious outbreak of infectious disease in the county had occurred in 1944-5.[282] At the suggestion of the Department of Health approaches were made to the Cork Street Fever Hospital and the Vergemount Fever Hospital authorities, who agreed to accommodate any future Wicklow fever cases in their institutions.[283] This enabled the council to sanction using the premises as a tuberculosis institution for the treatment of tuberculosis in children between the ages of five and fifteen years, thus closing 'an existing gap' in the council's tuberculosis service.[284] However to bring the premises up to the required standards it was necessary to engage the services of architects and builders.

Despite carrying out no detailed assessment of need, such as might have been provided by an examination of waiting lists, the local authority proceeded to spend £22,855 on altering and extending the premises. This was funded by a grant of £15,237 from the Hospital's Trust Fund and bank loans of £7,618.[285] The existing staff complement of two nurses was doubled to run the new twenty-eight bed institution.[286] As the construction

[279] Same to same, 11 Feb. 1959, 27 July 1959 and 1 Feb. 1960 (CSMA, C8/1/1).
[280] Same to same, 28 July 1960 (CSMA, C8/1/1).
[281] *Minutes of meeting of Wicklow County Council*, 1 Mar. 1954 (WWCCA).
[282] Ibid., 14 Sept. 1953.
[283] Patrick Maguire, staff officer, Wicklow County Council to Secretary, Department of Health, 2 Apr. 1953 (NAI, Health D32/43).
[284] *Minutes of meeting of Wicklow County Council*, 14 Sept. 1953; Patrick Maguire, staff officer, Wicklow County Council to Secretary, Department of Health, 11 June 1953 (NAI, Health D32/43).
[285] County Secretary to Secretary Department of Local Government, 24 June 1957 (NAI, Health H33/33/3).
[286] County Medical Officer to Secretary, Department of Health, 14 Mar. 1955; Patrick Maguire, staff officer, Wicklow County Council to Secretary, Department of Health, 30 July 1955. (NAI, Health D32/43).

works advanced it became evident to the county medical officer that using the premises as a preventorium was 'not practicable […] even if Wexford were added in, there would still not be nearly enough cases'[287]. Nevertheless following a conference in the Department of Health in April 1955, having considered Wexford County Council's expressed intention 'to send suitable patients to the hospital' it was decided to proceed with the proposal.[288]

The hospital opened for the reception of patients in August 1955. The cost of running the hospital for the remainder of the financial year to 31 March 1956 was estimated at £2,000. In considering the estimates for 1956-7 the council allowed the sum of £6,000 to cover the running costs of the institution.[289] However during the course of that financial year as an economy measure the council decided to discontinue its use as a preventorium.[290] The hospital was vacated at the end of October. Only the newly constructed laundry was retained in use as it was required to serve the Wicklow County Hospital.[291]

Conclusions

It was through private philanthropy that premises were acquired and subsequently adapted for the treatment of childhood tuberculosis. However fund raising to cover both annual running costs and the financing of capital developments was an ongoing concern for the institutions. The engagement of members of the aristocracy and other prominent members of society often proved crucial in securing such funds. Any contributions received from the local authorities proved grossly inadequate but entailed the institutions being subject to the close scrutiny of central government. The state authorities expected that the institutional organisers would secure from private sources adequate funding to make up for their shortfalls. From the 1930s some relief was forthcoming with the availability of sweepstakes monies. However access to such funds entailed even greater micro-management of the institutions affairs by central government than had already existed.

[287] County Medical Officer, 14 Mar. 1955.
[288] File note 18 May 1955 (NAI, Health D32/43).
[289] *Minutes of meeting of Wicklow County Council*, 20 Feb. 1956.
[290] Ibid., 7 Mar. 1957.
[291] Patrick Maguire, staff officer, Wicklow County Council to Secretary, Department of Health, 11 Oct. 1956 (NAI, Health D32/43).

The institutions were the first to address the educational and training needs of long-stay juvenile hospital patients. This even extended to pre-school infants as evidenced by the introduction of Montessori teachers in St Ultan's. The provision of education continued to be a main focus of the institutions. The religious ethos of the institutions impacted greatly on their patients, even to the extent of dictating their daily routines.

The children's hospitals were to the forefront in introducing modern treatment regimes such as heliotherapy, chemotherapy and the provision of aftercare. St Ultan's was instrumental in introducing the use of tuberculin and x-ray as diagnostic tools for tuberculosis in children. Its work was a major factor in changing parents' attitudes to seeking medical intervention for their tubercular children.

Despite the proven inadequacies of the provision made by the voluntary institutions for the treatment of tubercular children, as evidenced by the waiting lists, the state made no attempt to address the issue. This lack of provision of required bed-spaces resulted in longer hospital stays for late admissions, thus exacerbating the situation and leading to even longer waiting lists. A belated attempt by the state in Wicklow, when modern treatment methods had reduced the demand for beds, demonstrated how the overall lack of planning proved financially disastrous. Nevertheless, as evidenced by their treatment statistics, for almost a century, by filling a void these institutions made a major contribution to the treatment of tubercular children in Leinster.

Chapter 9
The final phase— the regional sanatoria and the contribution of technical and medical advances to the demise of the sanatorium in Ireland 1935-1973

Deaths from all forms of tuberculosis continued to exhibit a downward trend in the decade since the census of 1926 declining from 4,362 deaths (1.47 per 1,000 population) in 1926 to 3,480 deaths (1.17 per 1,000 of the population) in 1936, although anomalies occurred with deaths increasing from 3,825 (1.31 per 1,000 population) in 1930 to 3,902 (1.33 per 1,000 of the population) in 1931 and from 3,514 (1.18 per 1,000) in 1934 to 3,770 (1.27 per 1,000 population) in 1935. This persistent high number of deaths attributable to tuberculosis continued to place the government under pressure to provide specialised treatment facilities.[1] The provision of regional sanatoria was proposed as the most economical method of accommodating tuberculosis sufferers. Resulting from technological and medical advances, new diagnostic facilities and treatment methods were introduced in this post-war period. This was facilitated by the establishment of a separate Department of Health in 1947.[2] The appointment of a pioneering Minister for Health, who had a particular interest in tuberculosis, in the newly elected coalition government in February 1948, provided added impetus to the provision of new treatment facilities and to the introduction of new practices. These changes altered the situation irrevocably in ways that could not have been predicted.

Regional sanatorium

From the mid 1930s regional sanatoria were advanced as the solution to the plethora of uneconomic small county institutions in which tuberculosis was treated. They were to be strategically located to serve the needs of population conglomerates. The initiative was taken by medical officials in the Department of Local Government and Public Health, but this new approach was quickly taken on board by national and local politicians. Successive ministers for health had to resolve issues regarding the number and location of the facilities to be provided. The delivery of the sanatoria was micro-managed by these ministers aided by their officials.

[1] *Annual report of the Registrar General for the year 1936*, P 2757, xxiii.
[2] Ministers and Secretaries (Amendment) Act, 1946, 1946/38 [Éire] (24 Dec. 1946); Ministers and Secretaries (Amendment) Act, 1946 (Section 2) (Commencement) Order, 1947 (1947 no. 14) (21 Jan. 1947).

By 1935 it had become clear that the existing policy of equipping all small county sanatoria with up-to-date facilities was unwise and uneconomic. As an alternative the chief medical advisor in the Department of Local Government and Public Health recommended providing four regional sanatoria 'where early cases of tuberculosis of the lungs may be housed under conditions favourable to their recovery'. He considered that for the Leinster region a revamped Peamount sanatorium would fulfil this role. His recommendation also provided for the development of new regional chest hospitals. These were necessary to augment the work of the sanatoria. Initial referrals from the network of tuberculosis dispensaries would be made to these chest hospitals for further investigation. They would be equipped with operating theatres to provide for the surgical treatment of pulmonary tuberculosis.[3] The minister adopted the recommendations and requested the Hospitals Commission to investigate how they might be advanced.[4]

The commission maintained that two regional sanatoria would be required for the Leinster region. The needs of Dublin city and county could be met by providing a 300-bed replacement sanatorium for Crooksling, while the needs of the Leinster counties outside Dublin could be satisfied by redeveloping the 356-bed Peamount sanatorium. It recommended using the 156-bed Meath hospital in Dublin as the Leinster region's chest hospital and Our Lady of Lourdes Hospital, Dun Laoghaire for the accommodation of adult non-pulmonary tuberculosis patients.[5]

The commission considered that Newcastle sanatorium could cater mainly for paying patients a great number of whom 'tend to seek treatment outside the country', resulting in considerable loss to the national economy.[6] Many of these wealthy fee-paying patients underwent treatment in Swiss sanatoria. Bridgid Lyons, an Irish army doctor, recalled at least six fellow Irish patients in Dr Rollier's institution at Leysin in 1925; herself and another army officer were funded by the government while two were funded by the Irish White Cross.[7] The playwright Lennox Robinson visiting Switzerland in 1929 found 'Davos, to Ireland's shame, was crowded with Irishmen and women'.[8] In 1930 at least

[3] R. Percy Mc Donnell, 'Memorandum on the institutional (residential) care of pulmonary tuberculosis', 18 Jan. 1935; R. Percy Mc Donnell, 'Tuberculosis treatment', 31 May 1935 (NAI, Health D 112/10).
[4] Ar son Rúnaidhe to The Secretary Hospitals Commission, 11 Feb. 1936 (NAI, Health D 112/10).
[5] E. Cooney, Rúnaidhe, Hospitals Commission to The Secretary, Department of Local Government and Public Health, 12 Nov. 1936 (NAI, Health D 112/10); *The Hospitals Commission, second general report, 1935 & 1936* (Dublin, 1937), pp 16-25.
[6] *The Hospitals Commission, second general report, 1935 & 1936* (Dublin, 1937), p.22.
[7] John Cowell, *A noontide blazing* (Dublin, 2005), pp 243-6.
[8] Lennox Robinson, *Curtain up* (London, 1942), pp 213-4.

100 Irish people were recuperating in Davos.[9] Wealthy Irishmen rented houses in Leysin for their families whilst relations were undergoing treatment.[10]

In the late 1920s Richard Mulcahy the Minister for Local Government and Public Health had approved of the Rollier institute for the treatment of insured patients, allowing local authorities contribute towards such treatment. By 1931 a change of policy occurred and despite recommendations from tuberculosis medical officers in favour of Swiss treatment and the willingness of family members to co-fund the treatment, ministerial sanction was refused on the grounds that 'settled practice of this department precludes approval being given to expenditure on the provision of treatment for pulmonary cases of tuberculosis in Switzerland or other places abroad'.[11]

The 'feeling of insecurity created by the world situation in 1939' and the drop in the income of the hospital's sweepstakes' fund following the outbreak of war halted progress on the implementation of the Hospitals Commission's recommendations.[12] The question of regional sanatoria was re-addressed in 1943 in the Irish Red Cross proposals for a long-term scheme to deal with tuberculosis. The 1936 Hospitals Commission recommendations were based on the provision of beds at the rate of one bed per death attributable to tuberculosis, as recommended by the health section of the League of Nations in 1932. The Red Cross, having reviewed current best practice, anticipated that two beds were required per recorded tuberculosis death. Based on this revised assumption there was a deficit of 4,000 beds in the country for tuberculosis patients, with a further 1,000 beds required to treat primary tuberculosis in young children and adults. The Red Cross maintained that the segregation of advanced cases in separate institutions 'has a tendency to create the impression that the institutions for advanced cases are institutions for the dying and so in fact they are'. It felt it 'unreasonable' to expect patients to enter such institutions and thereby remove a source of infection from the community 'until they are in fact dying'. Apart from the psychological barrier created for patients, economic circumstances had prevented such institutions from offering a full range of services. To overcome these problems it recommended that all tuberculosis patients, regardless of the form or stage of development of their disease, be treated in the

[9] Editor's comment in *The Torque* (Apr. 1930) a magazine published by the Davos Irish Circle.
[10] Interview by Alan Carthy with Kathleen Caulfield, St Pappin's, Dublin (19 May 2011).
[11] County Wexford board of health minutes, 21 May 1928, 16 Feb. and 16 Mar. 1931.
[12] *The Hospitals Commission, fifth general report, 1939, 1940 and 1941* (Dublin, 1943), p. 6.

same institution.[13] Accordingly the Red Cross recommended that five 1,000-bed institutions be constructed on a regional basis, each containing 100 hospital beds 'oriented mainly towards thoracic surgery[14] and 900 sanatorium beds. Having visited the Dublin Corporation-owned site at Ballyowen it felt that 'it would be difficult to find a more suitable site in the immediate neighbourhood of Dublin' on which to construct a 1,000-bed facility 'to accommodate all grades of patients from early sputum negative[15] to advanced open cases'.[16]

The Red Cross 1943 scheme was accepted in principle by the minister. However in doing so, instead of the five institutions recommended by the Red Cross, he decided to build only three regional sanatoria, in Dublin, Cork and Galway. Because of the considerable delays experienced by local authorities in providing facilities, it was determined that the minister should have direct control of additional bed accommodation needs. It was therefore proposed to vest in the minister all the local authority powers for the acquisition and development of sanatoria sites. With the department controlling all aspects of the design and construction it was hoped to deliver the projects at an estimated cost of £550 per bed, a considerable reduction on the £1,200 construction cost of beds in general hospitals. As all the construction materials required for the Dublin project were immediately available or anticipated imminently, it was felt that this work should be proceeded with. Accordingly it was agreed to establish a specialist design team within the department under the direction of the New Zealand architect Norman White. The full cost of these sanatoria and the cost of the design team were to be defrayed from the Hospitals Trust.[17]

The transfer of local authority powers to the minister was crucial to the implementation of the new centralised provision of facilities. However the attorney general advised that

[13] Outlines of a long term policy recommended by the anti-tuberculosis section of the Irish Red Cross, 15 Dec. 1943; Hospitals Commission 'Memorandum on proposals for a long term policy recommended by the anti-tuberculosis section of the Irish Red Cross, 10 Mar. 1944 (NAI, Health D 102/5).
[14] 'Thoracic surgery' referred to the various operative procedures performed on the chest, which were a common feature in the treatment of pulmonary tuberculosis prior to the widespread use of newly discovered chemotherapy cures for tuberculosis in the 1950s.
[15] In the early stages of the disease examination of the sputum of infected persons did not always reveal the presence of the tuberculosis bacillus although such patients could still transmit the disease. Such early stage patients were referred to as sputum negative. Open cases are those where the bacillus is present in their expectoration.
[16] *Irish Press*, 3 and 4 Dec. 1937; file notes, 'Children's sanatorium Ballyowen', undated and 'Ballyowen sanatorium', 23 Apr. 1957 (NAI, Health D 34J/10); long term policy Irish Red Cross, 15 Dec. 1943. The site comprising 72 acres 2 roods and 28 perches had been purchased by Dublin Corporation for £4500, in September 1940, in order to erect a replacement sanatorium for Crooksling.
[17] Department of Local Government and Public Health, government brief 'Treatment of tuberculosis', 23 Dec. 1944 (NAI, Taoiseach S 13603A); Noel Browne, *Against the tide* (Dublin, 1986), p. 114.

to give effect to this the enactment of legislation was necessary. Because of the urgency with which the government regarded the matter, the cabinet granted authority for the priority drafting of a bill to secure the powers on 12 January 1945 and by the 30 January had approved the final text. The bill was passed by both houses of the Oireachtas on 28 February 1945 and signed into law by the president on 6 March.[18] The act gave the minister general powers to build and equip sanatoria, to defray costs from the Hospitals Trust Fund and to acquire land either by agreement or compulsory for this purpose. The act obliged him to hand over completed sanatoria to local authorities for management and maintenance.[19]

Government proposals regarding tuberculosis were elaborated in a white paper published in January 1946. The government considered it essential to locate the regional sanatoria 'near large cities so that the best medical talent might be available'. Such locations would facilitate 'the visiting of patients by their friends and staff recreation'. In addition to a new Dublin sanatorium serving the needs of Dublin city and county, it envisaged other Leinster patients being treated in an enlarged Peamount sanatorium, Newcastle sanatorium, Our Lady of Lourdes Hospital (Dun Laoghaire) and in 'modernised existing local institutions'.[20]

Regional sanatorium proposals for Santry, County Dublin

In April 1945 a 222-acre site was acquired at Santry Court on which to erect the Dublin sanatorium. It was the only site considered by the department's technical advisors to be 'in every way suitable'.[21] By March 1946 the design proposals for the project had been advanced to the stage where it was possible to advertise for tenders for site development works.[22] The successful tenderer P. J. Walls and Bros commenced work in June on a £75,000 contract.[23]

[18] Extracts from Cabinet minutes GC4/45, 12 Jan. 1945, Item 1, GC4/51, 30 Jan. 1945, Item 2 (NAI, Taoiseach S 13603).
[19] Tuberculosis (Establishment of Sanatotia) Act, 1945. 1945/4 [Eire] (6 Mar. 1945).
[20] *Tuberculosis*, P 7368 (1946), pp 13-4.
[21] *Irish Independent*, 13 Apr. 1945.
[22] Dr Con Ward, Dáil debates vol. 99, no. 2, 189-190, 31 Jan. 1946.
[23] Sean MacEntee, Dáil debates vol. 101, no. 13, 1761, 13 June 1946. MacEntee was the Fianna Fáil deputy for Dublin townships and Minister for Local Government and Public Health from August 1941 to February 1948. Although elected in 1919 and 1921to represent Monaghan he did not enter the Dáil until August 1927, representing Dublin County. He continued to represent different Dublin constituencies until his retirement from politics in 1969. From 1932 to 1965 when his party was in power he was a member of the cabinet holding several different ministries.

However the Department of Industry and Commerce's proposed extension of the runways at the adjacent Collinstown airport created an immediate conflict with the sanatorium proposal. Extended runways would result in aircraft passing over the proposed sanatorium 'at a height of not more than 400-500 [feet] and possibly as low as 200 [feet]'. Resultant high noise levels would render it impossible for sanatorium patients to obtain complete rest, which was an essential element in their treatment.[24] Although both projects were the subject of cabinet decisions, the staff actually involved in their implementation had not been informed. Therefore nobody in the respective departments was in a position to associate both projects and investigate their mutual impacts. In February 1947 the newly-appointed Minister for Health Dr. James Ryan instructed his officials 'to get a new site, quietly stop work on the old one and to say nothing'.[25] Unfortunately £25,000 worth of work had been certified as completed on the Santry site and this together with reinstatement works brought the total cost of the debacle to over £40,000.[26]

In May 1947 the abandonment of Santry was made public. The minister, James Ryan, sought to lessen the impact of the decision by informing the Dáil that the extensive building plans prepared for Santry Court could be modified to suit an alternative site, the acquisition of which was being pursued. He announced that because of the delay 'special measures' were in place to provide additional accommodation in existing institutions. These measures involved providing the authorities of both Peamount and Newcastle sanatoria with plans for forty-bed sanatoria blocks designed for quick development.[27] Work commenced on the provision of three forty-bed wards at Peamount in August 1947.[28] Although the work was completed in early 1949, patients were not admitted until the end of that year, as the accommodation for the additional staff required to manage the units was awaited.[29] Newcastle sanatorium commenced work on the erection of two forty-bed units in 1948. These units were occupied towards the end of 1949.[30] Ryan also

[24] Department of Local Government and Public Health, memorandum for the government, projected development of Collinstown airport as a transatlantic airport, 2 Dec. 1946 (NAI, Taoiseach S 13603A).
[25] James Deeny, *To cure & to care* (Dublin, 1989), pp.158-9. A separate Department of Health had been established by legislation passed in December 1946. Ministers and Secretaries (Amendment) Act 1946. 1946/38 [Eire] (24 Dec. 1946).
[26] *Sunday Independent*, 11 May 1947
[27] Dr James Ryan, Dáil debates vol. 105, no. 16, 2066, 6 May 1947.
[28] *Forty-first annual report of the Women's National Health Association of Ireland*, 1948, p. 21 (NAI, Priv 1212/wnha/6/2/25).
[29] Ibid.; *Report of the Department of Health 1949-50*, Pr. 191 p. 61; Minutes of conference on Peamount sanatorium, 7 Apr. 1948 (NAI, Health H 10/4/10).
[30] RNHCI, *Fifty-fifth report and statement of accounts with list of subscriptions for the year ending 31st December, 1947*, p. 12; RNHCI, *Fifty-sixth report and statement of accounts with list of subscriptions for*

proposed a forty-three-bed extension to Our Lady of Lourdes Hospital, Dun Laoghaire.[31] This would be provided by adding a four-ward floor to the main hospital building.[32] However a dispute between the hospital authorities and the department regarding the number of local authority patients to be treated in the new facility delayed the start of the project until mid 1947.[33] The work was completed during the financial year 1949-50.[34] Approval was given to refurbishing the existing tuberculosis huts and providing a new twelve-bed hut and a thirty-two-bed unit at St Laurence's Hospital.[35] These works enabled the treatment of sixty tuberculosis cases in a segregated block.[36] The hospital treated mainly cases of pulmonary tuberculosis suitable for surgical intervention.[37] The units were completed and occupied between April and June 1949.[38]

Blanchardstown, County Dublin

In late 1949 work commenced on building the Dublin regional sanatorium, on a site at Blanchardstown, following the abandonment of the sites at Ballyowen and Santry.

The new site identified by officials for the Dublin sanatorium comprised the southern portion of Abbotstown estate, Blanchardstown in the ownership of the eighteen-year-old James Hamilton.[39] Hamilton's representatives, 'influenced by the powers vested in the

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the year ending 31st December, 1948, p. 10; RNHCI, *Fifty-seventh report and statement of accounts with list of subscriptions for the year ending 31st December, 1949*, p. 9 (NHA); An Roinn Sláinte, progress report in respect of the period of two months ended 31 Jan. 1950 (NAI, Health D 112/334).

[31] Dr James Ryan, Dáil debates vol. 105, no. 16, 2066, 6 May 1947.

[32] William Byrne to the Reverend Mother, Our Lady of Lourdes Hospital, 're Our Lady of Lourdes Hospital, Rochestown Avenue, Dun Laoghaire under the care of the Sisters of Mercy', 3 Jan. 1944 (NAI, Health AD 110/L/4).

[33] T. F. Strahan to C. F. Dowling, 'Our Lady of Lourdes Hospital, Dun Laoghaire', 21 May 1947 (NAI, Health H 10/3/1); rúnaí to the Rev. Mother, Our Lady of Lourdes Hospital, 8 Apr. 1945; A. O'Hagan & Son to the Secretary, Department of Local Government and Public Health, 'Our Lady of Lourdes Hospital', 30 Apr. 1945 and 7 Feb. 1947; rúnaí to A. O'Hagan & Son, 10 Feb. 1947 (NAI, Health AD 110/L/4). Since the capacity of the hospital had been expanded to ninety-one beds in the late 1930s an average of fifty-two local authority patients had occupied those beds. The hospital authorities offered to make the same proportion of the proposed new beds available to local authority patients i.e. twenty-four beds, whereas the Department required that all the new beds be allocated to such patients. Eventually the Department agreed to the hospital authority's proposal.

[34] *Report of the Department of Health 1949-1950*, p. 73. The financial year ran from 1 Apr. 1949 to 31 Mar. 1950.

[35] St Laurence's Hospital was a statutory creation formed by the amalgamation of the former House of Industry hospitals, the Hardwicke, the Richmond and the Whitworth hospitals into a new general hospital. St Laurence's Hospital Act 1943, 1943/3 [Eire] (9 Mar. 1943). File note, 'St Laurence's Hospital accommodation for tuberculosis patients', 4 Mar. 1949 (NAI, Health D 110S/1).

[36] Sean MacEntee, Dáil debates vol. 101, no. 13, 1763, 13 June 1946.

[37] C. O'S. to the Secretary, St Laurence's Hospital, 21 Feb 1945 (NAI, Health D 111/50).

[38] Report on visit to St Laurence's Hospital on 13 Apr. 1949 and interview with staff, 14 Apr. 1949; C. O'S. to the Secretary, St Laurence's Hospital, 3 June 1949 (NAI, Health D 110S/1).

[39] *Irish Times*, 7 Sept. 1942.

government', agreed to sell a site of 241 acres 2 roods 9 perches for £65,000.[40] The department took possession of the lands on 7 November 1947 and began surveying to decide on the location of the various facilities within the site.[41] The mortuary was to be located at the western extremity of the site. To hide the reality of death from patients as in other sanatoria, it was determined to provide a separate entrance to the site at this extremity. This necessitated the acquisition of a 7.6 acre site from the Snow estate for £1,902.[42]

The design of the Blanchardstown complex provided for a 'central administration building, a hospital with full-scale operating, x-ray and treatment facilities, six single storey units for pulmonary cases, four non-pulmonary blocks, an isolation and infective children's unit, an adolescent primary unit, a nurses' home, a domestic staff home, a recreation unit, quarters for residential medical staff and chaplain, a chapel and ancillary services buildings' in total 26 separate buildings with accommodation for 540 patients.[43] It had been decided to reduce the number of beds from the originally planned 1,000 in acknowledgement of the arrangements made to provide additional accommodation in the voluntary hospitals.[44]

The development of the Blanchardstown site was effected by way of individual contracts in separate phases, covering site works, foundations and underbuilding, superstructures, mechanical works and electrical works.[45] The works commenced in November 1949.[46] In this post-war period with massive reconstruction taking place throughout Europe, especially in Great Britain, Ireland was experiencing severe shortages of both building materials and skilled labour. At the Minister for Health, Noel Browne's, instigation, a campaign was started to repatriate skilled building workers from England. Brochures were distributed amongst Irish workers in Great Britain. Resulting from this campaign by

[40] T. T. Mecredy, solicitor to the Secretary, Department of Health, 4 June and 4 July 1947; Lady Holmpatrick to the Minister for Health, apportionment account, Aug. 1948 (NAI, Health D 124); Certificate of deduction of income tax, 17 Sept. 1948 (FCCA, PHe/E/904).
[41] Certificate of deduction of income tax, 17 Sept. 1948; Dr James Ryan, Dáil debates vol. 109, no. 6, 732, 11 Dec. 1947. Although Ryan gives the date of possession as 30 Nov. 1947 since statutory interest on the compensation was paid from 7 Nov. 1947 this is the actual date of the department taking formal possession of the lands.
[42] Rúnaí to valuation commissioners, 8 May 1950; Chief State Solicitor's Office to the Secretary, Department of Health, 6 Nov. 1950 (NAI, Health D 140).
[43] *Report of the Department of Health 1955-56*, Pr. 3942, pp 62-3.
[44] Report 'Tuberculosis bed accommodation', Feb. 1948 (NAI, Health D 112/254).
[45] An Roinn Sláinte, progress report in respect of the period of two months ended 30 Nov. 1949; An Roinn Sláinte, progress report in respect of the period of three months ended 31 Dec. 1950; An Roinn Sláinte, reports in respect of the periods of six months ended 31 Mar. and 30 Sept. 1952 (NAI, Health D 112/334 and A 116/230); *Report of the Department of Health 1955-56*, p. 63.
[46] An Roinn Sláinte, progress report in respect of the period of two months ended 30 Nov. 1949.

March 1950 over 1,000 skilled building workers were listed in a register by the Department of Social Welfare.[47] With a worsening outlook regarding supplies of building materials, in early 1951, it was arranged to place orders for all the non-perishable materials needed to complete the three regional sanatoria and place them in storage pending delivery to contractors when appointed.[48] The works were completed at a cost of approximately £1,750,000.[49]

The almost completed Blanchardstown sanatorium was officially opened on 21 April 1955 by the Minister for Health Tom O'Higgins. In accordance with legislation it was handed over to Dublin Corporation to administer. All the ward units were detached single storey buildings, laid out in an isolated pattern in a woodland setting, each containing between thirty and forty beds (see Plates 9.1 and 9.2). Patients were strictly segregated according to gender. The main three-storey hospital block, in addition to the operating theatres and the x-ray unit, contained eighty bed spaces. The nurses' home had accommodation for twenty-one sisters and 100 nurses while the staff home provided for the catering superintendent and 111 domestic staff members. Staff recruitment commenced with a view to admitting the first patients in July, already identified as a group of 300 patients to be transferred from Rialto hospital, which thenceforth would revert to a general surgical and medical hospital as part of the St Kevin's hospital complex.[50]

As in other hospitals, religion played an important role in the sanatorium. The Catholic ethos was evidenced by the employment of a Roman Catholic chaplain, nominated by the archbishop, as a member of the full time staff. Pastoral care to Church of Ireland patients was provided by the rector from nearby Castleknock.[51] Although problems were experienced in maintaining general staffing levels, during the period 1955-1968 perfect continuity was maintained in the post of Roman Catholic chaplain (see appendix 19). A bungalow had been provided in the grounds for this chaplain adjacent to the church, which with accommodation for 150 was reserved solely for Catholic ceremonies. Mass

[47] An Roinn Sláinte, progress report, 31 Mar. 1950 (NAI, Health A 116/230); Seán MacBride, *That Day's Struggle* (Dublin, 2005), pp 218-9.
[48] An Roinn Sláinte, progress report in respect of the period of three months ended 31 Mar. 1951 (NAI, Health D 112/334 and A 116/230).
[49] *Irish Press*, 22 Apr. 1955.
[50] An Roinn Sláinte progress report 30 June 1955 (NAI, Health A 116/230); Address by Mr T. F. O'Higgins, Minister for Health, at the opening of the regional sanatorium Blanchardstown, County Dublin and the handing over of the completed section to Dublin Corporation on Thursday 21 Apr. 1955 (NAI, Health D 112/533); *Irish Times*, 22 Apr. 1955.
[51] Interview by Alan Carthy with Fr Seamus Cassidy of Kilmainham Wood, Co Meath (23 July 2012).

Plate 9.1 Front view of single-storey ward block at Blanchardstown Sanatorium, County Dublin. The sanatorium was opened to treat tuberculosis patients in 1955 (Alan Carthy, 2010)

Plate 9.2 Rear view of single-storey ward block at Blanchardstown Sanatorium, County Dublin (Alan Carthy, 2010)

was celebrated every morning and all Catholic patients in the sanatorium were visited by the chaplain at least weekly to receive communion. The chaplain was on call twenty-four hours a day and attended all patients scheduled for operation on the evening prior to surgery. Arrangements were in place with the chaplain in St Mary's Hospital in the Phoenix Park to provide mutual cover with a fall-back arrangement in place with the local parish clergy.[52] On the Feast of Corpus Christi each year a Eucharistic procession took place through the sanatorium grounds with loud speakers set up along the processional route and the ceremony relayed to non-ambulant patients through the hospital radio.[53]

Interim solutions 1944-1957

With significant delays being experienced in the delivery of the regional sanatoria and with the number of patients on sanatoria waiting lists growing, the government was coming under increasing pressure to find interim solutions to the tuberculosis accommodation problems. Government decisions to provide financial aid for tuberculosis sufferers and to introduce a mass x-ray service had increased patient numbers.

In January 1948 James Ryan the Minister for Health introduced regulations providing financial support to tubercular persons. Payments were made to patients who in accordance with the chief medical officer's advice, had to take precautions, which resulted in them being unable to make proper provisions for their own or their dependants' maintenance.[54] This measure was intended to relieve the financial pressure on seriously ill patients to continue working and to encourage early reporting of the disease as many breadwinners were reluctant to seek treatment knowing that their families would be left destitute.[55] The financial ability of a patient to undergo treatment had been identified by the government as an important social factor which influenced the course of the disease in its white paper on tuberculosis published in January 1946.[56] The removal of the financial burden on sufferers increased the pressure on waiting lists. This

[52] Ibid.
[53] John Quinn, S*ea of love, sea of loss, letters to Olive* (Dublin, 2003), p. 49.
[54] Infectious Diseases (Temporary Provisions) Regulations, 1948 (20/1948) (23 Jan. 1948); Infectious Diseases (Maintenance) Regulations, 1948 (21/1948) (23 Jan. 1948); Health Act, 1947, 1947/28 [Eire] (13 Aug. 1947).
[55] James Hughes, Dáil debates vol. 95, no. 14, 1908-9, 31 Jan. 1945. Hughes was Fine Gael deputy for Carlow-Kildare from 1938 to 1948.
[56] *Tuberculosis*, P 7368 (1946), p. 6.

in turn brought political pressure on the authorities to effect immediate solutions for tuberculosis patients.[57]

In order to improve tuberculosis diagnostic facilities, the government in 1949 introduced a scheme whereby medical practitioners could obtain free chest x-rays of their patients at county hospitals or other approved institutions. The local authorities financed the scheme, which was administered through the county medical officers. In communicating results to local practitioners the opportunity was availed of to inform them of 'further facilities available under the local tuberculosis scheme'.[58]

Further improvements in diagnostic facilities were achieved through the introduction of mass x-ray. Dublin Corporation opened a mass radiography unit at the Lord Edward Street clinic in 1946. This was followed by the institution of a mobile mass x-ray service in Cork in early 1949.[59] Following the success of these services, the minister, having received the report of officials sent to Scandanavia to assess the merits of various types of equipment and the role filled by mass x-ray units in the Swedish tuberculosis service, decided to organise a scheme to provide units containing mass radiography equipment. The films produced by such units would be interpreted at a centralised facility. To administer and operate the scheme he decided to form a limited company.[60]

The company 'The National Mass Radiography Association Ltd' was incorporated in May 1951 and commenced service using its three Swedish designed and manufactured units.[61] A further two units were acquired by September and another unit by January 1953.[62] The costs of the association were met by a sanatorium grant and by a substantial levy imposed on participating authorities, apportioned 'on the basis of the rateable valuation of their functional areas'.[63] In its first eleven months of operation the

[57] P. Ó Cinnéide to City Manager and Town Clerk, Dublin, 12 May 1949 (NAI, Health H 10/12/22).
[58] Department of Health circular P. H. 77/49, 20 Oct. 1949 (NAI, Health D 34A/50 vol. 3).
[59] *First report of the Department of Health 1945-49*, Pr 42, pp 44-5.
[60] File notes, 26 Aug. and 30 Oct. 1950 (NAI, Health D 114/2).
[61] *Irish Independent*, 23 May 1951; *Irish Press*, 18 July 1951; P. Ó Cinnéide to each County Secretary, 19 Jan. 1953 (NAI, Health BD 114/9).
[62] *Irish Press*, 15 Sept 1951; P. Ó Cinnéide to each County Secretary, 19 Jan. 1953.
[63] P. Ó Cinnéide to each County Secretary, 20 July 1951 (NAI, Health BD 114/9). The levy amounted to £36,000 for the first twenty-three months of operation. It amounted to £24,000 per annum for the next two financial years, increasing to £27,000 for the next two years, £29,000 for the year 1956-7, £30,000 for the year 1957-8 and £32,500 for the year 1958-59. C. Ó Síodhcháin to each County Secretary , 23 Jan. 1952; P. Ó Cinnéide to each County Secretary, 19 Jan. 1953, 18 Jan. 1954, 14 Jan. 1955, 13 Jan. 1956, 17 Jan. 1957 and 14 Jan. 1958 (NAI, Health BD 114/9).

association x-rayed 56,210 persons.[64] The following financial year, ending on 31 March 1953, 131,743 persons were x-rayed with 7,894 displaying abnormalities and 750 showing indications of active respiratory tuberculosis. Included in those whose x-rays showed abnormalities were 'early cases with minimal shadowing in which the presence of active tuberculosis may be uncertain'; a number of these were 'found on subsequent investigation by large film x-ray examination to have clinically significant tuberculosis'.[65] Many of the cases displaying abnormalities manifested 'the shadowing of healed primary tuberculosis not clinically significant'.[66] Over the next seven years the number of persons x-rayed increased annually, peaking at 303,917 in 1959 (see appendix 20). By the end of 1960, 2,056,082 persons had been x-rayed of whom 49,101 were recalled for further examination revealing 7,000 cases of active tuberculosis.[67] At this stage 20% of the annual cases found to be suffering from tuberculosis were discovered through the mass x-ray service.[68]

St Kevin's Rialto

One interim solution, to increase provision for tuberculosis patients, adopted by the government, from the mid 1940s onwards, involved expanding existing institutions by the construction of additional facilities.

By the mid 1930s St Kevin's Hospital, Rialto, located in the former South Dublin Union tuberculosis isolation blocks and administered by the Dublin Board of Assistance, was an integral part of Dublin Corporation's tuberculosis treatment scheme. The isolation blocks had been constructed in the early 1900s to cater for tubercular workhouse inmates. They accommodated 175 patients suffering from advanced and chronic pulmonary tuberculosis, despite proving 'distasteful to some persons' who refused to go there on account of its workhouse associations.[69] In November 1940 the Hospitals Commission recommended that Dublin Corporation take over the institution and administer 'it as a transitional stage in the realisation of one of their contemplated sanatoria'. Dublin Corporation took possession of the premises on 1 April 1943.[70]

[64] P. Ó Cinnéide to each County Secretary, 19 Jan. 1953.
[65] Same to same, 13 Jan. 1956 and 17 Jan. 1957 (NAI, Health BD 114/9).
[66] Same to same, 17 Jan. 1957 (NAI, Health BD 114/9).
[67] *Irish Times*, 24 Nov. 1961 and 25 Aug. 1962.
[68] Ibid., 6 Nov. 1961.
[69] J. A. Harbison, county medical officer of health to The Secretary, Department of Local Government and Public Health, 5 Aug. 1933 (NAI,Health D 112/10); M. Russell, medical officer of health, Corporation of Dublin to the Secretary, Department of Local Government and Public Health, 11 June 1937 (NAI, Health D 111/50); *Department of Local Government and Public Health report, 1936-1937*, p. 57.
[70] *Irish Press*, 2 Apr. 1943.

To relieve pressure on the already congested institution and provide a measure of relief to the voluntary general hospitals[71], the Hospitals Commission also recommended that 100 additional beds should be provided in pavilions.[72] Because of wartime restrictions on imports it was necessary to resort to available Irish materials such as mass concrete and concrete blocks which would result in permanent rather than temporary buildings.[73] In late 1944, following an innovative procedure whereby tenders were invited 'on a time and materials basis', a contract was placed to provide new female and male ward blocks at either end of the existing hospital building at an estimated cost of £100,000.[74] The works were completed by April 1947, providing accommodation for ninety-six additional patients. Due to delays in providing the new kitchen, enabling conversion of the existing kitchen into a ward, it was decided to retain the existing beds in the overcrowded wards 'in view of the large number of patients seeking admission to that institution'. All that remained was to engage the staff to run the enhanced facility.[75] However the recruitment process proved arduous and patients were not admitted until early December.[76]

St Mary's Phoenix Park

In the immediate post-war period, severe pressure to find interim accommodation led to the adaptation of some patently unsuitable premises as tuberculosis facilities. St Mobhi's in the Phoenix Park acquired by Dublin Corporation in 1948 is one such example. Because of its history and the condition of the buildings its acquisition and reconstruction proved arduous and expensive.

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[71] A visit by the commission to the Richmond hospital had revealed that despite that institution providing hut accommodation for twenty-one pulmonary tuberculosis sufferers, a further nineteen such cases were accommodated in the general wards under pressure from the city authorities pending the provision of alternative accommodation. These cases 'were the type who would stay at home and remain a source of infection to those around them rather than seek relief in the Rialto hospital'. E. Cooney, Rúnaidhe, Hospitals Commission to The Secretary, Department of Local Government and Public Health, 10 Nov. 1940 (NAI, Health H 10/2/14).

[72] Same to same, 10 Nov. 1940.

[73] C. Mac Fionnlaoċ, leas ailtire na cathrach to C. O'Nolan, staff officer, public health section, 'Suggested additions to Rialto hospital', 15 Apr. 1941 (NAI, Health H10/2/14).

[74] For City Manager and Town Clerk, Corporation of Dublin to the Secretary, Department of Local Government and Public Health, 'Rialto Hospital, proposed extensions', 14 Apr. 1943 (NAI, Health H 10/2/14); Rúnaidhe, Hospitals Commission to the Secretary, Department of Local Government and Public Health, 'Dublin County Borough. Proposed extensions to Crooksling sanatorium and Rialto hospital', 8 June 1944; Extension to Rialto hospital. Summary of proceedings at conference held in the department on 14 July 1944; E. Taylor, chief quantity surveyor, Corporation of Dublin to Collen Bros. etc., 'Re: alterations and additions to Rialto Hospital, 20 July 1944; for City Manager and Town Clerk to the Secretary Department of Local Government and Public Health, 15 Aug. 1944; T. F. Strahan 'Report on tenders received for extensions to Crooksling Sanatorium and Rialto Hospital', 23 Aug. 1944. (NAI, Health H 10/2/11).

[75] For City Manager and Town Clerk to the Secretary Department of Local Government and Public Health, 21 Apr. 1947 (NAI, Health H 10/2/11).

[76] *Irish Press*, 20 Dec. 1947.

In October 1941 the military authorities requisitioned St Mobhi's preparatory teacher training college located on a thirty-three acre site in the Phoenix Park for use as a hospital and barracks.[77] The college was housed in the former Hibernian Military School premises which consisted of buildings constructed to accommodate 510 pupils and staff between 1770 and 1818.[78] In July 1946, Dr James Deeny, the chief medical advisor in the department, pointed out that, as the proposed regional sanatoria would not be delivered as early as anticipated, it would be necessary to seek to otherwise expand the provision of beds to deal with tuberculosis patients. He maintained that the pressure on bed spaces would increase due to the implementation of new case finding initiatives, such as miniature radiographic examination. He suggested that military hospitals, being vacated 'owing to the termination of the emergency period', be used to address the 'grave need […] for beds for tuberculosis patients', citing St Moibhí's as one example.[79]

In accepting this proposal Seán MacEntee, the Minister for Local Government and Public Health, sought to acquire the premises from Tom Derrig, the Minister for Education, pointing out the size of the Dublin waiting list, which resulted in an average wait of four months for sanatorium admission, with inevitable serious deterioration in the health of the sufferers, considerably diminishing their prospects of a cure. He stated that the advent of mass x-ray was likely to swell these waiting lists as its use had already revealed large numbers of unsuspected active cases of tuberculosis.[80] However, as he was unable to provide suitable premises in which to relocate the college, Derrig rejected his approach.[81]

Following the general election in February 1948, Noel Browne was appointed as Minister for Health.[82] In March Browne personally supervised the acquisition of

[77] *Report of the Department of Education 1945-46*, P 8508 (1947), p. 14; notes compiled by D. W. Roberts, honorary secretary, Royal Hibernian Military School Association on the 'Royal Hibernian Military School' in possession of Eddie Matthews, director of social inclusion, Health Service Executive.
[78] Warburton *et al.*, *History of the city of Dublin*, i, p. 604.
[79] James Deeny, Chief Medical Officer, Department of Local Government and Public Health, memo dated 1 July 1946 (NAI, Health H 10/12/3).
[80] Seán MacEntee to T. Derrig, 25 July 1946; Draft cabinet briefing document 'Proposed use of St Mobhí's Hospital, Phoenix Park as a sanatorium', 28 Aug. 1946 (NAI, Health H 10/12/3). Although prepared this document was not submitted to government.
[81] T. Ó Deirg to Seán MacEntee, 31 July 1946 (NAI, Health H 10/12/3).
[82] Due to personal, family and professional circumstances Browne had a particular interest in tuberculosis. His parents had died from pulmonary tuberculosis as did two of his adult sisters, an infant sister had died from miliary tuberculosis whilst his eldest brother who suffered from tuberculosis of the spine died following an operation on his cleft palate in a London workhouse. Shortly after meeting his future wife Phyllis Harrison, she was hospitalised with tuberculosis of the spine in 1938. While studying medicine Browne was diagnosed as suffering from pulmonary tuberculosis in 1939 and underwent treatment at King Edward VII sanatorium in Sussex. Following qualification in 1942 he trained at Newcastle, Wicklow and several British sanatoria. At the time of his appointment as minister he was employed as assistant medical officer at Newcastle sanatorium. He served as Minister for Health from 2 February 1948 until 11 April

Shanganagh Castle, Shankill, in which to relocate the college.[83] Vacated by both the college and the Department of Defence, St Mobhi's was handed over to Dublin Corporation on 1 October 1948.[84] Obtaining a lease of the premises cost the corporation £120,000. This sum consisted of £33,000 to cover the acquisition of Shanganagh Castle, £7,000 in respect of adaptation works and £40,000 in respect of new buildings at Shanganagh and £40,000 'in respect of the many unforeseen items which will arise at Shanganagh, the cost of conversion of military buildings elsewhere and the various removals which will have to be made'.[85] In addition the costs of executing a lease amounting to £5,119 had to be paid.[86] These expenses were met in full from the Hospitals Trust.[87]

On 18 May 1948 Browne personally issued instructions to the city architect on how to proceed with the adaptation of the St Mobhi premises.[88] As the condition of that section of the premises formerly devoted to the training college rendered it suitable for adaptation for sanatorium purposes, the minister decided that it should be used to house female patients. Male patients could then be accommodated in the section which had been adapted for military purposes.[89] Estimates were that this work would provide for 120 female and 100 male patients. However as a substantial female waiting list would still exist the corporation was requested to have two forty-bed blocks erected to cater for female patients.[90]

The adapted female block was opened, 'under extreme pressure' from the minister, in October 1948. By 1 November forty beds were occupied. The number of patients increased to seventy-four by Christmas. Difficulties in recruiting staff and the incomplete nature of the works delayed full occupation of the premises.[91]

1951 when he was dismissed from the post. Browne, *Against the tide*, pp 25, 58, 71-6, 85; Phyllis Browne, *Thanks for the tea Mrs Browne* (Dublin, 1998), pp 61-3; Deeny, *To cure and to care*, p. 161.

[83] *Irish Times*, 22 Mar. 1948; Arthur Barton to Noel Browne, 22 Mar. 1948 enclosing extract from letter Lillian Duncan to Arthur Barton, 20 Mar. 1948 (NAI, Health H 10/12/3).

[84] File note, 18 Jan. 1949 (NAI, Health H 10/12/3).

[85] Memo 'Royal Hibernian Military School', 24 May 1949 (NAI, Health H 10/12/3).

[86] For Principal Officer, Health Department, Corporation of Dublin to the Secretary, Department of Health, 27 Mar. 1956 (NAI, Health H 10/12/3).

[87] P. Ó Cinnéide to Rúnaí, Roinn Airgeadaís, 20 May 1955 (NAI, Health H 10/12/3).

[88] Memo 'Royal Hibernian Military School', 24 May 1949.

[89] P. J. Hernon, Banisteoir na Cathrach agus Ard Chléireach to an Rúnaidhe, an Roinn Sláinte, 16 Apr. 1948; Memo 'Royal Hibernian Military School', 24 May 1949 (NAI, Health H 10/12/3).

[90] File note, 'St Mobhí's Sanatorium', undated (*c.* Aug 1948); Rúnaidhe to City Manager and Town Clerk, 21 Aug. 1948 (NAI, Health D 111/61).

[91] City Manager and Town Clerk to Dr Noel Browne, Minister for Health, 30 Dec. 1948 (NAI, Health D 111/61).

With the now 188-bed male block due for completion before the end of July 1949, the minister approved of the conversion of the swimming pool and the gymnasium into two forty-bed female wards. He also directed the conversion of fourteen of the ex-army huts, remaining in the grounds, into ten and twelve-bed units for male patients.[92] The huts were intended to provide hostel style accommodation for ambulant patients. These would be mainly patients from other institutions whose active treatment had been completed but were not medically fit for discharge. Accommodating such patients would free up much-needed beds in other institutions.[93] However when an examination of the waiting lists in early November revealed a serious shortage of beds for females, it was decided to reserve the hut accommodation for females and to move the male patients then occupying the huts to Rialto.[94]

By May 1950 the completed hospital, now called St Mary's, had accommodation for 224 male and 368 female tuberculosis patients. 198 male and 329 female patients were occupying the beds. The vacant beds could be considered to be transitional between patients leaving and new patients being admitted as there were forty-eight male and twenty-nine female patients on the waiting list for the institution.[95] Up to the end of 1955, the Hospitals Trust fund had provided £711,800 to facilitate the conversion of the former school into a hospital.[96]

Rural counties

In providing interim tuberculosis accommodation in the rural counties outside Dublin similar strategies of adapting and extending existing premises were employed. Many of these premises had recently been developed for other medical purposes at considerable cost. Their short-lived use as tuberculosis facilities points up the waste of scare financial resources in their adaptation, though this was not of course forseen at the time.

In December 1947 the department sanctioned the acquisition of Kilcreene House a seventeenth-century manor house set in 106 acres for use by Kilkenny County Council as

[92] P. Ó Cinnéide to City Manager and Town Clerk, Dublin, 12 May 1949 (NAI, Health H 10/12/22).
[93] Dr McWeeney to Chief Medical Advisor, 'St Mary's chest hospital 'Hostel Scheme'', 8 June 1949; File note, 13 June 1949 (NAI, Health D 111/61).
[94] Minutes of meeting between corporation and department officials re 'Waiting lists of TB patients Dublin Corporation', 5 Dec. 1949 (NAI, Health D 111/61).
[95] Month of May 1950, Dublin County Borough, bed accommodation for cases of pulmonary tuberculosis (NAI, Health D 111/61).
[96] O'Sheehan and de Barra, *Oispidéil na hÉireann*, p. 61.

a sanatorium for £8,770 plus fees.[97] However it quickly became evident that owing to the inadequate water and sewerage provision the immediate development of Kilcreene was not feasible.[98] In July, following a review by the minister of the hospital building programme, with 135 proposals estimated to cost £27,000,000 competing for the limited funds available, the conversion of Kilcreene House was deferred.[99]

In March 1949 the minister expressed concern that 'notwithstanding the provision of a considerable number of additional beds for tuberculosis patients' the waiting lists 'had not shown a corresponding diminution'.[100] Pending the completion of the regional sanatoria he was anxious to make local temporary provision to address the bed crisis. In this regard it was suggested that the fever hospital in Kilkenny city be used for the accommodation of pulmonary tuberculosis cases (see Plate 9.3).[101] To secure council agreement to this proposal the minister personally undertook to advance plans to develop an orthopaedic hospital at Kilcreene House to treat non-pulmonary tuberculosis patients.[102] He authorised a grant of £3,480 from the Hospitals Trust to cover the cost of converting and equipping the fever hospital.[103] On the recommendation of the county medical officer it was agreed to accept only female patients into the new facility and to treat only male patients in the existing county sanatorium. The first patients were transferred to the thirty-six-bed facility on 7 June 1949.[104] When the Waterford sub-regional sanatorium was fully functioning, this auxiliary sanatorium was no longer required. In November 1955 it was decided to convert it into a convalescent home to relieve overcrowding in the county hospital.[105] The female patients were transferred to the county sanatorium which reverted to treating patients of both sexes.[106]

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[97] *Kilkenny People*, 6 and 27 Dec. 1947; National Inventory of Architectural Heritage, 'Kilcreene Lodge, Kilkenny, County Kilkenny' (www.buildingsofireland.ie/niah) (6 Jan. 2014).
[98] County medical officer of health to S. Deegan, Secretary, Kilkenny County Council, 25 Mar. 1948 (NAI, Health D 14/42).
[99] Dr Noel Browne, Dáil debates vol. 111, no. 16, 2273-4, 6 July 1948; Rúnaí to an Rúnaí, Comhairle Chontae Chill Choinnigh, 31 July 1948; Brief for minister's visit to Kilkenny, 21 May 1949 (NAI, Health H 14/4/4); *Kilkenny People*, 26 Sept 1948.
[100] Rúnaí to County manager, Kilkenny, 25 Mar. 1949 (NAI, Health H 14/4/4).
[101] Ibid.
[102] *Kilkenny People*, 28 May 1949; S. Deegan to the Secretary, Department of Health, 24 May 1949 (NAI, Health H 14/4/4).
[103] *Kilkenny People*, 28 May 1949; S. Deegan, Rúnaidhe to the Secretary, Department of Health, 24 Nov. 1949 and 7 Feb. 1950; Draft letter (not issued) Dec. 1949 to Secretary, Kilkenny County Council; Draft letter (not issued) Dec. 1949 to Rúnaí, Comhairle Chontae Chill Choinnigh; File note, 'Auxiliary sanatorium Kilkenny- recoupment of expenditure', 14 Aug. 1950 (NAI, Health H 14/4/4).
[104] Report of medical inspector, 3 June 1949 (NAI, Health H 14/4/4); File note, 'Kilkenny County institutional accommodation for TB', 4 July 1949 (NAI, Health D 14/42).
[105] *Kilkenny People*, 26 Nov. 1955.
[106] Report of Michael F. Daly, medical inspector, on inspection of county sanatorium Kilkenny, 28 May 1956 (NAI, Health BD 14/48).

Advertisements for tenders for the construction of the orthopaedic hospital were placed in December 1953 with the hospital opening to receive patients in early 1959.[107]

In May 1949 at the behest of the department the recently reconstructed thirty-bed County Longford fever hospital was opened for the reception of tuberculosis patients.[108] The reconstruction had cost £19,000 partly funded by a Hospitals Trust grant of £12,710.[109] Being a new premises the cost of the conversion was only £80, spent on sub-dividing the wards. By 1953 the capacity of the hospital now named 'Mount Carmel Hospital' had increased to thirty-nine patients through bed reorganisation and the provision of six chalets.[110] With the completion of the regional sanatoria Mount Carmel sanatorium was no longer required and in 1957-58, twenty-two of the beds 'were taken over for use as general medical beds to supplement the accommodation in the county hospital'.[111]

Carlow County Council converted the sixteen-bed Tullow district hospital to a pulmonary tuberculosis treatment facility in September 1949 at the request of the minister.[112] The provision of an additional six-bed ward and a nurses' home in 1950/51 facilitated the reorganisation of the institution to accommodate twenty-six patients.[113] The conversion and construction costs amounted to £4,404, funded by the Hospitals Trust.[114] By 1957 its use for tuberculosis purposes ceased and the department had under consideration its restoration as a general hospital.[115] However due to economic circumstances the hospital was closed and a caretaker installed.[116]

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[107] *Kilkenny People*, 12 Dec. 1953 and 1 Nov. 1958.
[108] *Meath Chronicle*, 3 Apr. 1948; *Longford Leader*, 13 Mar., 3 Apr. 1948 and 24 Dec. 1949.
[109] *Longford Leader*, 5 July 1947; O'Sheehan and de Barra, *Oispidéil na hÉireann*, p. 57.
[110] List of principal tuberculosis institutions. Position at 31/3/1953 (NAI, Health AD 112/567).
[111] *Report of the Department of Health 1957-1958*, Pr. 4914, p. 42.
[112] Dr Francis Humphreys, Dáil debates vol. 137, no. 7, 1088-9, 25 Mar. 1953; Bed accommodation for tuberculosis patients, 23 June 1951 (NAI, Health D 112/493); *Annual report of the acting county medical officer, Carlow County Council, 1949*, p. 7 (HSE library Kilkenny). Humphreys was Fianna Fáil deputy for the Carlow-Kilkenny and Carlow-Kildare constituencies intermittently from 1932-1961 successfully contesting seven elections and failing to retain his seat on three occasions.
[113] Chief Medical Officer, Carlow county Council to the Secretary, Carlow County Council, 'Recreation/graduated exercise, tuberculosis hospital Tullow', 4 Jan. 1950 (NAI, Health D 1/28); Bed accommodation for tuberculosis patients, 23 June 1951 (NAI, Health D 112/493); *Annual report of the acting county medical officer, Carlow County Council, 1950*, p. 34 (HSE library Kilkenny).
[114] O'Sheehan and de Barra, *Oispidéil na hÉireann*, p.54.
[115] Joseph Hughes and Dr James Ryan, Dáil debates vol. 164, no. 1, 19, 23 Oct. 1957. Hughes was Fine Gael deputy for Carlow-Kilkenny from 1948 to 1961. Ryan was appointed Minister for Finance in March 1957.
[116] Desmond Governey, Dáil debates vol. 210, no. 5, 784, 4 June 1964.Governey was Fine Gael deputy for Carlow-Kilkenny from 1961 to 1977 and from 1981 to 1982.

Plate 9.3 Former fever hospital Wolfe Tone Street, Kilkenny, which was converted into an auxiliary sanatorium in 1949. It is currently used for community purposes (Alan Carthy, 2014)

In County Louth during 1952-53 the eighteen-bed Drogheda fever hospital, formerly part of the workhouse premises, was converted to a tuberculosis sanatorium.[117] The following year work commenced on reconstructing the thirty-six-bed Dundalk fever hospital.[118] In 1954-55 it was decided to utilise these premises for tuberculosis patients and the plans were revised to provide accommodation for fifty patients at an estimated cost of £58,000.[119] The premises were further extended in 1960, increasing the accommodation to sixty-two beds and bringing the total cost of the works to over £64,000.[120] When the converted Dundalk premises became available in 1957 the dedicated tuberculosis facilities at Ardee and Drogheda together with the twelve beds reserved in Dundalk district hospital for tuberculosis patients, 'comprising a total of 61 beds, were released for the accommodation of general patients'.[121]

To provide emergency tuberculosis accommodation in Offaly the county council converted two wards on the top floor of the recently-renovated old county hospital buildings, formerly the workhouse infirmary, to tuberculosis use.[122] The twenty-two-bed facility named St Vincent's opened on 18 July 1949.[123] It had cost £1,715 to convert.[124] Much to the total dissatisfaction of local councillors, the department provided a capital grant of only £800 towards the project.[125] Following the completion of the regional sanatorium, use of the premises for tuberculosis purposes was discontinued on 1 April 1957.[126]

In the mid 1940s with only the 'very limited and unsuitable'[127] facility at Trim available for the institutional treatment of County Meath tuberculosis patients a number of infectious cases were accommodated in the county hospital at Navan. Faced with the prospect of sending them home 'where they cannot obtain the nursing they require and

[117] *Report of the Department of Health 1952-1953*, Pr. 2147, p. 41.
[118] *Report of the Department of Health 1953-1954*, Pr. 2735, p. 57.
[119] *Report of the Department of Health 1954-1955*, Pr. 3319, p. 68; Note on letter, S. Ó Mathúna to an Rúnaí, Roinn Rialtais Áitiúil, 10 Mar. 1954 (NAI, Health H 20/1/4).
[120] Rúnaí, Comairle Conndae Lugbaide to the Secretary, Department of Health, 'Dundalk fever hospital and sanatorium extension', 13 Oct. 1960 (NAI, Health H 20/1/4); *Outline of the future hospital system - Report of the consultative council on the general hospital services*, Prl. 154, p. 113.
[121] *Report of the Department of Health 1957-58*, p. 42.
[122] Minutes of adjourned monthly meeting of Offaly County Council, 26 Jan. 1948; Minutes of monthly meeting of Offaly County Council, 15 Mar. 1948 (OCCA).
[123] Minutes of monthly meeting of Offaly County Council, 17 Jan. 1949; Minutes of adjourned monthly meeting of Offaly County Council, 26 July 1949.
[124] Minutes of monthly meeting of Offaly County Council, 17 Oct. 1949.
[125] Ibid., 20 Mar. 1950.
[126] Tuberculosis institutions discontinued (NAI, Health D 112/313).
[127] F. C. McDermott, Secretary, anti-tuberculosis section, Irish Red Cross Society to an Rúnaí, Department of Local Government and Public Health, 14 Sept. 1944 (NAI, Health D 22/9).

where they will spread infection to other members of their households'[128], the county manager decided to convert the rear block of the county hospital, a derelict former workhouse building, into a thirty-bed tuberculosis hospital as a temporary expedient.[129] The facility, which in the opinion of the county medical officer of health 'could never be regarded as suitable for a sanatorium', was opened on 8 June 1946.[130] The minister consented to the expenditure, on the understanding that it would be funded from receipts the council obtained through leasing Dunshaughlin workhouse.[131] Despite spending £814 on upgrading the premises, an inspection of the premises in February 1947 found 'that the condition of the building and the care of the patients are most unsatisfactory'.[132] The facility had no dayroom or facilities for exercise out-of-doors thus providing 'a pretty grim prospect for those who are not confined to bed to see a bare hospital ward as their whole world'.[133] By the end of 1948 the capacity of the facility had been expanded to accommodate forty-two patients, eight of them in chalets.[134]

In late 1954 there was sufficient accommodation for tuberculosis patients in Navan and external institutions to close the Trim tuberculosis facility. It was converted to use for long-stay and chronic cases.[135] In April 1958 a newly-constructed forty-six-bed orthopaedic unit opened in the grounds of the county hospital.[136] This unit intended as a regional orthopaedic unit for the north-eastern counties had been provided at a cost of £52,000 funded from the Hospitals Trust.[137] However as this unit did not provide adequate accommodation it was decided to convert the ground floor of the tuberculosis

[128] P. Barry, Príomh Oifigeach, Meath County Council to the Secretary, Department of Local Government and Public Health, 22 May 1946 (NAI, Health D 22/9)
[129] F. C. McDermott, Secretary, anti-tuberculosis section, Irish Red Cross Society to an Rúnaí, Department of Local Government and Public Health, 14 Sept. 1944; for County Engineer to the County Manager, 'Rere blocks of buildings, county hospital Navan', 10 July 1944; P. Barry, Príomh Oifigeach, Meath County Council to the Secretary, Department of Local Government and Public Health, 22 May 1946 (NAI, Health D 22/9); *Meath Chronicle*, 6 Jan. 1945 and 8 June 1946.
[130] *County of Meath, Nineteenth annual report upon the health and sanitary conditions of the county, 1948* (Navan, 1949), p. 11 (MCCA).
[131] Rúnaí to Secretary, Meath County Council, 15 June 1946 (NAI, Health D 22/9).
[132] Rúnaí Cúnta to the County Manager, Meath County Council, 26 Feb 1927; D. C. Lawlor, Conndae Banisteoir to the Secretary, Department of Health, 25 Mar. 1947 (NAI, Health D 22/9).
[133] *Meath County Council, Annual report of the county medical officer for the years 1956 and 1957* (Navan, 1958), p. 24 (MCCA).
[134] *Meath Chronicle*, 11 Nov. 1948 and 8 Apr. 1950.
[135] *Meath County Council, Annual report of the county medical officer for the years 1953, 1954, 1955* (Navan, 1956), p. 23; *Meath County Council, Annual report of the county medical officer for the years 1956 and 1957* (Navan, 1958), p. 34; B. Ó hIarfalaithe, 'Hospital facilities in County Meath- improvements and extensions', 8 Nov. 1954 (NAI, Health D 22/23).
[136] *Meath Chronicle*, 19 Apr. 1958.
[137] Speech by Neil Blaney, Minister for Local Government at the official opening of the orthopaedic unit , Our Lady's Hospital, Navan, 16 Apr. 1958 (NAI, Health D 112/533); *Report of the Department of Health 1957-58*, p.61.

block into a twenty-bed orthopaedic unit.[138] The conversion was completed at an approximate cost of £6,500.[139] With the regional sanatoria completed, the Navan tuberculosis hospital closed in March 1959 and was used in conjunction with the adjoining hospital.[140]

The County Kildare fever hospital was built between 1935 and 1939 at a cost of £38,470 funded by the Hospitals Trust.[141] With thirty housebound tuberculosis cases requiring institutional care, in August 1951, the county medical officer recommended converting the hospital to a tuberculosis sanatorium.[142] Having received ministerial sanction, the forty-eight-bed facility opened for the reception of patients in September.[143] It had been converted at a cost of £1,000 provided by the Hospitals Trust. As in other counties the completion of the regional sanatoria obviated the need for this facility, which closed in May 1956. Although initially considered for use as a maternity unit, it lay vacant until 1959 when it was converted to office accommodation for county council staff and a staff home for nurses from the county hospital.[144]

Ballyowen, County Dublin

Acquired originally as a site for a regional sanatorium plans were subsequently prepared to provide a children's tuberculosis facility at Ballyowen, County Dublin. However as development was progressing on the site the sanatorium was requisitioned to meet the interim needs of female tuberculosis sufferers.

In March 1948 Noel Browne decided to construct a children's sanatorium on the Dublin Corporation site at Ballyowen, Lucan.[145] On the suggestion of the Catholic archbishop of Dublin John Charles McQuaid, a private company 'The Hospital Association Limited' was established in December, charged with constructing the 250-bed sanatorium.[146]

[138] *Meath Chronicle*, 19 Oct. 1957.
[139] Ibid., 1 Feb. 1958; Speech by Neil Blaney 16 Apr. 1958.
[140] An Roinn Sláinte, Progress report for quarter ending 31 Mar. 1959 (NAI, Health A 116/230).
[141] Memorandum, 'St Mary's Hospital Naas' (NAI, Health 2010/63/52).
[142] Chief Medical Officer, Kildare County Council to County Manager, 3 Aug 1951 (NAI, Health AD 13/75).
[143] *Irish Press*, 10 Sept. 1952; Department of Health to an Rúnaí , Comhairle Chontae Chill Dara, 17 Feb. 1952; Michael F. Daly and P. W. Flanagan, Report of visit to Kildare County Council on 3 Mar. 1952, 4 Mar. 1952 (NAI, Health AD 13/75).
[144] Memorandum, 'St Mary's Hospital Naas'.
[145] R. Ó Cearbhaill to Mr McGuill, 25 Mar. 1952 (NAI, Health D 112/535).
[146] Address by Dr James Ryan TD Minister for Health on the formal handing over to the Minister for Health by the Hospital Association Limited, of the new sanatorium at Ballyowen, County Dublin, on the 28th Apr., 1952 (NAI, Health D 112/535); Memorandum of Association of the Hospital Association

Under the direction of the company work commenced on site in July 1949.[147] In September 1950, resulting from the increased numbers of adults 'requiring and requesting' treatment for tuberculosis, the minister requested the association to adapt the buildings under construction for adult patients.[148] The completed sanatorium with accommodation for 236 adult patients was handed over to the corporation on 28 April 1952. The short construction time was facilitated by the use of prefabricated units, which were assembled on site as the foundations were being poured.[149]

The single-storey Ballyowen sanatorium covering a built area of 16,000 sq. yards cost £455,000.[150] As agreed with Archbishop McQuaid it featured 'a beautifully appointed chapel'. Pressure from the archbishop to provide a house for a full-time chaplain to be employed at an annual salary of £400 was resisted. The parish priest from the adjoining Lucan parish was appointed as chaplain at an annual salary of £216 plus 8⅓% bonus. For this salary he was required to offer mass on Saturdays, Sundays, holy days and the first Friday of each month in addition to providing bed bound patients with communion each Saturday.[151] It had been decided to accommodate only women in the sanatorium. Accordingly, on 14 July the task of moving female patients from Crooksling commenced. Thenceforth only male tuberculosis patients were treated at the Crooksling sanatorium.[152]

New tuberculosis treatments and the demise of the sanatoria 1946-1973

As a result of the development of the regional sanatoria, the role played by smaller tuberculosis institutions began to decline resulting in their closure or reassignment for alternative purposes. The introduction of chemotherapy in the form of streptomycin, para-aminosalicylic acid (PAS) and isonicotinic acid hydrazide (isoniazid) had a significant impact on the time spent by patients under treatment and ultimately on patient numbers. The community immunity built up through the successful

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Limited, 31 Dec. 1948 (NAI, Health D 34J/10); *Irish Independent*, 29 Apr. 1952; *Irish Press*, 29 Apr. 1952; *Irish Times*, 29 Apr. 1952.

[147] Memorandum of Association of the Hospital Association Limited, 31 Dec. 1948; Dr Noel Browne, Dáil debates vol. 118, no. 11, 1540, 30 Nov. 1949.

[148] R. Ó Cearbhaill to Mr McGuill, 25 Mar. 1952; Draft speech 'A few words from the Minister for Health'(NAI, Health D 112/535); Address by Dr James Ryan TD, 28th Apr., 1952.

[149] *Irish Press*, 29 Apr. 1952.

[150] *Irish Independent*, 29 Apr. 1952.

[151] Ibid., 29 Apr. 1952; Minutes of deputation received in the Department of Health from the Hospital Association Limited and Dublin Corporation on 16 Apr. 1952; T. O'Broin ar son Bainisteora agus Ard-Chléirigh na Cathrach to An Rúnaí, Department of Health , 14 Oct. 1952 and 7 Aug. 1953 (NAI, Health D 34J/8).

[152] *Irish Independent*, 9 July 1952; J. P. Keane, Corporation of Dublin to P. S. O'Muireadhaigh, Assistant Secretary, Department of Health, 28 July 1952 (NAI, Health D 34J/8).

implementation of the Bacillus Calmette-Guérin (BCG) inoculation scheme contributed to a considerable reduction in the number of tuberculosis sufferers. The combined effect of the new chemotherapeutic treatment and the BCG vaccination scheme in reducing the demand for tuberculosis facilities made the larger tuberculosis facilities redundant.

From late 1946 small quantities of the newly-discovered anti-tuberculosis antibiotic drug streptomycin were released by the American authorities for use in Ireland.[153] The importation and distribution of the drug was initially strictly controlled at the minister's request by the Medical Research Council of Ireland. However by January 1950, with improved production methods releasing adequate supplies and medical experience standardising treatment, the controls were relaxed. Thereafter streptomycin together with another new drug, PAS, first synthesized in Sweden in 1946, were widely available and used in combination to successfully treat tuberculosis.[154] In 1952 the 'relatively cheap' and readily available drug isoniazid, newly discovered to treat tuberculosis, was introduced further improving the treatment options available.[155] Extensive newspaper coverage of the success of the new drugs, including the award of the Nobel Prize to Selman Waksman, the discoverer of streptomycin, in 1952 and the return of cured patients to their local communities had all contributed to heightening public awareness of the success of the new treatments. This chemotherapeutic treatment later proved a substantial factor in reducing the average length of stay of tuberculosis patients in institutions, dropping from 283 days in 1954 to 277 days in 1955 and 249 days in 1956, which in turn contributed to 'a substantial surplus of tuberculosis beds'.[156] The small scale of these initial reductions in the length of stay in hospitals has been attributed to the reluctance of medical personnel to accept that the drugs were in fact working. However once it was generally accepted that the multidrug treatment of tuberculosis was 'not

[153] Thomas V. Cummins to the Secretary, Department of External Affairs, 10 Oct 1946; Rúnaí, Department of External Affairs to Rúnaí, Roinn Rialtais Aítiúil agus Sláinte Póiblí,18 Oct. 1946 (NAI, Health D 112/419).
[154] A. Mac Cormac th. c. Rúnaí to Honorary Secretary, Medical Research Council of Ireland, 22 Oct. 1946; J. U. O'Connor, acting Honorary Secretary, Medical Research Council of Ireland to the Secretary, Department of Local Government and Public Health, 25 Oct. 1946 (NAI, Health D 112/419); File note on the control and use of PAS and streptomycin by local authorities, 26 July 1950 (NAI, Health D 112/393/1); Cilag, 'Summary of the literature on the treatment of tuberculosis with para-amino-salicylic acid', 1948 (NAI, Health D 112/296).
[155] *Report of the Department of Health 1952-1953,* p. 26. Isoniazid was a synthetic drug first developed in Prague in 1912. Laboratory experiments in 1951 showed it to have 'a high degree of anti-tuberculous activity'. (Walsh McDermott, 'The story of inh' in *The Journal of Infectious diseases*, cixx, no. 6 (1969), pp 678-83.)
[156] *Report of the Department of Health 1956-57, P*r. 4634, p. 38.

alone curing the patient but rendering him non-infective' the length of hospital stay rapidly reduced, initially to three months, and then to one month.[157]

Bacillus Calmette-Guérin **(**BCG), an attenuated form of the tubercle bacillus, was developed in France by Leon Calmette and Camille Guerin between 1908 and 1921 when they demonstrated that the preparation provided immunity against tuberculosis. From 1921 its use in France was gradually extended and from 1927 on it 'was adopted in Scandinavia with great enthusiasm'.[158] In 1937 Dr Dorothy Price introduced BCG into Ireland when she vaccinated five children in St Ultan's hospital. The intervention of the war caused Price to defer her programme. It was resumed in 1945 with 406 children inoculated up to 1949.[159] In 1947 the Medical Research Council of Ireland reported to the Minister for Health that 'a good case has been established for the use of BCG in this country as a means of increasing resistance to tuberculosis'.[160]

Following successful trials of the vaccine by Dublin Corporation, the minister, in July 1949, established a BCG committee 'to direct and be responsible for the expansion of BCG vaccination'. The appointment of vaccinators, the importation of the vaccine from Scandinavia and the production of propaganda were all part of the committee's remit. It was financed by the Hospitals Trust.[161] The committee set out its objective of successfully vaccinating with BCG 'every child and young adult in the land who, by tuberculin testing, reveal the need for it'. Through this it hoped to achieve a level of immunity in the community 'so that instead of opening still more sanatoria we shall find ourselves in the happy position of having to close some for want of patients'.[162] The tuberculin test involved the treatment of the skin with a small quantity of tuberculin, which produced 'a localised red reaction in persons who have at any time been infected with enough tubercle bacilli to produce this allergic response'.[163] Two pre-inoculation tests were administered to most persons. The negative reactors were vaccinated within twenty-four hours of the second test and wherever possible positive reactors were x-

[157] Interview with Jimmy Walsh (former junior physician St Mary's Hospital, Phoenix Park and assistant chief medical officer in the Department of Health) of Marlay, Dublin (4 Nov. 2011).
[158] Linda Bryder, "We shall not find salvation in inoculation': BCG vaccination in Scandinavia, Britain and the USA, 1921-1960' in *Social Science and Medicine*, xlix, no. 9 (1999), pp 1157-67.
[159] Dorothy Price and Patricia Alston, 'Report on BCG vaccinations in St Ultan's hospital' in *Irish Journal of Medical Science*, xxiv, no. 7 (1949), pp 330-1.
[160] *First report of the Department of Health 1945-49*, p.43.
[161] File note, 'BCG committee', Aug. 1950 (NAI, Health BD 113/24).
[162] The National BCG Committee, *Report for period July 1949 to December 1950*, p. 6 (NAI, Health BD 113/23).
[163] William Hartson, *BCG vaccination for school children*, pamphlet reprinted from *Mother and Child*, Jan. 1958 (NAI, Health BD 113/24).

rayed, leading to the discovery of many cases of unsuspected active tuberculosis, which required treatment.[164]

Having sought and obtained the co-operation of local authorities, local vaccination schemes were initiated. Initially vaccinations were limited to contacts of identified tuberculosis sufferers and key workers.[165] Between July 1949 and December 1950, 34,800 tuberculin tests were completed (>17,400 persons tested) and 18,693 vaccinations administered. The number of individuals with positive tuberculin tests discovered was 'too great to be dealt with by the already overtaxed [x-ray] plants in county towns'. However it was envisaged that this problem would be overcome by the mass x-ray services about to be instituted.[166] In 1951 the committee's operations expanded to cover 'the young adult and child population at large who, through large-scale tuberculin-testing, show the need for protection'. Resulting from the expansion of the service, in 1951 74,233 tuberculin tests were completed (>37,116 people tested) and 32,435 vaccines administered.[167] The service expanded considerably in 1952 when local authority staff were recruited as vaccinators. That year 170,698 tuberculin tests were completed (>85,349 persons tested) and 65,401 vaccines administered.[168] By the end of 1958, 1,251,932 tuberculin tests had been completed and 487,191 vaccines administered.[169]

Closure of Sanatoria 1955-1973

The opening of the regional sanatoria combined with the effects of chemotherapy and BCG made the smaller tuberculosis treatment facilities redundant. However as the long-term effects of chemotherapy and BCG on the need for tuberculosis facilities came into play, the irreversible trend for closure extended even to the regional sanatoria.

Resulting from the handing over of Blanchardstown sanatorium, Dublin Corporation, no longer had a need for the Pigeon House Road or Crooksling facilities. Accordingly they

[164] The National BCG Committee, *Report for period July 1949 to December 1950*, pp 4-5; William Hartson, *BCG vaccination*.
[165] The National BCG Committee, *Report for period July 1949 to December 1950*, pp 3-4.
[166] Ibid., p. 19.
[167] The National BCG Committee, *Report for the year ending 31st December 1951*, p. 2 and p. 20 (NAI, Health BD 113/23).
[168] The National BCG Committee, *Report for the year ending 31st December 1952*, p. 25 (NAI, Health BD 113/23).
[169] Memorandum prepared for meeting with executive of National BCG committee, 30 Jan. 1959 (NAI, Health BD 113/24).

were closed in August 1955 and October 1956 respectively.[170] Attempts to market the Pigeon House Road premises in 1958 failed and it was thenceforth used by the corporation's works departments.[171] Upon closure Crooksling was handed over to the Grangegorman Hospital authorities for the accommodation of senile patients who required 'only simple nursing care' thus helping resolve the serious overcrowding in Grangegorman.[172] Following a review of the national tuberculosis bed position by the minister in November 1957, the closure of Ballyowen commenced. The final 126 patients were transferred from the institution on 18 February 1958 mainly to St Mary's, Phoenix Park and Blanchardstown.[173] The property was transferred to the Grangegorman authorities on 14 April 1958.[174]

As only 250 beds out of 650 in St Mary's hospital were occupied by tuberculosis patients, in January 1960, it was agreed to transfer a number of geriatric senile patients from Grangegorman to the vacant beds.[175] The same month due to the falling number of tuberculosis patients in the institution the corporation sought to transfer thirty-four nurses to Blanchardstown sanatorium.[176] By July 1960, 144 geriatric patients were transferred and other vacant beds used to provide overflow accommodation for St. Kevin's hospital.[177] The number of geriatric patients in the institution had grown to 320 by July 1962.[178] By 1966 the institution no longer treated tuberculosis cases being dedicated to the treatment of geriatric, psycho-geriatric and acute medical patients.[179]

[170] Tuberculosis institutions discontinued (NAI, Health D 112/313).
[171] *Irish Press*, 27 Nov. 1958.
[172] An Roinn Sláinte, Progress report for quarter ending 31 December 1956 (NAI, Health A 116/230).
[173] A. E. Johnston to City Manager and Town Clerk, Dublin, 9 Nov. 1957; J. J. Delaney, Principal Officer, Corporation of Dublin to the Secretary, Department of Health, 13 Dec. 1957; E. Ó Caoimh, manager, Grangegorman Mental Hospital Board to the Secretary, Department of Health, 25 Feb. 1958; Eamonn Sheehan for Principal Officer, Corporation of Dublin to Secretary, Department of Health, 25 Mar. 1958 (NAI, D 34J/19).
[174] Chief Clerk, Grangegorman Mental Hospital Board to the Secretary, Department of Health, 29 Mar. 1958 (N.A.I, D 34J/19).
[175] Minutes of meeting in connection with the future use of St Mary's chest hospital, 18 Jan. 1960 (NAI, Health AD 34G/45).
[176] Declan Costello and Seán MacEntee, Minister for Health, Dáil debates vol. 180, no. 14, 2057-8, 7 Apr. 1960. Costello the son of the former Taoiseach John A. Costello was Fine Gael deputy for Dublin North-West from 1951-1969 and Dublin South-West from 1973 to 1977. He had undergone extensive treatment for tuberculosis of the kidney in Switzerland from 1946 to 1948. David McCullagh, *The reluctant Taoiseach* (Dublin, 2010), p. 147. MacEntee was Táiniste and Minister for Health and Minister for Social Welfare from June 1959 to October 1961.
[177] Information requested by the secretary, 21 July 1960; Minutes of discussion in Department of Health, 8 Sept. 1960 (NAI, Health AD 34G/45).
[178] Seán MacEntee, Dáil debates vol. 196, no. 16, 2825-6, 19 July 1962.
[179] Donogh O'Malley, Dáil debates vol. 222, no. 5, 1028, 28 Apr. 1966. O'Malley the Fianna Fáil deputy for Limerick East from 1954 to 1968 was Minister for Health from April 1965 to July 1966.

The completion of the regional sanatoria and the reduced demand for tuberculosis beds made other facilities redundant. In September 1957 Wicklow County Council approved of the closure of St Kevin's Rathdrum. The patients were transferred to Newcastle sanatorium. The vacated St Kevin's was used to provide additional accommodation for the aged and chronic sick patients in the adjoining St Colman's hospital.[180] The last tuberculosis patients were transferred from the institution on 14 October 1957.[181] In December 1960, on the recommendation of the Department of Health, 'against well-reasoned protests and despite the warning of the medical authorities' in the county, Kilkenny County Council decided to close the county sanatorium.[182] In April 1961 Laois County Council closed St Bridgid's sanatorium and converted it to house older inmates from St Fintan's mental hospital Portlaoise.[183] All tuberculosis patients were transferred from Brownswood in February 1965 and the medical section of the Wexford county hospital and geriatric patients from the county home accommodated therein.[184]

The advent of the regional sanatoria and fall in demand for beds also impacted on the voluntary institutions. In February 1960 Seán MacEntee stated that the government were 'hoping that Our Lady of Lourdes (Dun Laoghaire) may be closed as a TB hospital and that we shall have another use for it'.[185] In June he announced that he had under consideration a plan put forward by the hospital authorities in conjunction with the National Organisation for Rehabilitation to redevelop the institution as a rehabilitation centre.[186] Having obtained approval the new centre opened in April 1961.[187]

By May 1960 the average number of beds occupied in Newcastle sanatorium had dropped to ninety-nine from an average occupancy of 228 during 1955.[188] The decline in patient numbers had 'the inevitable result that the cost of maintaining each patient had risen' and contributed to an annual running deficit of £40,000.[189] This necessitated constant reliance on grants from the Hospitals Trust to keep the deficit within

[180] Staff officer, Wicklow County Council to Secretary, Department of Health, 'Use of St Kevin's sanatorium Rathdrum', 27 June 1957; P. Maguire, staff officer, Wicklow County Council to Secretary, Department of Health, 19 Sept. 1957 (NAI, Health A 32/169).
[181] File note, 29 Oct. 1957 (NAI, Health A 32/169).
[182] *Kilkenny People*, 4 July 1959 and 23 Dec. 1960.
[183] *Irish Times*, 17 Apr. 1961.
[184] *Irish Independent*, 25 Feb. 1965.
[185] Seán MacEntee, Dáil debates vol. 179, no. 1, 156, 10 Feb. 1960.
[186] Seán MacEntee, Dáil debates vol. 183, no. 5, 666-7, 29 June 1960.
[187] *Irish Times*, 2 Feb. and 29 Sept. 1961
[188] M. A. Croker, Secretary, National Hospital for Consumption for Ireland to the Secretary, Department of Health, 21 June 1960 (NAI, Health AD 110N/35).
[189] RNHCI, *Sixty-eight report and statement of accounts with list of subscriptions for the year ending 31st December, 1960*, p. 8 (NHA); M. A. Croker, 21 June 1960.

manageable limits.[190] This state of affairs led the majority of the board of governors to the conclusion that 'as it is now obvious that the institution had fulfilled its original function, they should hand it over for other health purposes and wind themselves up'.[191] In December 1960 the board at the suggestion of the department resolved to transfer the sanatorium to Wicklow County Council for use as a mental hospital.[192] In September 1963 arrangements were made to transfer the thirty patients remaining in the hospital to Peamount.[193] The last tuberculosis patient vacated the hospital on 10 October 1963.[194]

The 1968 land mark report by the Consultative Council on the General Hospital Services, on the future of hospital services in Ireland, signalled a dramatic policy shift regarding facilities for treatment of tuberculosis The council found that with advances in the treatment of tuberculosis 'elaborate hospital facilities are unnecessary and there is no advantage in centralising the hospital care of tuberculosis patients'. It recommended that tuberculosis patients 'be cared for in separate wards of general hospitals'. As an interim measure it recommended that 'small county sanatoria should be continued until their bed occupancy renders them completely uneconomic'. In Leinster the only such sanatorium still functioning was Dundalk with sixty-two beds. However, as a further 100 beds were necessary to meet the interim need, it recommended that these should be provided in Peamount. This would free up Blanchardstown sanatorium for other hospital purposes. It recommended that, as part of the reorganisation of the Dublin hospital services, Blanchardstown should be redeveloped as a general hospital containing ultimately 500 beds. The recommendation was influenced by the facility being 'immediately suitable for limited use as a general hospital while awaiting further development'.[195] In pursuance of the recommendation the hospital was officially inaugurated as a general hospital on 1 August 1973.[196]

Due to the declining numbers of tuberculosis patients using Dundalk sanatorium, the Department of Health suggested the facility be used to accommodate 'geriatric patients from the county home, which was in a poor state of repair and was unsatisfactory for

[190] Ibid., p. 22.
[191] Minutes of meeting between Dr Edward Freeman, chairman of the board and Department of Health official (P. C. Ó N), 22 July 1960 (NAI, Health AD 110N/35).
[192] Minutes of meetings of board of governors, 20 Dec. 1960 (NHA).
[193] *Irish Times*, 19 Sept. 1963.
[194] Minutes of meetings of board of governors, 24 Sept and 15 Oct. 1963 (NHA).
[195] *Outline of the future hospital system, report of the Consultative Council on the General Hospital Services*, Prl. 154, pp 75-76, 118.
[196] *James Connolly Memorial Hospital, draft development brief* (1983), p. 1.

institutional or welfare care'. The suggestion was adopted by the board of health at its meeting in October 1970.[197] By July 1972 arrangements were underway to make the premises available to accommodate elderly patients.[198]

With reduced numbers of patients undergoing treatment in Peamount, John O'Donoghue, the chairman of the board, announced in April 1963 that the hospital authorities had 'made proposals to the Department of Health for the utilisation of vacant beds for the treatment of other illnesses'.[199] By the end of that year forty adult mentally handicapped patients had been accepted into the adapted children's unit.[200] The number of mentally handicapped patients in the institution had increased to eighty by June 1964.[201] In 1970 only 44% of the patients in the hospital were being treated for tuberculosis. With the continual decline in tuberculosis patients only 34% of patients fell into that category in 2002.[202] By March 2006 only one tuberculosis patient remained in the institution. The focus of the institution had changed to the care of patients with an 'intellectual handicap', with chronic neurological disease and the elderly.[203]

Conclusions

From the mid 1930s the replacement of small, uneconomical, local tuberculosis treatment sanatoria with regional facilities was government policy. However, the delivery of these facilities required legislative change, innovative tendering and construction procedures as well as manpower and material sourcing. Delays in their provision, exacerbated by growth in patient waiting lists, meant interim solutions had to be found. The solutions involved the provision of new tuberculosis facilities, the extension of existing sanatoria and the conversion of other hospital facilities to tuberculosis use. The short lifespan of these institutions as interim tuberculosis facilities resulted in considerable waste of public funds. However, they did achieve a measure of success in removing infective cases of tuberculosis from the community. The introduction of new diagnostic facilities, which

[197] 'Dept seeks to close town's TB hospital' (www.independent.ie/regionals/argus) (20 Jan. 2014).
[198] Erskine Childers, Dáil debates vol. 262, no. 4, 592, 4 July 1972. Childers the Fianna Fáil deputy for Monaghan had represented various constituencies from 1938 to 1973. From 1951 to 1973 he was a member of cabinet when his party was in power occupying different ministries. He was Tánaiste and Minister for Health from July 1969 to March 1973.
[199] *Irish Times*, 23 Apr. 1963.
[200] Seán MacEntee, Dáil debates vol. 207, no. 10, 1298-9, 20 Feb. 1964; T. M. Healy, *From sanatorium to hospital* (Dublin, 2002), p. 137.
[201] Frank Sherwin, Dáil debates vol. 207, no. 11, 1462-3, 25 Feb. 1964; Seán MacEntee, Dáil debates vol. 210, no. 5, 689, 4 June 1964. Sherwin was the independent deputy for Dublin North Central from 1957 to 1965.
[202] Healy, *From sanatorium to hospital*, p. 122.
[203] *Sunday Independent*, 12 Mar. 2006.

led to the earlier detection of the disease, enabled patients to benefit from new chemotherapy treatments. These therapies in turn lead to shorter treatment times and together with the community immunity provided by BCG, helped bring about the obsolescence of specialist institutions to treat tuberculosis. The statistics show that from the mid 1950s to 1970 there was a spectacular and very welcome decrease in the disease.[204] This resulted in surplus beds, empty wards and in some cases vacant buildings in many local tuberculosis facilities. Only some of this excess capacity, which had been provided at considerable expense, was converted to alternative medical uses. The detailing of the impact the diagnostic services and facilities and the chemotherapeutic treatments put in place had on tuberculosis has provided support for Jones contention that 'the availability of an effective drug treatment' together with the creation of a capable public health infrastructure to deal with tuberculosis and the tracking down of sufferers were significant factors 'in hastening the decline of TB' in Ireland.[205]

[204] In 1955, 889 persons died from tuberculosis in Ireland a ratio of one in every 41 deaths. By 1960 the number of deaths attributable to the disease dropped to 468 a ratio of 1 in every 70 deaths. The number of deaths from tuberculosis decreased further to 334 in 1965 a ratio of 1 in every 99 deaths. By 1970 the number of tuberculosis deaths decreased to 221 a ratio of 1 in every 152.4 deaths. *Department of Health, report on vital statistics 1955*, Pr 3984. *Department of Health, report on vital statistics 1960*, Pr 6366. *Department of Health, report on vital statistics 1965*, Pr 9536. *Department of Health, report on vital statistics 1970*, Prl 3222.

[205] Jones, *Captain of all these men of death*, pp 229-31.

Conclusions

As stated at the outset of this thesis, there was a remarkable, unexpected collapse in the number of deaths attributed to tuberculosis between the late 1800s and the 1970s. In the decade to 1891 one in every 8.5 deaths in Ireland was attributed to tuberculosis; by 1970 only one in every 152.4 deaths resulted from the disease.[1] Nobody could have forseen this dramatic change. This thesis has examined how facilities were developed and used for the treatment of tuberculosis in Leinster from the 1890s to the 1970s. It has demonstrated how the origins of these facilities can be traced back to the understanding of the disease expounded by physicians well before the modern period and elaborated on in the ensuing millennia, ultimately resulting in the development of the sanatoria movement. The shared common belief of these physicians in the benefits to be derived from fresh air, nutrition, rest and graduated exercise was to form the basis of treatment practices employed in Irish tuberculosis facilities until after the introduction of multidrug treatment of the disease.

The German sanatoria movement, which developed from the mid 1850s for wealthy patients, began to treat working-class patients following the enactment of social legislation in the 1880s. The treatment practices developed in Germany, involving open-air rest and graduated exercise, and the architectural and spatial forms developed to facilitate them were followed in subsequent Leinster developments. The Swiss sanatoria movement, initially developed without the close medical supervision of its German counterparts, relied mainly on the therapeutic benefits of its high Alpine climate to establish a reputation for successfully treating the disease. In time it became the treatment location of choice of the wealthier British and Irish tuberculosis sufferers. The heliotherapeutic practices developed by Auguste Rollier in Leysin formed the basis of the regimen applied by many Leinster institutions in the treatment of surgical tuberculosis.

A key feature in the institutional treatment of tuberculosis was the development by the Edinburgh physician Robert Philip of his treatment regime with the tuberculosis dispensary at its core. His system, having being adopted by the British government, formed the basis of the Irish treatment system. Using the existing poor law dispensaries and providing specifically constructed central tuberculosis dispensary facilities enabled

[1] *Forty-fifth detailed annual report of the registrar general for Ireland containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1908*, 1 [Cd 4769], H.C. 1909, xi, 689; *Department of Health, report on vital statistics 1970*, Prl 3222.

Leinster authorities to spread the reach of tuberculosis services. Although Jones maintained that 'the treatment actually available in the typical Irish dispensary fell short of their ideal',[2]. nevertheless they facilitated the early identification of many tuberculosis sufferers who would otherwise have gone undetected and their subsequent referral for sanatorium treatment or placement under domestic treatment. The development of the tuberculosis dispensary system enabled the expeditious referral of patients to the regional sanatoria and other expanded tuberculosis treatment facilities, which became available in the early 1950s. Jones has maintained that 'the effectiveness of (this) public health structure to deal with TB' together with improving economic circumstances and drug theraphy played a role 'in hastening the decline of TB' in the Republic of Ireland.[3]The success of the Leinster dispensaries can be attributed to their good geographical spread within the province, with one dispensary available for every 8,000 population outside of Dublin [4], allied to the integral part they formed within the tuberculosis service in Ireland. They did not face the problems of their English counterparts. Bryder identified that 'little status and finance accrued to dispensaries and their administrators' within the British tuberculosis service,[5] while the problem of the inaccessibility of English dispensaries in rural areas was identified by Bowden and Sadler[6] with only one tuberculosis dispensary available for every 84,000 population throughout Great Britain in the 1940s.[7] Bryden and Sadler also described the reluctance amongst patients to visit dispensaries because of the social stigma attached to attendance, a problem also faced by Leinster tuberculosis dispensaries in attracting patients.[8]

In the early 1920s, through its amalgamation schemes the newly-established Irish government sought to eliminate the vestiges of the British legacy poor law system by closing the workhouses. Under central government pressure, local authorities replaced these with institutions for tuberculosis sufferers by acquiring manor houses for use as sanatoria, by adapting existing facilities and by providing specifically-designed premises. The provision of these facilities was characterised by lack of adequate financial provision and central government micro-management which frequently resulted in increased costs and delayed delivery. The statutory autonomy which the local authorities appeared to

[2] Jones, *Captain of all these men of death*, p.138.
[3] Ibid, p. 231.
[4] Calculated from data contained in appendix 17.
[5] Bryder, *Below the magic mountain*, p. 95.
[6] Sue Bowden and Alex Sadler, 'Getting it right? Lessons from the interwar years on pulmonary tuberculosis control in England and Wales' in *Medical History*, lix, no. 1 (2015), pp 101-135.
[7] R. Y. Keers, *Pulmonary tuberculosis* (London, 1978), p. 156.
[8] Bowden and Sadler, 'Getting it right?'.

enjoy was largely illusory. Legislation in the 1930s establishing the Hospitals Trust Fund, to disburse sweepstakes monies, provided, albeit still inadequate, funding for tuberculosis treatment projects.

Securing funding had also been a constant problem for voluntary and religious run tuberculosis institutions. Initially relying mainly on philanthropy to meet their financial requirements, as patient income coming predominantly from the poorer classes proved totally inadequate, they were in constant competition with the many hospitals, organisations and causes making demands on the same limited pool of available funds. They had to compete with the demands made by the various wars and their associated charities, which appeared to obtain public priority thus reducing hospital funding. Rowlette in 1920 identified the funding shortfall resulting from the passing of wealth in the country 'to a different class of the community and the hands that now hold it areas yet unused to giving'.[9] This situation was exacerbated by the departure of many members of the aristocracy, a reliable source of philanthropic funding, to England in the 1920s. This left the voluntary institutions with little alternative but to rely more heavily on other fundraising methods such as bazaars, sales-of-work, field days, football pools, and radio and newspaper appeals. Their poor financial position was not assisted by the constant refusal of state authorities to provide adequate recompense in respect of patients they referred to these hospitals. Matters were marginally improved by the making available of limited grants through the Hospitals Trust Fund but this subjected the receiving institutions to more intensive central government micro-management.

Walsh has shown that in Dublin, during the Victorian era, amongst Anglican women, the middle class enjoyed a virtual monopoly of philanthropic work, as their social and religious practice 'emphasised the obligations inherent in social privilege'.[10] Luddy has described how this 'spiritual responsibility' in many cases manifested itself 'as a grim determination to do gods will'. She saw the involvement of such women in philanthropic activity 'as a socially acceptable way to engage in purposeful work'.[11] The involvement of both Lucinda O'Sullivan in the Bray Cripples Home and Florence Wynne in Newcastle sanatorium provide typical examples of Anglican women inspired by religious fervour embarking on acceptable philanthropic endeavours. Both women enlisted the aid

[9] Robert J. Rowlette, 'The problem of the Dublin voluntary hospitals' in *The Dublin Journal of Medical Science*, fourth series, no. 1 (1920), pp 9-24.
[10] Oonagh Walsh, *Anglican women in Dublin* (Dublin, 2005), p. 92.
[11] Maria Luddy, 'Women and charitable organisations in nineteenth century Ireland' in *Women's Studies International Forum*, xi, no. 4 (1998), pp 301-5.

of viceroy's wives to help achieve their aims. Walsh maintains that 'any charity or function that managed to secure the endorsement of members of the nobility was practically assured of success'.[12] Women from the upper echelons of society had the capacity to access resources through acquaintances and family not available to members of other classes of society. The involvement of such titled women, at the apex of the social scale, in charitable work in Ireland is little documented.

Luddy has detailed how female members of the aristocracy were involved in organising and as members of the British and Irish Ladies Society for the Promotion of the Welfare of Female peasantry in Ireland, a non-evangelical organisation removed from clerical influence, although much of the social elite's involvement was merely as patrons of the society.[13] She has shown how members of the nobility directed the operations of the Belfast based Society for Providing Nurses for the Sick Poor, a non-sectarian, non-denominational organisation.[14] However the involvement of the female aristocracy in the development of tuberculosis treatment institutions and anti-tuberculosis organisations in Leinster was extremely active. Lady Abercorn provided assistance both financial and in kind to the Bray Cripples Home, while her successor Lady Marlborough became a leading benefactress of the home. Lady Zetland's role in the initial development process of the Newcastle facility was akin to the role of a commercial body's managing director. She also secured the involvement of Lady Arnott and Lady Fitzwilliam as significant fundraisers. The main responsibility for the funding and erection of the Maryborough sanatorium lay with Lady Coote.

Of the members of the aristocracy the most active participant in the development of Irish tuberculosis services was Lady Aberdeen. In developing the WNHA she succeeded in securing cross denominational support for the organisation and its aims, a task extremely difficult to achieve at a time when most Irish philanthropic bodies were organised on sectarian lines for evangelical purposes. With the support of Catholic clergy the WNHA provided an outlet for lay Catholic women to engage in philanthropic work, which as Luddy has pointed out had previously been reserved to those catholic women in religious congregations.[15] Perkin has demonstrated how privileged women were expected to exert

[12] Walsh, *Anglican women*, p. 109.
[13] Maria Luddy, *Women and philanthropy in nineteenth-century Ireland* (Cambridge, 1995), pp 183-7.
[14] Ibid., 196-7.
[15] Luddy, *Women and philanthropy*, p. 21.

direct influence over political decision-makers.[16] Lady Aberdeen who had personally developed a high political profile and standing used her influence to secure political support for legislative change on tuberculosis matters and to secure funding for her tuberculosis treatment projects. She also used her position to establish boards and committees to promote her anti-tuberculosis aims. Many of these were male dominated but were nevertheless effectively controlled by Lady Aberdeen through her chairing of them. Lady Aberdeen was the prime mover in the introduction of domiciliary nursing care of tuberculosis sufferers and their families and in the provision of post-sanatoria care of patients. Without the active involvement and support of these aristocratic women it is unlikely that the facilities and organisations in which they were involved could have been successfully developed to the extent that they were.

Fahey has shown how, from the mid-seventeenth century with the foundation of the Sisters of Charity of St Vincent de Paul, a movement began removing female religious from the confined world of the cloister into communities where they provided active pastoral service and care. After 1800 this process accelerated with 'open and active congregations' gaining the ascendant over 'traditional enclosed orders. In Ireland the number of nuns increased from '120 in1800 to 1,500 in 1851 and over 8,000 in 1901'.[17] In accommodating this increase the number of convents increased from ninety-one in the early 1850s to 368 in 1901.[18]

Luddy has shown that not all these women joined religious congregations 'through a sense of religious idealism'.[19] Owens has contended that the lack of an alternative career for females, from the newly emerged catholic middle classes, was a factor contributing to this increase in numbers.[20] In support of this contention Magray has found that most women joined these religious congregations believing that they had useful work to do, citing 'the chance to do significant valuable labour' as the most frequently stated reason for joining religious orders.[21] For many of these nuns the valuable labour took the form of the provision of 'education and health care' (tasks for which male religious were not

[16] Joan Perkin, *Victorian Women* (London, 1993), pp 202-4.
[17] Tony Fahey, 'Nuns in the Catholic church in Ireland in the nineteenth century' in Mary Cullen (ed.), *Girls don't do honours* (Dublin, 1987), pp 7-30.
[18] Caitríona Clear, 'The limits of female autonomy: nuns in nineteenth-century Ireland' in Maria Luddy and Cliona Murphy (eds), *Women surviving* (Dublin, 1990), pp 15-50.
[19] Maria Luddy, *Women and philanthropy*, p. 30.
[20] Rosemary Cullen Owens, *A social history of women in Ireland 1970-1970* (Dublin 2005), p. 71.
[21] Mary Peckham Magray, *The transforming power of nuns* (Oxford, 1998), pp 39-41.

considered particularly suitable). Their engagement in these areas helped achieve 'popular acceptability' for the Catholic Church.[22]

Although Clear acknowledged that the founding aims of many congregations 'centred around teaching and nursing care broadly defined' she erroneously maintained that none of the congregations involved in the provision of hospital nursing services in Ireland were specifically set up as nursing congregations.[23] Many of these congregations had been founded specifically to provide care and nursing services to the poor and others had shortly after their foundation adopted such a provision as one of their core objectives. Within a short period after the formation of these orders, the nursing and care services were being provided within institutional settings. It is likely that, having developed a reputation for the care of the sick, such orders attracted members who had a particular aptitude for this form of philanthropic work. The congregations who became involved in the care of tuberculosis patients had been heavily involved in the provision of nursing services to the poor prior to their particular involvement in managing and staffing institution for the care of consumptives. The expansion of their services into this particular form of nursing was in response to needs identified from their involvement in the provision of nursing services to the poor either in hospitals or otherwise. It also provided useful employment outlets for the increased numbers of nuns available.

Owens found that nuns were engaged in hospitals and workhouses as 'they cost less than lay nurses, they were not working for personal gain and they were amazingly versatile'.[24] Clear, with similar findings, added that they never complained about pay and 'were working until they dropped'.[25] These were clearly the considerations of the various Boards of Guardians who sought to keep down costs as they engaged nuns in the workhouses. It was the achievement of financial economy which motivated Dublin Corporation to secure nuns as nurses in the Pigeon House Road hospital and Wicklow County Council to extend the remit of the Poor Servants of the Mother of God to provide similar services in the new sanatorium at Rathdrum. However Dublin Corporation also had the objective of providing their patients with the 'comfort and consolation which a

[22] Fahey, 'Nuns in the Catholic church'.
[23] Caitríona Clear, *Nuns in nineteenth century Ireland* (Dublin, 1987), p. 107 and p. 112.
[24] Owens, *A social; history of women,* p. 66.
[25] Clear, 'The limits of female autonomy'.

community of nuns would be eminently able to give'.[26] The religious ethos of the nuns permeated all the institutions in which they were involved. In the institutions they provided for children religious observance and teaching was afforded primacy even to the extent of dictating the daily routines of the institutions. In Cappagh the introduction of the annual Corpus Christi procession enabled the nuns extend hospital religious practices to the general community.

Providing for the religious needs of patients was a matter constantly addressed by the promoters and managers of secular sanatoria both with regard to the appointment of chaplains and the provision of places of worship. The central government health authority, displaying a distinct Catholic bias, often at the behest of catholic chaplains, dictated the layout and use of facilities to assist catholic religious practices. It also consented to the introduction of regulations making attendance at Catholic ceremonies compulsory for patients. Following the example of Cappagh the chaplain in Blanchardstown was facilitated in introducing a Corpus Christi procession for the benefit of patients and the general community. The importance placed by the Catholic religious hierarchy on the functions performed by the sanatoria chaplains is illustrated by the unbroken continuity in the post of hospital chaplain in Blanchardstown.

Following the example of Ventnor, the rules adopted by Irish tuberculosis institutions provided for the almost complete separation of the sexes, by providing separate physical environments for their occupation. The implementation of this separation rule and other regulations was vigorously enforced in the early institutions. However evidence suggests that from the 1930s there was a relaxation in their application. This together with the provision of entertainment helped create a convivial fellowship in the sanatoria. To a certain extent the enforcement measures were dependent on the persons in charge of the various institutions. As evidenced in Blanchardstown, by the early 1960s, a more relaxed regime existed with the rules not being greatly observed.

From the mid 1930s the provision of regional sanatoria was promoted as the most economic solution to providing for the needs of tuberculosis sufferers. Initial attempts to locate the Leinster sanatorium on sites at Ballyowen and Santry expensively floundered due to inadequate planning, before a 540 bed facility was opened in Blanchardstown in

[26] *Report of tuberculosis committee of management recommending the adoption of a scheme for the appointment of nuns in connection with the nursing at the tuberculosis hospital Pigeon House Road, 28 Aug. 1917*, Dublin Corporation reports 1917, vol.3, report no. 194, pp 373-7.

1955. Pending the provision of this sanatorium, costly interim solutions were embarked upon involving the major upgrading and redevelopment of St Kevin's and St Mary's hospitals and the construction of Ballyowen sanatorium in Dublin, together with the adaptation and redevelopment of smaller facilities throughout Leinster, almost all of which works were made redundant following the provision of the regional facilities. Through lack of foresight the repercussions of improved diagnostic methods resulting from the mass-x-ray service, the community immunity provided by the BCG inoculation scheme and the impact of the new multi-drug chemotherapeutic treatment of tuberculosis on the need for specialist hospital facilities were never assessed. In combination these medical advances made the regional sanatoria and other extant tuberculosis facilities obsolete by the late 1960s and led to their closure or redeployment.

In Ireland until after the development of the regional sanatoria the lack of sanatoria and other facilities in which to treat tuberculosis meant that for many sufferers institutional treatment was not an option. In 1935/36 there were 2,960 beds reserved for tuberculosis treatment nationwide.[27] The Red Cross had estimated that in 1943 there was a deficit of 5,000 in the number of beds required to treat the disease.[28] The number of available beds had increased to 3,900 by 1948 and 4,806 by 1958.[29] As a result of these deficiencies in the period 1938-1941 of an estimated 11,700 tuberculosis deaths 3,296 occurred in sanatoria and general hospitals, 780 occurred in mental hospitals, 2,752 occurred in county homes and district hospitals while 4,872 took place elsewhere mainly in patients own homes. The corresponding figures for 1942-1945 were 12,528 tuberculosis deaths, 3,604 in sanatoria and general hospitals, 812 in mental homes, 2,580 in county homes and district hospitals and 5,532 elsewhere mainly in patients own homes. In 1946-1949 there were 10,116 tuberculosis deaths, 3,692 in sanatoria and general hospitals, 688 in mental homes, 1,768 in county homes and district hospitals and 3,968 elsewhere mainly in patients own homes.[30]

Even in the 1950s the greater availability of tuberculosis facilities did not alter the attitude of certain sectors of the population towards the diseases: 'The middle classes wouldn't dream of going to a sanatorium that was only for the poor people'. They remained at home in bed with treatment provided by their general practitioners, visiting

[27] Department of Local Government and Public Health report, 1936-1937, P. 2907.
[28] Outlines of a long term policy recommended by the anti-tuberculosis section of the Irish Red Cross, 15 Dec. 1943 (NAI, Health D 102/5).
[29] Department of Health memo 19 Feb. 1959 (NAI, Health D 112/706).
[30] *Tuberculosis in Ireland report of the national tuberculosis survey (1950-53).*

chest specialists in Dublin 'once every one or two months'. 'The ignorance of these GPs (regarding tuberculosis) was alarming'.[31] Private nurses were often engaged to administer to these patients while at home.[32] If the family had the financial means they sent the patients abroad for treatment.[33] This had the added advantage of concealing the existence of tuberculosis in the family from friends and neighbours. Even amongst poorer families the stigma attaching to tuberculosis was such that 'nobody ever admitted to having TB. Whatever else you had you didn't have TB. Nobody in your family, seed, breed or generation had TB.'[34]

Bates, referring to generally declining mortality rates from tuberculosis, has speculated that rising standards of living with consequential improved health and housing conditions, especially ventilation decreased peoples 'chances of being infected or improved their resistance thus reducing their risk of developing the disease'.[35] In doing so she dismisses sanatoria treatment regimes as being ineffective, although she does consider that the rising rate of institutionalisation of tuberculosis patients and their increased length of stay from the 1920s and 1930s may have favourably impacted on mortality.[36] She admits that segregating infected people 'must have reduced the danger to others', however because of large waiting lists and the advanced stage of the disease in many admitted to sanatoria 'they had probably already infected most of their contacts'.[37] She has dismissed the benefits of fresh air but acknowledges that rest did help 'acutely ill, feverish or exhausted patients and for some severely malnourished patients nourishment 'may have made a critical difference'.[38] Mark Caldwell has from a scientific point of view queried the efficacy of bed rest and segregation in sanatoria in countering tuberculosis. Nevertheless he does acknowledge the positive psychological effect of sanatoria on tuberculosis sufferers and the general population in that 'the reassurance that something was being done … relieved anxiety for the unaffected … and made it easier for the stricken to bear their affliction'.[39] However an examination of the

[31] Interview with Dr Jimmy Walsh.
[32] June Goulding, *The light in the window* (Dublin, 1998), pp 1-2.
[33] Interview with Dr Jimmy Walsh.
[34] John O'Connell, *Doctor John* (Dublin, 1989), pp.6-7. O'Connell a medical doctor served as a TD from 1965 to 1987 and from 1989 to 1997, as a member of both the Labour Party and Fianna Fáil and as an independent, representing various south Dublin constituencies. He was Minister for Health from Febuary 1992 to January 1993. His fifteen year old sister died from tuberculosis in Crooksling sanatorium in the early 1940s.
[35] Bates, *Bargaining for life, p. 322.*
[36] Bates, *Bargaining for life,* pp 320-6.
[37] Ibid., p. 318.
[38] Ibid., p. 320.
[39] Mark Caldwell, *The last crusade* (New York, 1988), p. 284.

statistics pertaining to the survival rates of former sanatoria patients demonstrate that the doubts expressed by Bates and Caldwell regarding the efficacy of sanatorium treatment are not borne out.

The statistics published by Burckhardt on the Basle sanatorium at Davos demonstrated that treatment in that institution facilitated medium term survival and a return to economic activity.[40] Statistics gathered on over 80,000 patients treated in German sanatoria between 1898 and 1907 showed that over 30% were restored 'to health and usefulness permanently', continuously working for four years following discharge and 66% had displayed 'temporary recoveries'.[41] Commenting on these figures, Alexander Walker maintained that 'in almost every case an immense benefit was derived from the treatment'. He queried as to why anyone would begrudge sufferers their respite of a 'few months of relief or a few years of life '.[42] Modern day analogies to this can be observed with the provision of radium and chemotherapy treatment to terminally ill cancer patients.

A report compiled in 1913 on the patients discharged from Frimley Sanatorium, Surrey, England between 1905 and 1908 showed that of 690 patients discharged during that time 274 (55.9%) were well and able to work at the end of the fourth year following their discharge (this figure had decreased to 48.4% at the end of the fifth year), a further seventy-six (15.5%) were alive while 140 (28.6%) had died. It had not been possible to trace the remaining patients. [43] The physicians in charge of the sanatorium maintained that the survival rates would have been higher if in 'many cases' the patients had not returned 'to unsatisfactory home conditions and unsatisfactory food with consequent relapse'.[44] In Frimley the selection of patients may have ensured good survival rates as only patients 'who possessed considerable vitality and had already begun to show signs of improvement' following initial treatment in the Brompton Chest Hospital and had a likelihood of obtaining work on discharge were admitted.[45]

[40] The statistics are set out in Chapter 1, pp 38-9.
[41] Quoted in Alexander Walker, 'The provision of sanatoria for the curative treatment of phthisis among the poorer classes' in *The Edinburgh Medical Journal*, xxiii (1908), pp 321-33.
[42] Ibid.
[43] S. H. Habershon, F. J. Wethered, P. Horton-Smith Hartley, J. J. Perkins and W. O. Meek, *Report on the after-histories of patients discharged from the Brompton Hospital Sanatorium at Frimley in Surrey during the years 1905-1910* (!914).
[44] Ibid, p. 7.
[45] Ibid, p. 3.

John Guy, the medical superintendent at the Bridge-of-Weir Sanatorium in Scotland, acknowledged that 'it is extremely difficult to estimate the value of sanatorium treatment'. [46] He examined the five year survival rate of the patients discharged from that institution in 1907. Of the 133 patients he traced, twenty-five (19%) were alive, twenty-two of whom stated that they were well; 108 (81%) had died. The relatively poor survival rates, when compared to other institutions, may be attributed to the fact that in most patients on admission the disease was either moderately advanced (seventy-four patients) or far advanced (twenty-seven patients). The five year survival rate of the thirty-two patients admitted in the early stages of the disease was 63% (twenty patients).[47]

Lawrason Brown the resident physician at the Adirondack Cottage Sanatorium, Saranac Lake, New York demonstrated that of the 156 patients treated in that institution in 1901, seventy-four (47%) were alive in October 1910.[48] In Peamount Sanatorium, the only Leinster facility for which relevant statistics are available, of the 158 patients discharged in 1915, 111 survived for five years, sixty-eight for ten years and fifteen for twenty years. Of those twenty-eight patients in the early stages of the disease on admission, twenty-three were alive five years after discharge and seven survived for twenty years (see appendix 22). As Peamount follows the general patient survival trends of foreign sanatoria it can be safely assumed that the survival rates of patients in other Irish facilities, which in general under the micro-management of central government operated analogous regimes to Peamount, was along similar lines.

These statistics demonstrate that by providing patients with rest and nutrition in fresh air locations and removing them from stressful situations and unhealthy environments, especially in urban situations, the sanatoria in many cases enabled their bodies' natural defences counteract the disease. The resultant apparent recovery or at least remission of the disease would have had a positive impact on other patients and have contributed to the positive psychological effect of sanatoria identified by Caldwell. The sanatoria also played an important educational role in training patients to adopt the necessary precautions to prevent the spread of the disease. Contrary to Bates belief, isolation of patients worked insofar as not everybody in contact with infected sufferers had succumbed to the disease, thus removing infected persons from the home and workplace

[46] John Guy, 'The sanatorium treatment of pulmonary tuberculosis and its results' in *Edinburgh Medical Journal,* xiv (1915), pp 25-37.
[47] Ibid.
[48] Lawrason Brown, 'Ten years after sanatorium treatment' in *BMJ*, ii, no. 2649 (1911), p. 860.

lessened the chances of transferring infection. In addition certain cohorts of patients treated in sanatoria were admitted to the institutions prior to the disease reaching the stage where they were infective. In Ireland the examination of patient's contacts in the tuberculosis dispensaries had assisted in the identification of many of these non-infective tuberculosis sufferers.

Between 1880 and 1922 there were 50,862 new dwellings constructed in Ireland. In the decade 1922-1932 26,384 new homes were provided. The residential construction rate increased considerably between 1933 and 1948 with 90,253 units built. In the post Second World War period, from 1948-1964, 137,000 new residential units were constructed, 19,903 of these being local authority units provided by Dublin Corporation.[49] Jones identified the effect of 'badly housed urban poor' as a contributory factor to the high tuberculosis rates found in Dublin.[50] Bates speculation regarding the general decline in tuberculosis infection brought about by improved health, arising from rising standards of living, better housing conditions and ventilation of dwellings can readily be applied to Ireland. That the medical establishment supported this viewpoint is evidenced by the declaration of the St Ultan's Hospital authorities that 'better housing and higher standards of living' together with chemotherapy and BCG vaccination were contributory factors to the decrease in the incidence of tuberculosis.[51] The statistical evidence, of an increasing rate of housing construction between 1880 and 1964 coinciding with a decreasing rate of tuberculosis mortality, dropping from one in every 8.5 deaths in Ireland in the decade to 1891, to one in every 12.24 deaths by 1936, one in every 22.23 deaths in 1952, one in every 81.36 deaths in 1964 and to one in every 152.4 deaths by 1970, demonstrates the positive impact that improved living conditions have on the incidence of tuberculosis infection.[52]

Major histories of tuberculosis have been produced by Barnes (France), Bryder (UK), Rothman (USA), Feldberg (USA), Daniel (USA and general) and McCuaig (Canada).[53]

[49] *Housing- progress and prospects*, 1964, Pr 7981.
[50] Jones, *Captain of all these men of death*, p.232.
[51] *Teach Ultain Inc. forty-ninth annual report 1967*, p. 14
[52] *Forty-fifth detailed annual report of the registrar general for Ireland containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1908*, 1 [Cd 4769], H.C. 1909, xi, 689; *Annual report of the Registrar General for the year 1936*, P 2757; *Tuarascáil an ard-chláraitheora 1952*, Pr 2555; *Report on vital statistics 1964*, Pr 8898; *Department of Health, report on vital statistics 1970*, Prl 3222.
[53]David S. Barnes, *The making of a social disease: tuberculosis in nineteenth-century France* (Berkeley, 1995); Bryder, *Below the magic mountain;* Sheila M. Rothman, *Living in the shadow of death* (paperback ed. Baltimore, 1995); Georgina D. Feldberg, *Disease and class* (New Jersey, 1995); Daniel, *Captain of death: the story of tuberculosis;* McCuaig, *The weariness, the fever and the fret.*

However as they are dealing with different time periods and with circumstances which were not akin to Ireland their findings in general are not applicable to the areas covered by this thesis. Barnes history of tuberculosis treatment in France concentrates on the nineteenth century concluding in 1919.The tuberculosis dispensary formed a cornerstone of the Irish tuberculosis service whereas dispensaries had a low status within the English system. The USA did not introduce anti tuberculosis vaccination in the form of BCG. In addition there was no central authority there responsible for tuberculosis control until after the commencement of the Second World War. As with much of American medical facilities many of their sanatoria were private institutions (in 1910 only one third of the then 400 sanatoria were state facilities). In Canada due to the lack of sanatoria the dispensary system developed along similar lines to France providing treatment as well as diagnosis.Greta Jones author of the only comprehensive history of tuberculosis in Ireland to date has pointed to the need for further studies on the tuberculosis epidemic in Ireland, 'its causes, course and the reaction of state and society'.[54] Using mainly hitherto unexplored and disconnected sources this thesis has provided new insights into the external influences that determined the forms of development of Irish sanatoria, the governance and financing of the institutions and how reforms and developments were shaped by the interaction of the political and health systems. In demonstrating how individual contributions, institutional practices, geographic location and evolving public attitudes to tuberculosis dictated how services evolved, in illustrating the importance of private philanthropy and the role of religious congregations in the provision of treatment facilities for children and in elucidating how advances in diagnostic and therapeutic treatments reduced the national significance of the disease this thesis has opened up avenues of exploration which merit further research.

[54] Jones, *Captain of all these men of death*, pp 234-5.

Appendices

Appendix 1

British institutions for the treatment of tuberculosis employing the 'Nordrach' treatment regime *c.* 1900, compiled from Frederick Rufenacht Walters, *Sanatoria for consumptives,* pp 333, 342-3, 351-2, 355, 358, 363, 369, 373-381, 386-391

Location	Year Opened	Medical Officers	Weekly Charge
England			
Cotswold Sanatorium, Cheltenham	1898	Dr S. T. Pruen, Dr C. Braine-Hartnell	5 guineas
Stourfield Park Sanatorium, Bournemouth	1899	Dr David Thompson	4-6 guineas
Linford Sanatorium, Ringwood, New Forest	1899	Dr Mander Smyth	5 guineas
Moorcote Sanatorium, Winchfield, Hampshire	1899	Dr W. Langworthy Baker	4-5 guineas
Durham Sanatorium, Horn Hall, Stanhope	1899	Dr John Gray	free to subscribing workmen
Mundesley Sanatorium, Norfolk	1899	Dr Burton Fanning	
Nordrach-upon-Mendip	1899	Dr Thurnam Dr Gwynne	5 guineas
Crooksbury Sanatorium, Farnham, Surrey	1900	Dr Frederick R. Walters	from 4 ½ guineas
Brinklea Sanatorium, Bournemouth	1900	Dr Kinsey Morgan	4-6 guineas
Brookside Close Colchester	1900	Dr Jane Walker, Miss Sharpe	2 guineas
East Anglian Sanatorium Colchester	1900	Dr Jane Walker, Miss Paine	4-6 guineas
Alderney Manor, Bournemouth	1901	Dr Denton Jones	from 4 guineas
Dunstone Park Consumptive Home, Paignton, Devon	1902	Dr Alexander	5 guineas
Timbercombe, Bridgewater, Somerset		Dr Brown	3 guineas
Ireland			
Rossclare, Fermanagh	1899	Dr P. S. Hitchens	3 ½ guineas
Altadore, Wicklow	1902	Dr J. C. Smyth	4-5 guineas
Wales			
Nordrach-in-Wales, Pendyffryn Hall, Conway		Dr G. Morton Wilson	5 guineas
Scotland			
Bridge of Weir Consumption Sanatorium,Renfrewshire	1898	Dr Campbell	free for the poor
Woodburn Sanatorium, Edinburgh	1899	Dr J. J. Galbraith	5 guineas
Nordrach-on-Dee, Banchory	1900	Dr D. Lawson, Dr N. Bardswell	5 guineas

Appendix 2

Membership of Provisional Committee of National Hospital for Consumption for Ireland November 1891 as set out in the minutes of first meeting of the provisional committee of the project for the erection of the National Hospital for Consumption for Ireland, 20 November 1891 (Newcastle Hospital archives)

Name	Address	Occupation
John K. Barton	6 Merrion Square, Dublin	Surgeon to the Adelaide Hospital
Thomas Wrigley Grimshaw	Priorsland, Carrickmines, Co. Dublin	Registrar General for Ireland
John Magee Finny	36 Merrion Square, Dublin	President of the Royal College of Physicians of Ireland
Edward Bennett	26 Lower Fitzwilliam Street, Dublin	Professor of Surgery Trinity College Dublin, Surgeon to Sir Patrick Duns Hospital
George Symes	Mount Druid, Killiney, County Dublin	Stockbroker
Robert O'Brien Furlong	Clonevin, K Killiney, County. Dublin	Barrister-at-law
James Forrest	Thornhill, Blackrock, County Dublin	Merchant
John W. Moore	40 Fitzwilliam Square, Dublin	Physician to the Meath Hospital
William Watson	25 Fitzwilliam Place, Dublin	Businessman
Miss Alice Goodbody	Obelisk Park, Blackrock, County Dublin	
Miss Emily C. M. Wynne	The Providence Home, Charlemount Street, Dublin	Lady Superintendent
Miss Florence E. L. F. Wynne	115 Lower Baggot Street, Dublin	

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Appendix 3

Additional members of Provisional Committee of National Hospital for Consumption for Ireland recruited between first and second meetings December 1891 as set out in the minutes of second meeting of the provisional committee of the project for the erection of the National Hospital for Consumption for Ireland, 8 December 1891 (Newcastle Hospital archives)

Name	**Address**	**Occupation**
Philip Crampton Smyly	4 Merrion Square, Dublin	Physician to the Lord Lieutenant of Ireland
William Smyly	The Masters House, Rotunda Hospital, Dublin	Master of the Rotunda Hospital
Charles Uniake Townsend	Hatley, Burlington Road., Dublin	Land Agent
The Duchess of Leinster	Carton, Maynooth, County Kildare	
Mrs. Forrest	Thornhill, Blackrock, County Dublin	
Mrs Walter Wilson	Stranmillis, Belfast	

Appendix 4

Membership of first executive committee of the National Hospital for Consumption for Ireland January 1892 as set out in the minutes of the sixth meeting of general committee, 27 Jan. 1892 (Newcastle Hospital archives)

President of the RCPI	George Symes	William Kenny
President of the RCSI	Henry P. Goodbody	John R. Orpen
Colonel Gerald R. Dease	Charles U. Townsend	Thomas Plunkett Cairnes
Thomas J. Stafford M.D.	William Watson	
James Forrest	Thomas. W. Grimshaw	
Robert O'Brien Furlong	Sir Percy Grace	

Appendix 5

Voluntary consultant physicians appointed to the National Hospital for Consumption for Ireland, Newcastle, County Wicklow 1896 compiled from minutes of meetings of the board of governors, 28 Apr. 1896, 12 May 1896, 9 June 1896 (Newcastle Hospital archives)

Consultant Physicians	Nominating Hospital
Sir Francis R. Cruise	Mater Misericordiae
Wallace Beatty	Adelaide
James B. Coleman	Jervis Street
Michael F. Cox	St Vincent’s
Thomas P. Mason	Mercer's
John W. Moore	Meath
Guy P. Nugent	House of Industry
Henry C. Tweedy	Dr Steevens'

Appendix 6
National Association for the Prevention of Tuberculosis Dublin branch handbill 1906

Information for

CONSUMPTIVE PEOPLE

and those who live with them.

Consumption is preventable.

Consumption is not usually inherited, although some children are born with a constitution which favours them catching it.

Intemperance; overcrowding; the stuffy air of ill ventilated rooms, dirty, damp, or dark dwellings are among the cause which render people liable to consumption.

Consumption is caused by very small living germs, which may enter the body by the air or by the food.

Cows suffer from consumption and the milk from consumptive cows is likely to contain the germs of the disease.

PRECAUTIONS- WHAT NOT TO DO.

A consumptive person must NOT spit on the footpath, or on the floor of any room, railway carriage, tramcar, cab, etc. Such person should neither swallow the spit nor allow it to be smeared on the bedclothes, beard or wearing apparel. He should carefully guard his mouth with the hand when in the act of coughing and those who live with him should avoid too close approach, especially if the attacks of coughing sre frequent and violent.

A window or chimney of a living room should NOT be kept always closed, especially if the room is inhabited by a consumptive person.

A consumptive person should NOT sleep in the same bed as another person.

A consumptive mother must NOT suckle a baby.

Overcrowding should be avoided.

ADVICE - WHAT TO DO TO PREVENT CONSUMPTION

Many persons recover from consumption.

Good health is the best protection against the disease.

FRESH AIR, LIGHT, and SUNSHINE are most important in the prevention and cure of consumption; therefore you should keep your rooms well ventilated, lightsome, and free from dust,

Keep the windows open as much as possible, for pure air and sunshine destroy the germs of the disease. The more fresh air and sunshine a consumptive person gets the more likely he or she is to recover.

A consumptive person should spit into a handkerchief out of doors or a cup containing a little water indoors. The contents should be burnt and the handkerchief should be thrown into boiling water and left there for a few minutes before being washed. If rags or paper are used to spit into they should be burnt at once.

Rooms, passages and staircases should be kept free from dust by the use of damp cloths; for dust is dangerous to breathe. Floors should be swept with tea-leaves.

Rooms that have been occupied by consumptives should be thoroughly cleansed and disinfected before they are again occupied, as also should the carpets and bedding etc. Houses, rooms bedding, etc., will be disinfected by the sanitary authorities on application to the department of the Superintendent Medical Officer of Health, Municipal Offices, Cork Hill.

MILK, more especially that intended for young children, should be brought to the boil before being used.[1]

[1] Dublin Corporation reports 1907. Report upon the state of public health and the sanitary work performed in Dublin during the year 1906, pp 57-9.

Appendix 7

Distribution of district nurses employed in Leinster by branches of the Women's National Health Association and otherwise in 1910 compiled from Women's National Health Association of Ireland, *Report for 1910* (NAI Priv/1212/wnha/6/1)

County	Category of person employed	Employed by WNHA branches	Employed otherwise
Carlow	Nurse	1	
Dublin	Jubilee Nurse	4	6
	Nurse	1	
Kildare	Jubilee Nurse	2	6
	Nurse		2
Kilkenny	Jubilee Nurse	1	1
	Nurse		1
Longford	Jubilee Nurse	1	
	Nurse	1	
Louth	Jubilee Nurse	1	1
Meath	Jubilee Nurse	5	
Offaly	Jubilee Nurse	1	
Westmeath	Jubilee Nurse	1	
Wexford	Jubilee Nurse	1	1
	Jubilee Health Worker	1	
Wicklow	Jubilee Nurse	1	2
	Nurse	1	2

Appendix 8

Membership of Dublin Hospitals Tuberculosis Committee 1907 compiled from the minutes of the meeting of a special conference of representatives of the Dublin clinical hospitals, 26 November 1907 (NAI, Priv/1212/wnha/1/15)

Name	**Organisation**
Sir John Moore, chairman	Meath Hospital
Sir William J. Thompson, hon. sec.	Jervis Street Hospital
Lady Ishbel Aberdeen	Women's National Health Association
Sir Arthur Chance	Mater Misericordiae Hospital
Alfred R. Parsons	City of Dublin Hospital
Henry C. Drury	Sir Patrick Dun's Hospital
Michael F. Cox	St Vincent's Hospital
Percy C. Kirkpatrick	Steevens' Hospital
J. Lumsden	Mercer's Hospital
Joseph O'Carroll	Richmond Hospital
George J. Peacock	Adelaide Hospital

Appendix 9

Schedule of dispensary opening times adopted by County Wexford Tuberculosis Management Committee in April 1914 as set out in the committee's minutes 15 April 1914

Location	Attendance Day	Time
Gorey	Monday	11:30 AM
New Ross	Tuesday	11:30 AM
Wexford	Wednesday	10:00 AM
Enniscorthy	Thursday	11:00 AM
Newtownbarry	alternate Thursdays	1:30 PM
Ballycullane	alternate Fridays	1:30 PM

Appendix 10

Location of branch tuberculosis dispensaries in Leinster counties in 1914, Compiled from *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1914, being the forty-second report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cd 7561], H.C. 1914, xxxix, 595

County	Location of branch dispensaries
Carlow	Bagenalstown, Borris, Tullow, Rathvilly, Hacketstown
Kildare	Monastereven, Maynooth, Celbridge, Athy, Castledermot, Naas, Newbridge, Carbury, Rathangan, Kildare
Kilkenny	Thomastown, Kilmoganny, Pilltown, Callan, Freshford, Johnstown
King's County	Birr, Edenderry, Shinrone, Banagher, Ferbane
Louth	Ardee, Carlingford
Queen's County	Abbeyleix, Ballickmoyler, Mountmellick, Mountrath, Portarlington, Rathdowney, Stradbally
Westmeath	Athlone, Multyfarnham, Tyrellspass, Moate, Delvin, Castlepollard
Wexford	Enniscorthy, New Ross, Gorey, Newtownbarry, Ballycullane

Appendix 11
Institutions approved by the Local Government Board for Ireland for the treatment of tuberculosis in Leinster 1913-1920[1]

Name of Institution	Location	Year approved	Cases for which approved
Royal Sanatorium for Consumption	Newcastle Co. Dublin	1912-14	Pulmonary tuberculosis
Crooksling Sanatorium	Brittas Co. Dublin	1912-13	Pulmonary tuberculosis
Alan A. Ryan Hospital	Pigeon House Rd Dublin	1912-13	Pulmonary tuberculosis
Peamount Sanatorium	Lucan Co.Dublin	1912-13	Pulmonary tuberculosis
Our Lady's Hospice for the Dying	Harolds Cross Dublin	1912-13	Advanced cases
House of Rest for the Dying	Camden Row Dublin	1912-13	Advanced cases
Jervis Street Hospital	Jervis St Dublin	1912-13	Surgical tuberculosis
Dublin Skin Cancer and Urinary Hospital	Hume St. Dublin	1912-13	Skin tuberculosis
St Vincent's Hospital	St Stephen's Green Dublin	1912-13	Surgical tuberculosis
Louth County Infirmary	Dundalk Co. Louth	1912-13	Surgical tuberculosis
Meath Hospital Dublin County Infirmary	Dublin	1912-13	Surgical tuberculosis and advanced cases
Richmond Hospital	North Brunswick St Dublin	1912-13	Surgical tuberculosis
Whitworth Hospital	North Brunswick St Dublin	1912-13	Advanced cases of surgical tuberculosis
Hardwicke Fever Hospital	North Brunswick St Dublin	1912-13	Miliary tuberculosis and tubercular meningitis
Queen's County Infirmary	Maryborough Queen's Co.	1912-13	Surgical Tuberculosis
Children's Hospital	Temple St Dublin	1912-13	Surgical tuberculosis
Adelaide Hospital	Dublin	1913-13	Surgical tuberculosis and advanced cases
Royal City of Dublin Hospital	Upper Baggot St Dublin	1912-13	Surgical tuberculosis and advanced cases
King's County Infirmary	Tullamore King's Co.	1912-13	Surgical tuberculosis
Rotunda Hospital	Dublin	1912-12	Surgical tuberculosis in pregnant women
Dr Steevens' Hospital	Dublin	1912-12	Surgical tuberculosis
Carlow County Infirmary	Carlow	1912-13	Surgical tuberculosis
Sir Patrick Dun's Hospital	Dublin	1912-13	Surgical tuberculosis
Mercer's Hospital	Dublin	1912-13	Surgical tuberculosis
The Coombe Hospital	Dublin	1912-13	Surgical tuberculosis in pregnant women
Larch Hill Sanatorium	Rathfarnham Co. Dublin	1912-13	Pulmonary tuberculosis
Meath Convalescent Home	Bray Co. Wicklow	1912-13	Surgical tuberculosis and advanced cases

Appendix 11 (*continued)*

Institutions approved by the Local Government Board for Ireland for the treatment of tuberculosis in Leinster 1913-1920

Name of Institution	Location	Year approved	Cases for which approved
Incorporated Orthopaedic Hospital of Ireland	Upper Merrion St Dublin	1912-13	Surgical tuberculosis
Convalescent Home for Little Children	Cheeverstown Co. Dublin	1913-14	Surgical tuberculosis
Linden Convalescent Home	Blackrock Co. Dublin	1913-14	Surgical tuberculosis
National Children's Hospital	Harcourt St Dublin	1913-14	Surgical tuberculosis
Meath County Infirmary	Navan Co. Meath	1913-14	Surgical tuberculosis
Wexford County Infirmary	Wexford	1913-14	Surgical tuberculosis
Cork St Fever Hospital	Dublin	1913-14	Tubercular peritonitis and meningitis
Kilkenny County Infirmary	Kilkenny	1913-14	Surgical tuberculosis
Drumcondra Hospital	Whitworth Rd Dublin	1914-15	Surgical tuberculosis
Mater Misericordiae Hospital	Dublin	1916-17	Surgical tuberculosis
Our Lady of Lourdes Hospital	Kill o' the Grange Co. Dublin	1917-18	Advanced cases
Kildare County Infirmary	Kildare	1918-19	Surgical tuberculosis
Kilkenny Tuberculosis Institution	Kells Rd Kilkenny	1918-19	Pulmonary tuberculosis and advanced cases
King's County Tuberculosis Institution	Tullamore King's Co.	1919-20	Pulmonary tuberculosis

[1]Compiled from *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1913, being the forty-first report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cd 6978], H.C. 1913, xxxii, 457. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1914, being the forty-second report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cd 7561], H.C. 1914, xxxix, 595. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1915, being the forty-third report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cd 8016}, H.C. 1914-16, xxv, 314. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1917, being the forty-fifth report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1[Cd 8765], H.C. 1917-18, xvi, 257. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1918, being the forty-sixth report under the "Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., s. 69,* 1 [Cmd 65], H.C. 1919, xxv, 1. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1919, being the forty-seventh report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cmd 578], H.C. 1920, xxi, 1. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1920, being the forty-eighth report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cmd 1432], H.C. 1921, xiv, 781.

Appendix 12

Distribution of deaths in Ireland 1864-1920 from tuberculosis and respiratory disease at home, in institutions and workhouses [i]

Date	Total No. of deaths	No. of tuberculosis deaths	No. of respiratory disease deaths incl. pneumonia	No. of deaths respiratory disease and tuberculosis	No. of deaths in own home	No of deaths in institutions	% of total deaths in institutions	No. of deaths in workhouses	% of total deaths in workhouses	% of total deaths due to respiratory disease/tuberculosis	No. of deaths due to respiratory disease/tuberculosis in workhouses	% of total deaths due to respiratory disease/tuberculosis in workhouses
1864	93144	16686	15433	32119						34		
1869	89593	13234	12845	26079						29		
1874	91961	12547	11419	23966						26		
1879	105089	14164	18441	32605						31		
1884	87154	13446	13084	26530	73186	13968	16	10946	13	30	3464	4
1889	82908	12632	13545	26177	70245	12663	15	9745	12	32	2822	3
1894	83528	12125	14139	26264	70788	12740	15	9329	11	31	2849	3
1899	79699	12812	12259	25071	65851	13848	17	9657	12	31	2830	4
1900	87606	12848	15157	28005	72322	15284	17	11131	13	32	3268	4
1901	79119	12323	13370	25693	64942	14177	18	10104	13	32	3089	4
1902	77676	11837	13644	25481	63178	14498	19	10080	13	33	2868	4
1903	77358	12180	12946	25126	62933	14425	19	10118	13	32	3294	4
1904	79513	12694	13441	26135	64345	15168	19	10709	13	33	3481	4
1905	75071	11882	12633	24515	60277	14794	20	10371	14	33	3225	4
1906	74427	11756	12479	24235	59224	15203	20	10721	14	33	3520	5
1907	77334	11679	13349	25028	61459	15875	21	11096	14	32	3783	5
1908	76891	11293	13294	24587	60857	16034	21	11268	15	32	3782	5
1909	74973	10594	13330	23924	59713	15260	20	10353	14	31	3653	5
1910	74894	10016	12940	22956	59456	15438	20	10407	14	31	3954	5
1911	72475	9623	10421	20044	57501	14974	21	9904	14	28	3293	5

Appendix 12 (*continued)*

Distribution of deaths in Ireland 1864-1920 from tuberculosis and respiratory disease at home, in institutions and workhouses

Date	Total No. of deaths	No. of tuberculosis deaths	No. of respiratory disease deaths incl. pneumonia	No. of deaths respiratory disease and tuberculosis	No. of deaths in own home	No of deaths in institutions	%of total deaths in institutions	No. of deaths in workhouses	%of total deaths in workhouses	% of total deaths due to respiratory disease/tuberculosis	No. of deaths due to respiratory disease/tuberculosis in workhouses	% of total deaths due to respiratory disease/tuberculosis in workhouses
1912	72187	9427	10929	20356	56864	15323	21	9977	14	28	3381	5
1913	74694	9387	10524	19911	59169	15525	21	10193	14	27		
1914	71345	9089	9855	18944	56010	15335	21	9767	14	27		
1915	76151	9525	11536	21061	60028	16123	21	10516	14	28		
1916	71391	9323	9574	18897	55868	15523	22	9751	14	26		
1917	72724	9680	10675	20355	56993	15731	22	10080	14	28		
1918	78695	9576	11914	21490	61200	17495	22	10540	13	27		
1919	78612	8643	11838	20481	62197	16415	21	10182	13	26		
1920	66538	7651	9375	17026	51794	14744	22	8919	13	26		

[i] Compiled from *Annual reports of the Registrar-General (Ireland),* 1868-1921, *Annual reports of the Commissioners for Administering the Laws for Relief of the Poor in Ireland* 1854-55 to1870 and *Annual reports of the Local Government Board for Ireland* 1875-1921.

Appendix 13
Percentage of institutional deaths occurring in all Irish workhouses 1884-1920 compiled from *Annual reports of the Registrar-General (Ireland),* 1884-1921, and *Annual reports of the Local Government Board for Ireland* 1884-1921

Date	% of institutional deaths occurring in workhouses	Date	% of institutional deaths occurring in workhouses
1884	78	1909	68
1889	77	1910	67
1894	73	1911	66
1899	70	1912	65
1900	73	1913	66
1901	71	1914	64
1902	70	1915	65
1903	70	1916	63
1904	71	1917	64
1905	70	1918	60
1906	71	1919	62
1907	70	1920	60
1908	70		

Appendix 14

Note on workhouse deaths in Ireland attributable to tuberculosis 1854-1920

In 1854-55, 2,353 tuberculosis deaths were recorded in workhouses nationally, accounting for fifteen percent of the total workhouse deaths, which numbered 15,808 (see chart below). Over the next ten years the number of tuberculosis deaths in workhouse infirmaries appears to have dropped, accounting for 13% of the deaths recorded in 1859-60 and 9% of the deaths recorded in 1864-65. However the variation in the figures may be attributed to the inaccuracy of the classification system used. A catch-all category of deaths from 'inflammation of the lungs' clearly contained a number of deaths which should have been attributed to tuberculosis. The registrar-general for Ireland was aware of this anomaly. Writing about causes of death in 1884 he stated that 'many persons suffering from but slightly developed forms of consumption are attacked by bronchitis, pneumonia (inflammation of the lungs) or other forms of acute lung disease, whereas the chronic consumption, from which the patient previously suffered, may have been and probably was the determining cause of the fatal event'.[1]

This statistical error in the diagnosis of tuberculosis can be clearly seen by an examination of the returns for the years 1907-8 to 1910-11. In 1907-8, 833 of workhouse deaths were recorded from tuberculosis, 7% of the total, while that year 3,066 deaths, 27% of the total were attributed to inflammation of the lungs. The corresponding figures for 1908-9 were 1,290 tuberculosis deaths and 2,301 deaths from inflammation of the lungs 12% and 21% of the total respectively. In 1909-10 a new more rigorous classification system was introduced. No longer were deaths from lung inflammation lumped together in one category. Instead such deaths were categorised as deaths due to diseases of the respiratory system and divided into the subcategories of deaths from bronchitis, pneumonia and other more rare respiratory diseases. This new system appears to have concentrated the minds of workhouse doctors in ensuring that more correct returns were made and more diligence exercised in classifying the cause of death. As a result the returns for 1909-10 showed 1916 workhouse deaths from tuberculosis, 18% of the total and 1788 from diseases of the respiratory system, 17% of the total. The following year 1910-11 the corresponding figures were 1,929 tuberculosis deaths and 1,576 respiratory system deaths, nineteen and fifteen percent of the total workhouse deaths respectively. With no great change in circumstances occurring to account for the increased number of tuberculosis deaths over the period 1907-11, it is clear that under the previous classification system there was a considerable underreporting of tuberculosis deaths. Therefore in order to get a more accurate depiction of the magnitude of tuberculosis deaths it is necessary to look at the combined total of deaths from tuberculosis and inflammation of the lungs in the certain knowledge that somewhat over fifty percent of the latter deaths were in fact from tuberculosis.

From 1854 to 1885 between 24% and 27% of workhouse deaths were attributed to tuberculosis and inflammation of the lungs. From 1890 to 1903 the same diseases accounted for between 29% and 31% of workhouse deaths. In the period 1904 to 1909 workhouse deaths from these causes continued to increase registering between 32% and 34% of the total. From 1910 to 1918 between 16% and 19% of workhouse deaths were attributable to tuberculosis alone. Although in 1918-19 the percentage of workhouse deaths attributable to tuberculosis dropped to 12% in real terms, they increased

[1] *Supplement of the seventeenth report of the Registrar-General of Marriages, Births, and Deaths in Ireland, containing decennial summaries for the years 1871-1880,* 1 [C. 4153], H.C. 1884, xx, 983.

marginally to 1,487 from the previous year, when 1,469 tuberculosis deaths were recorded. The percentage drop can be explained by the large increase in workhouse deaths, as a result of the Spanish flu epidemic of that year, from 8,786 in 1917-18 to 12,115 in 1918-19.[2] However in 1919-20 the number of recorded workhouse deaths due to tuberculosis declined to 1147, 13% of the total.

[2] Caitriona Foley, *The last Irish plague* (Dublin, 2011), pp 35-6.

Appendix 14 (*continued*)

Workhouse deaths in Ireland 1854-1920 attributable to tuberculosis and lung diseases compiled from the annual reports of the Commissioners for Administering the Laws for Relief of the Poor in Ireland 1854-55 to 1870 and the annual reports of the Local Government Board for Ireland 1875-1921

Year	Total deaths from all causes	Deaths attributed to Inflammation of lungs/ respiratory system	Deaths attributed to Tuberculosis	Deaths attributed to Inflammation etc % of total	Deaths attributed to Tuberculosis % of total	Combined Deaths Tuberculosis/ inflammation % of total
1854-5	15808	1824	2353	12	15	26
1859-60[2]	7105	972	908	14	13	26
1864-5	12901	1952	1174	15	9	24
1869-70	11801	1933	1014	16	9	25
1874-5	10968	1645	1074	15	10	25
1879-80	12789	2274	1089	18	9	26
1884-5	11238	1929	1158	17	10	27
1889-90	10973	2019	1240	18	11	30
1894-5	9701	1816	1165	19	12	31
1899-1900	11151	1940	1399	17	13	30
1900-1	9980	1570	1282	16	13	29
1901-2	10025	1711	1344	17	13	30
1902-3	10123	1628	1355	16	13	29
1903-4	10492	2215	1219	21	12	33
1904-5	11372	2504	1122	22	10	32
1905-6	10319	2347	905	23	9	32
1906-7	11121	2792	903	25	8	33
1907-8	11430	3066	833	27	7	34
1908-9	10950	2301	1290	21	12	33
1909-10	10455	1788	1916	17	18	35
1910-11	10406	1576	1929	15	19	34
1911-12	10084	1480	1845	15	18	33
1912-13	10167	1394	1929	14	19	33
1913-14	10348	1331	1830	13	18	31
1914-15	10502	1527	1734	15	17	31
1915-16	9981		1567		16	
1916-17	10634		1721		16	
1917-18	8786		1469		17	
1918-19	12115		1487		12	
1919-20	8580		1147		13	

[2]Relates to forty-four week period.

Appendix 15

Mortality rates from tuberculosis in Ireland 1900-1920[1]

Year	TB death rate per 100,000 population
1900	274
1901	266
1902	255
1903	262
1904	277
1905	259
1906	255
1907	255
1908	250
1909	234
1910	224
1911	212
1912	210
1913	210
1914	205
1915	219
1916	211
1917	218
1918	212
1919	188
1920	165

[1] Extracted from compilation in R. C. Geary, 'The mortality from tuberculosis in Saorstat Eireann. A statistical study in *Journal of the Statistical and Social Inquiry Society of Ireland*, xiv, 7 (1929/30), pp 67-103.

Appendix 16
Workhouse deaths in Leinster 1899-1908[1]

Year	Deaths nationally in workhouses	Deaths in Leinster workhouses	%of workhouse deaths occurring in Leinster
1899-1900	11514	3979	35
1900-1901	10023	3460	35
1901-1902	9881	3367	34
1902-1903	10239	3483	34
1903-1904	10705	3655	34
1904-1905	10322	3411	33
1905-1906	10366	3472	33
1906-1907	11131	3728	33
1907-1908	11520	3919	34

[1] Compiled from *Annual report of the Local Government Board for Ireland, for the year ended March, 1900, being the twenty-eighth report under "the Local Government Board (Ireland) Act." 35 & 36 Vic., c. 69,* 1 [Cd. 338], H.C. 1900, xxxv, 1. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1901, being the twenty-ninth report under "the Local Government Board (Ireland) Act 1872," 35 & 36 Vic., c. 69,* p.1, [Cd 1259], H.C. 1902, xxxvii,1. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1902, being the thirtieth report under "the Local Government Board Ireland Act, 1872," 35 & 36 Vic., c. 69,* p.1, [Cd 1606], H.C. 1903, xxv, 531. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1903, being the thirty-first report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cd. 2012], H. C. 1904, xxvii, 1. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1904, being the thirty-second report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,* 1 [Cd. 2320], H.C. 1905, xxxii, 703. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1905, being the thirty-third report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69,*1 [Cd. 2655], H.C. 1905, xxxiii, 1. Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1906, being the thirty-fourth report under "the Local Government Board (Ireland) Act, 1872," 35 & 36 Vic., c. 69, p.1, [Cd 3102], H.C. 1906, xxxvi, 495. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1907, being the thirty-fifth report under "the Local Government Board (Ireland) Act, 1872," 35 &36 Vic., c. 69.* [Cd. 3682], H.C. 1907, xxviii, 1. *Annual report of the Local Government Board for Ireland, for the year ended 31st March, 1908, being the thirty-sixth report under "the Local Government Board (Ireland) Act, 1872," 35 &36 Vic., c. 69,* 1 [Cd.4243], H.C. 1908, xxxi, 1.

Appendix 17

Tuberculosis dispensaries in Leinster (excluding Dublin) 1947[1]

County	**Distribution of Tuberculosis Dispensaries** Frequency of clinics (where known) (w)weekly (f)fortnightly (m)monthly	**Nurses**	**Domiciliary visits by nurses**	**County Population**	**Area of County** (Sq. Miles)
Carlow	Monacurra (w), Tullow (w), Muinebeag (w), Borris (w) Total 4	1 Public Health 2 Jubilee	1,233	34,452	346
Kildare	Naas (f), Athy (f), Monasterevin (f), Kildare (f), Newbridge (f), Maynooth (m) Total 6	1 Public Health 14 Jubilee	1,300 (1939)	64,559	654
Kilkenny	Kilkenny (w), Castlecomer (f), Glenmore (m), Thomastown (m), Graiguenamanagh (m), Gowran (m), Callan (f), Kilmacow (f) Johnstown (m) Total 9	2 Public Health 8 Jubilee	2,988 (1945)	68,006	796
Laois	Portlaoise (w), Portarlington (m), Rathdowney (m), Mountrath (m), Abbeyleix (f), Mountmellick (f) Stradbally (f), Ballylinan (m), Borris-in-Ossory (by appointment) Total 9	2 Public Health 3 Jubilee	450	49,260	664
Longford	Longford, Granard, Ballymahon, Mostrim, Colehill, Ballinalee, Smear, Drumlish, Newtowncashel Total 9	1 Public Health 1 Jubilee	n/a	37,107	403
Louth	Dundalk (w), Drogheda (w), Ardee (f) Total 3	2 Public Health 3 Jubilee	672	65,108	318
Meath	Trim (w), Navan (w), Kells (f) Total 3	2 Public Health 8 Jubilee	2283	65,298	905

Continued over

Appendix 17 (*continued*)

Tuberculosis dispensaries in Leinster (excluding Dublin) 1947

County	**Distribution of Tuberculosis Dispensaries** Frequency of clinics (where known) (w)weekly (f)fortnightly (m)monthly	**Nurses**	**Domiciliary visits by nurses**	**County Population**	**Area of County** (Sq. Miles)
Offaly	Tullamore (w), Birr (f), Edenderry (f), Portarlington (m), Cloneygowan (m), Glashill (m), Clara (m), Banagher (m), Cloghan (m), Ferbane (m), Daingean (m), Shinrone (m), Moneygall (m), Kilcormac (m) Total 14	2 Public Health 2 Jubilee	n/a	53,644	771
Westmeath	Athlone (f), Mullingar (w), Moate (m), Castlepollard (m), Tyrellspass (m), Ballymore (m), Delvin (m), Kilbeggan (m) Total 8	2 Public Health 4 Jubilee	2,124	56,133	710
Wexford	Wexford (w), Enniscorthy (f), Gorey (f), New Ross (f), Ballycullane (m) Total 5	2 Public Health 5 Jubilee	3,223	91,136	909
Wicklow	Rathdrum (f), Arklow (m), Baltinglass (m), Blessington (m), Bray (m), Delgany (m), Tinahealy (m), Wicklow (m) Total 8	1 Public Health 8 Jubilee	3,372	58,295	782

Compiled from reports on operation of county tuberculosis schemes, 12 July 1948 (NAI, Health D112/361). Report by E. J. McWeeney medical inspector on inspection 2 May 1940 in County Kildare (NAI, Health D13/57). *Annual report of county medical officer of health, County of Carlow, 1947,* p. 33 (HSE library Kilkenny). *Offaly, annual report of the acting county medical officer of health, 1947,* p. 36 (OCC, archives). Report on inspection in County Kilkenny 4-5 Jan. 1946. Report by E. J. McWeeney, 27 Oct. 1947 on inspection 10-11 Oct 1947 (NAI, Health D14/48). *Meath Chronicle,* 6 Sept. 1947.

Appendix 18

St Ultan's children's hospital Dublin TB patient statistics 1960-69 compiled from *St Ultan's Hospital annual reports 1960-69*

Year	No. of TB admissions	No. of visits to TB clinic
1960	26	77
1961	26	64
1962	16	38
1963	17	9
1964	8	16
1965	11	11
1966	5	6
1967	3	3
1968	4	3
1969	1	4

Appendix 19

Catholic chaplains employed in Blanchardstown sanatorium, County Dublin 1955-1968[1]

Name	Period of employment
Fr Michael Geaney	23 July 1955 – 28 July 1956
Fr Cornelius Sayers	28 July 1956 – 22 June 1957
Fr John Stokes	22 June 1957 – 21 December 1957
Fr Thomas Cullen	21 December 1957 – 15 August 1959
Rev. Cornelius Dowling	16 August 1959 – 28 July 1961
Rev. Seamus Cassidy	29 July 1961 – 7 December 1963
Rev. Francis Dooley	8 December 1963 – 25 July 1964
Rev. Eoin Murphy	26 July 1964 – 12 September 1964
Rev. Patrick Gleeson	13 September 1964 – 26 June 1965
Rev. Benedict Mulligan	27 June 1965 – 5 August 1967
Rev. Enda Lloyd	5 August 1967 – 2 December 1967
Fr D. McMahon CSSP	3 December 1967 – 22 January 1968

[1]Data abstracted from personnel files maintained in hospital manager's office, Connolly Memorial Hospital, Blanchardstown, County Dublin.

Appendix 20

Mass x-ray service in Ireland 1953-1960[1]

Year	X-rayed	Displaying abnormalities	Further investigation	Active TB
1953-4	177,901	7,924	5,786	711
1954-5	188,878	7,853	5,678	659
1955-6	200,195	9,444	2,460	157
1956-7	243,821	10,462	2,752	
1957	293,091		5,600	1,200
1958	272,662		5,720	1,100
1959	303,917		5,811	1,000
1960	264,996	4,673	2,567	

[1]Compiled from P. Ó Cinnéide to each County Secretary, 17 Jan. 1957 and 14 Jan. 1958 (NAI, Health BD 114/9). *Irish Times*, 13 Feb. 1959, 26 Feb. 1960 and 8 April 1961. *Irish Independent*, 13 Feb. 1959. *Irish Press*, 30 Dec. 1958, 13 Feb. 1959 and 26 Feb. 1960.

Appendix 21

The impact of hospital rules on patients

All aspects of patient's lives in the sanatoria were regulated by the rules of the institutions, with most adopting rules similar to those applied in Newcastle(see pp 74-5). In Crooksling, where recreation space was allocated strictly on a gender basis, to ensure the complete segregation of the sexes all communications between male and female patients were initially banned. To ensure no illicit messages could be passed or inducements offered to assist in the breaching of other rules communication was also forbidden with servants of the institution.[1] By the early 1950s the rules had been eased to permit communication with prior staff consent.[2]

Most institutions, to keep patients occupied, permitted various forms of games and entertainment. These were frequently organised by patient committees. From the mid 1930s in Our Lady of Lourdes Hospital, Dun Laoghaire, the entertainment committee organised film shows, whist drives and concerts with occasionally visiting artistes on 'feast days, church holidays and bank holidays. Although the males and females occupied separate parts of the ward where the films were shown, the males availed of every opportunity 'to chat with the girls'. Communication was easier at the whist drives held in the sun-room, although the girls were only permitted to enter at 'the last minute'.[3] With the nuns attention riveted on the entertainment at the concerts, also held in the sun-room 'some of the boys and girls held hands at the back'.[4] As male patients recovered in this institution, relaxation of the rules enabled a patient to be 'free to spend my afternoons where and how I wished as long as I was back in bed for rest hour at five o'clock'. This enabled patients become familiar with the local area and to 'get to know' the local public houses. These measures created in the institution an atmosphere which provided 'a sense of freedom, companionship and devil-may-careness.[5]

In Peamount from the 1940s the patients committee organised various entertainments including theatrical productions, bingo, cinema shows, concerts by visiting societies, billiards and clock golf. Radios were provided in the wards and a well stacked library

[1] 'Dublin Corporation – Crooksling sanatorium rules governing the conduct of patients in the sanatorium' (NAI, Health AD 34 D3).
[2] 'Dublin Corporation Crooksling sanatorium rules and information for patients'(NAI, Health AD 34 D3).
[3] William J. Heaney, *House of courage* (Dublin, 1952), pp 75-6.
[4] Ibid., pp 109-10.
[5] Ibid., 68-9.

provided books. The film shows and bingo gave male and female patients a chance to meet. 'Many male patients took nurses and other female friends for walks in the adjoining fields'. Resulting from this regime, 'a great camaraderie prevailed' amongst the patients.[6]

Following its opening as a tuberculosis institution, the rules in St Mary's Hospital, Phoenix Park were rigorously enforced by Dr C. K. McArdle, the medical superintendent. He dismissed 'a fair few patients' for breaking the rules. Breaking bounds, consumption of alcohol and contact between male and female patients were the most common infractions. To ensure there was no contact between the sexes separate dining facilities had been provided. McArdle observed visitors arriving and if he found them in possession of alcohol declared 'if he has that tonight he will go home tomorrow'. The catholic chaplain to the hospital frequently tried 'to rescue the patients from McArdle'. His pleading of their cases often resulted in them remaining in the hospital. Entertainment took the form of concerts by visiting professional performers. These were organised by McArdle and took place only 'spasmodically'.[7]

In Blanchardstown, the units were segregated on a gender basis and a strict regime similar to 'boarding school life' existed. In the early 1960s patients confined to the wards played cards for small sums of money and placed bets with local bookmakers courtesy of the hospital porters.[8] When patients had reached a certain stage of recovery they were 'allowed up for walks, trips to the shop (located immediately outside the main entrance), cinema, church etc.'.[9] These male and female ambulant patients met at mass and organised activities such as the pictures, weekly bingo and organised concerts (broadcast to all the units), which took place in a building specifically provided for these purposes. On these occasions males were allowed escort females back to their wards but were not allowed to enter the buildings. For non-ambulant patients letters were smuggled by porters and nurses between male and female wards.[10] The rear entrance to the hospital grounds was used by ambulant patients to gain unsupervised access to the Greyhound Bar in Blanchardstown village and to return with alcohol for bed-bound patients. During

[6] Anna Day, *Turn of the Tide* (Dublin, 1987), p. 56 and pp 66-8.
[7] Interview with Jimmy Walsh.
[8] Quinn, *Sea of love*, pp 29-30.
[9] Ibid., p. 36.
[10] Ibid. pp 35-6 and pp 46-8. Interview with Fr Seamus Cassidy.

the early 1960s no patients appear to have been dismissed from the hospital for breaking the rules.[11]

[11] Interview with Fr Seamus Cassidy.

Appendix 22
Survival rate of patients discharged from Peamount Sanatorium in 1915[ii]

Year	No. of patients alive admitted in early stage of TB	No. of patients alive admitted moderately affected with TB	No. of patients alive admitted severely affected with TB
Discharged 1915	28	97	33
Alive 1920	23	73	15
Alive 1925	16	47	5
Alive 1930	9	21	2
Alive 1935	7	7	1
Alive 1938	4	3	0

[ii] Extracted from *Peamount annual report 1938-39* (NAI D 110P 22).

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