Conflict, Consensus and Charity: Politics and the Provincial Voluntary Hospitals in the Eighteenth Century[*]

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THE voluntary hospitals were amongst the most original and enduring monuments of Georgian England. Financed on the seemingly flimsy basis of voluntary benefactions and annual subscriptions,[1] they nevertheless flourished in the eighteenth century and subsequently became the leading medical institutions of the industrial age. By entitling even the small subscriber to recommend patients, they recruited substantial support amongst the large class of shopkeepers and traders; by weighting this power in proportion to the size of the contribution, they nevertheless preserved the pre-eminence of local magnates. By making subscription open to men and women of all confessions, they worked for the hegemony and unity of property against the threat of religious divisions; by enlisting subscribers as governors, they rewarded the act of giving with a share of power. Managed by honorary committees elected annually from the subscribers themselves, they enabled the shopkeeper to join the grandee in a common enterprise; by restricting committee membership to male subscribers, they kept within bounds the participation of 'the sex'. Through the annual publication of the financial accounts, the subscribers' names, and the numbers of patients `cured' and `relieved', they ensured probity of management, gave publicity to the subscribers great and small, and assured those subscribers that their money had been well spent. With their strong local roots, they promoted a sense of civic identity; by bringing together local medical men as honorary consultants, they helped to forge a professional medical community; by constructing a new context for medicine, they led to innovations in medical practice and teaching. And by making charity dependent upon the channel of personal recommendation, they exacted a political tribute from the sick poor who sought the benefit of their facilities. To each individual patient the hospitals made available a massive though brief donation of help in a time of need. To the poor collectively they offered a profound and highly visible subordination, translating the practice and rhetoric of personal dependence into an institutional setting)[2]

Although the voluntary-hospital form was invented in London, where the Westminster Infirmary was founded in *1719,* the wider hospital movement which dates from the *I730s* was just as strong in the provinces as in the capital. Like 'Sylvanus Urban', the pseudonymous editor of the *Gentleman's Magazine,* the provincial infirmaries elegantly united country and town - the two synergistic sources of polite Georgian culture. Most such infirmaries were county hospitals; all of them were situated in substantial towns, and

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[1] Addenbrooke's at Cambridge (1766) and the Radcliffe at Oxford (1770) each benefited from personal legacies made some decades earlier, and duly took their names *from* the respective benefactors; both of them, however, owed their actual foundation to collective local action and functioned as county hospitals.

[2] For overviews of hospital procedures, see Anne Borsay, "`Persons of Honour and Reputation": The Voluntary Hospital in an Age of Corruption', *Medical History,* xxxv (1991), 281-94, and Adrian Wilson, 'The Politics of Medical Improvement in Early Hanoverian London', in *The Medical Enlightenment of the Eighteenth Century,* ed. Andrew Cunningham and Roger K. French (Cambridge, 1990), pp.- 4-39, at pp. 24-34

had some sense of responsibility towards the town. Sometimes this dual identity was enshrined in the infirmary's very name, from the *Winchester County* Hospital *(1736)* to the *Kent and Canterbury* Hospital *(1793).* Elsewhere the connection took other forms. The Infirmary at Newcastle upon Tyne *(1751)* served the counties of Northumberland and Durham and the town itself, whose corporation made available a permanent site at a nominal rent. At Lincoln the County Infirmary *(1769)* conferred *ex officio* membership of its governing board on the mayor and aldermen of the town.[3]

Just as each individual infirmary linked county and town, so collectively the provincial voluntary hospitals displayed both national and local features. On the one hand, they were linked in a national movement. Four of the first five provincial infirmaries were inspired by two individuals: Alured Clarke, successively prebendary at Winchester and cathedral dean at Exeter, who set up the county hospitals at Winchester and at Exeter *(1741),* and Lady Elizabeth Hastings, who helped to initiate both the York County Infirmary *(1740)* and the Bath General Hospital *(1742).*[4] Their leading role was continued by such activists as Martin Benson and Isaac Maddox, bishops of Gloucester and Worcester, and Thomas Secker, Archbishop of Canterbury.[5] Several subsequent infirmaries were modelled on individual predecessors: thus the Winchester Hospital was the model for the Salop Infirmary *(1747),* the rules of the Bristol Infirmary *(1737)* were copied by the Worcester Infirmary *(1746),* and those of Northampton *(1743)* were imitated at Newcastle.[6] And many later infirmaries asserted a wider emulation: thus at Liverpool it was stated in *1748* that `the advantages of Infirmary Hospitals are now ... evident from their own good effects', and the town's own Infirmary opened in the following year.[7]

On the other hand, each infirmary necessarily had strong local roots, making for variety: thus different hospitals had distinct management practices, medical activities, and local relationships.[8] And the most striking aspect of this diversity concerns the very origins of these institutions - for as Table 1 reveals, the chronology and geography of hospital foundation show no easily explicable pattern. Indeed, the eighteenth-century movement was not exactly national in scope, for not all towns or counties were persuaded of the `evident advantages' of infirmaries. Thus in the early *1740s* attempts were made to create county infirmaries in Berkshire, Lincolnshire and Norfolk, but without success.[9] Each of these plans attracted some backing: the Norfolk proposal was published in the *Norwich Gazette* in *1744,* and reiterated in *1750;*[10] that for Berkshire reached the pages of the *Gentleman's Magazine* in *1743* and *1744*[11]

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[3] S. Middlebrook, *Newcastle upon Tyne: Its Growth and Achievement* (Newcastle upon Tyne, 1950), p. 122; G. H. Hume, *The History of the Newcastle Infirmary* (Newcastle upon Tyne, 1908), p. 7; Francis Hill, *Georgian Lincoln* (Cambridge, 1966), p.71.

[4] Roy Porter, `The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in *The Hospital in History,* ed. Lindsay Granshaw and Roy Porter (London 1989), pp. 149-78; Ann Borsay, `Cash and Conscience: Financing the General Hospital at Bath, c. 1738-17S0', *Social History of Medicine, iv* (1991), 207-29, at 207; Beatrice Scott, `Lady Elizabeth Hastings', *Yorkshire Archaeological journal,* 1v (1983), 95-118, at 110

[5] For Benson (1689-1752, Bishop of Gloucester from 1735), see Hume, History *of the Newcastle Infirmary,* p. 125; *Dictionary of National Biography s.v.;* and Donna T. Andrew, 'On Reading Charity Sermons: Eighteenth-Century Anglican Solicitation and Exhortation', Journal of *Ecclesiastical History,* xliii (1992), 581-91, at 583 (the 1736 sermon mentioned there seems to have been for Christ's Hospital); Isaac Maddox, *The Duty and Advantages of Public Infirmaries* (London, 1743); id., *The Duty and Advantages of Public Infirmaries ... Further Considered* (London, 1744); id., *The Necessity of Persisting in Well-Doing* (Worcester, 1748). For Secker, see John R. Guy, 'Archbishop Secker as a Physician', *The Church and Healing,* ed. W. J. Sheils (Ecclesiastical History Soc., Oxford, 1982), pp. 127-35, at pp. 132, 13 S; Porter, 'The Gift Relation', p. 163; cf. *infra,* p.604, n.4.

[6] Porter, 'The Gift Relation', p. 151; Joan Lane, *Worcester Infirmary in the Eighteenth Century* (Worcester Historical Soc., Occas. Pubs., vol. vi, 1992), p. 1; W. E. Hume, 'The Origin and Early History *of* the Infirmary of Newcastle upon Tyne', *Archaeologia Aeliana,* 4th set. xxii (19 54),72-99, at 78.

[7] George McLoughlin, A *Short History of the Liverpool Infirmary, 1749-1824* (Chichester, 1978), p. 16.

[8] Porter, 'The Gift Relation', p. 151.

[9] And also an unsuccessful proposal for a dispensary at Coventry: see *infra,* p. 605, n. 5.

[10] P. Eade, *The Norfolk and Norwich Hospital 1770 to 1900* (Norwich, 1900), p. 17; Kathleen Wilson, 'Urban Culture and Political Activism in Hanoverian England: The Example of Voluntary Hospitals', in *The Transformation of Political Culture: England and*

and the Lincoln proposal came from 'several lords and gentlemen of the county', was supported by the high sheriff and grand jury, and issued in a twenty-seven-page printed plan.[12] Yet all three attempts lapsed - in contrast with contemporary initiatives in three other counties[13] - and they

Table 1 Provincial Voluntary Hospitals Founded before i8oo, with Dates of Foundation and Associated Constituencies

County	Hospital name	Date	Borough
Hants*	Winchester CH	1736	Winchester
Somerset	Bristol I	1737	Bristol*
Yorks*	York CH	1740	York*
Devon*	Devon & Exeter H	1741	Exeter*
Somerset	Bath GH	1742	Bath
Northants*	Northampton CI	1745	Northampton'
Worcs*	Worcester I	1746	Worcester*
Salop*	Salop I	1747	Shrewsbury
Lancs	Liverpool I	1749	Liverpool*
Northumb'd, Durham	Newcastle I	1751	Newcastle*
Lancs	Manchester PI	1752	
Cheshire*	Chester I	1755	Chester*
Gloucs*	Gloucester I	1755	Gloucester*
Cambs*	Addenbrooke's H	1766	Cambridge
Staffs*	Stafford CH	1766	Stafford
Wilts*	Salisbury CH	1766	Salisbury
Yorks	Leeds GI	1767	
Lincs*	Lincoln CH	1769	Lincoln*
Oxon*	Radcliffe I	1770	Oxford*
Leics	Leicester I	1771	Leicester*
Norfolk*	Norfolk & Norwich H	1771	Norwich
Herefs*	Hereford GI	1776	Hereford*
Warwickshire	Birmingham GH	1779	
Notts*	Nottingham GH	1782	Nottingham*
Yorks	Hull I	1782	Kingston-upon-Hull*
Somerset*	Somerset CI	1792	Taunton
Kent*	Kent & Canterbury H	1793	Canterbury*
Yorks	Sheffield I	1797	

Notes:

1. Asterisks in the county and borough columns identify the `hospital constituencies' discussed in the text.
2. Key to names of hospitals:

H	Hospital
I	Infirmary C County
G	General
P	Public

were not revived until a generation later in Lincolnshire and Norfolk, and almost a century later in Berkshire.[14] The fate of such early initiatives did not depend in any simple way upon a

Germany in the Late Eighteenth Century, ed. E. Hellmuth (Oxford, 1990), pp. 165-84, at P. 170, n. 11. In 1751 it was thought in Newcastle that the Norwich initiative had succeeded: see Frederick J. W. Miller, 'The Infirmary on the Forth, 1753-1906', *Archaeologia Aeliana*, 5th set. ix (1986), 143-65, at 143

[11] *Gentleman's Magazine, xiii* (1743), 640 and ibid., xiv (1744),47-I am grateful to Mike Woodhouse for these references.

[12] Hill, *Georgian Lincoln, pp.* 70-1; D. Mary Short, *A Bibliography of Printed Items Relating to the City of Lincoln* (Lincoln Record Soc., vol. lxxix, 1990),P-315.

[13] In the 1740s county infirmaries were established at Northampton (1743), Worcester *(1746)* and Shrewsbury (1747).

[14] The Lincoln County Infirmary was established in 1769, the Norfolk and Norwich Hospital in 1771, and the Royal Berkshire

town's demographic size or local importance. Of the regional capitals, Bristol, York and Exeter all acquired hospitals by 1741, and Newcastle followed suit in 1751, but Salisbury not until 1766 and Norwich only in 1771 (despite the attempt of 1744). The counties, too, behaved in very different ways: for instance, in the West Country, Devon entered the movement early (1741), as we have seen; Somerset joined it very late (1792); and Dorset and Cornwall had still not joined it by 1800, even though a Cornish Infirmary was projected without success in 1799.[15] In short, the hospital `movement' was patchy and its complexities remain unexplained. Many counties and substantial towns still lacked an infirmary in 1800; and it is far from clear why (say) Northampton, Leicester and Nottingham founded hospitals in the eighteenth century, whereas (for example) Derby, Bury St Edmunds and Great Yarmouth did not.

Equally unresolved is the question as to the political and religious identity of the hospitals. The prevailing view sees them as associated with elite or class consensus - as a focus through which Tory and Whig, Anglican and Dissenter could unite in the pursuit of common objectives.[16] This account looks forward implicitly, and sometimes explicitly, to the nineteenth century, when the mechanism of voluntary subscription - of which the hospitals were early exemplars - served as an instrument to unite the middle class and indeed, it has been argued, to forge the very identity of that class.[17] While this interpretation matches much of the hospitals' own eighteenth-century rhetoric, at least until the 1770s,[18] it is still unclear how well it describes their real origins, activities and bases of support. Only seldom has this view been backed up by systematic study of the records, and even then with ambiguous results.[19] In those few hospitals whose conjunctures of founding or leading governors have been investigated, distinct political or religious institutional identities have repeatedly emerged, both in London (just as in the endowed hospitals there) and in the provinces.[20] Thus the very first voluntary hospital, the Westminster Infirmary, began as a Tory project in the wake of the calamitous political defeats of *1714-15;* the London Hospital, created in *1740,* was `patronized by the great Whig families, and was dominated by Whig officers and Whig subscribers'; and a preliminary investigation suggests that the Middlesex Hospital, established in *1745,* was equally Whig.[21] Similarly, the Bristol Infirmary was `largely governed by Quakers'; the governors of the Bath General Hospital were predominantly Tories; while at Leicester the Tory corporation `gave not a penny towards the founding of the infirmary, which was managed by a cabal of prominent Whigs'.[22] These findings suggest that a case can be made for linking the hospitals back to the `first age of party', rather than forwards to the age of class.

One reason for this uncertainty as to the political and religious meaning of the hospitals is that political historians have taken little interest in these institutions. The main activists behind the national hospital movement - Lady Elizabeth Hastings, Alured Clarke, Isaac Maddox, Thomas Secker - are seldom discussed, even though each of these individuals had

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Infirmary in 1839.

[15] Porter, 'The Gift relation', p. 16o. Somerset had acquired the Bath General Hospital in 1742, but this was not designed for local patients. However, it apparently treated a disproportionately large number from Somerset: see Borsay, 'Cash and Conscience', 218, n. 68.

[16] Porter, 'The Gift Relation'; Borsay,'Cash and Conscience', 219; Donna Andrew, *Philanthropy and Police: London Charity in the Eighteenth Century* (Princeton, 1989).

[17] R. J. Morris, 'Voluntary Societies and British Urban Elites, 1780-1850: An Analysis', *Historical Journal, xxvi* (1983), 95-118, at 97-8; id., *Class, Sect and Party: The Making of the British Middle Class, Leeds, 1820-1850* (Manchester, 1990); Wilson, 'Urban Culture and Political Activism'.

[18] It seems that the appeal in charity sermons to 'the pacific and unifying effects of joint charitable activity', common at mid-century, disappeared 'after the 1770s': Andrew, 'On Reading Charity Sermons', 583, 585.

[19] P. Langford, *Public Life and the Propertied Englishman, 1689-1798* (Oxford, 1991), pp. 128-30; see further *infra,* p.605, n.2.

[20] See Craig Rose, 'Politics and the London Royal Hospitals, 1683-92', in *The Hospital in History,* pp. 123-48.

[21] Wilson, 'The Politics of Medical Improvement'; Langford, *Public Life and the Propertied Englishman, p.* 129; Adrian Wilson, *The Making of Man-Midwifery: Childbirth in England,* 1660-1*770* (London, 1995), ch. 11.

[22] M. Fissell, *Patients, Power and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), p. 90; Borsay,'Cash and Conscience', 219; Porter, 'The Gift Relation', p. 154.

particular allegiances in politics and religion.[23] Though political historians are increasingly widening their focus from parliamentary and electoral processes to other activities, such as petitions, addresses, sermons and charities, the infirmaries have for the most part remained beyond their horizon.[24] This is all the more regrettable since many of the hospitals were established in towns notable for their continuous political traditions.[25] The one political historian who has directly researched any of the hospitals, Paul Langford, has produced a contradictory set of findings. On the one hand, `Propertied combination was meant to unite rather than divide'; `the clearest test case is perhaps that of the infirmaries'; and in support of this thesis, the Northampton Infirmary of 1743 showed `no hint of party bias'. Yet on the other hand, `even the voluntary bodies found it difficult to steer completely clear of party politics', as was shown by party troubles affecting the infirmaries at Shrewsbury, York and Liverpool.[26] The historiographic exception confirms the rule: it remains unclear just how the infirmaries fitted on to the eighteenth-century political map. Here we have one reflection amongst many of the persistent gulf between `social' and `political' history.[27] The present essay attempts to bridge this divide by relating the foundation of the hospitals to electoral contests. For strategic reasons this exercise will be conducted at the national level, though as we shall see the subject demands intensive local research.

To the extent that the hospitals have been connected with eighteenth-century politics at all, the link between the two spheres has been seen as eirenic. Specifically, Roy Porter has observed that infirmaries were designed to transcend party and religious divisions; and Langford has taken this further, arguing that these institutions actually helped to create a unified propertied interest.[28] That is, hospitals were intended to reduce party conflict, and they succeeded in mitigating its effects. While such claims were a commonplace of sermons in support of the hospitals, at least one eighteenth-century observer suggested that the association ran in the opposite direction. In 1744 one 'W.H.', attempting to revive a plan put forward three years earlier for a dispensary at Coventry, wrote in the *Northampton Mercury:*[29]

> The following plan was drawn up at Coventry in August 1741 during the epidemic fever that then raged there. ... [The plan] being communicated to a few of the leading inhabitants, they hinted many difficulties which, from the rancour of party, at that time too predominant, would inevitably retard, if not wholly defeat the attempt. Their diffidence of its success suppressed its publication; yet this very plan enlarg'd, partly gave rise, in the year 1743, to ... the County Infirmary at Northampton: And as

[23] Hastings was associated with Henry Hoare, Mary Astell and the SPCK, suggesting a Tory allegiance. Clarke and Maddox were comprehensionists, working for an eventual union between the Established Church and the Dissenters; Seeker was apparently sympathetic to this view. For Hastings, see Borsay, 'Cash and Conscience', 207, and Scott, 'Lady Elizabeth Hastings', *passim.* For Clarke and his circle, see Barbara Carpenter Turner, *A History of the Royal Hampshire County Hospital* (Chichester, 1986), *p.4,* and *DNB, s.v.* 'Charlotte Clayton, lady Sundon'. For Maddox, see W. H. McMenemy, *A History of the Worcester Royal Inftrmary* (London, 1947), and Philip Doddridge,'Compassion to the Sick Recommended and Urged'(1743), in *Works,* ed. Edward Williams and Edward Parsons (IC vols., Leeds, 1802-5), iii. 93-116, at 107. For Seeker, see Geoffrey Nuttall, 'Doddridge's Life and Times', in *Philip Doddridge 1702-51: His Contribution to English Religion,* ed. Nuttall (London, 1951), *PP-* 11-31, at pp. *25-26.*

[24] John Money, *Experience and Identity: Birmingham and the West Midlands, 1760-1800* (Manchester, 1977); James E. Bradley, *Religion, Revolution, and English Radicalism: Nonconformity in Eighteenth-Century Politics and Society* (Cambridge, 199o); Linda Colley, *Britons: Forging the Nation, 1707-1837* (New Haven/London, 1992). This historiographic boundary is strikingly apparent in Bradley's excellent study, which mentions charities only in passing and only for Bristol (p. 209), without discussing the Infirmary there. Yet at Newcastle, which is the focus of another of Bradley's case-studies, Kathleen Wilson has found that 'several radical leaders served their political apprenticeships in the ... Infirmary, or took a leading role in founding similar charities': 'Urban culture and Political Activism', p. 182.

[25] Five of the twelve boroughs listed by O'Gorman as having the most active and continuous traditions of party politics were hospital towns (Bristol, Gloucester, Leicester, Nottingham, York). Eight of the twenty-two boroughs in O'Gorman's next most politically-active grade of boroughs were hospital towns (Chester, Exeter, Lincoln, Liverpool, Newcastle upon Tyne, Norwich, Oxford, Worcester). Together these account for almost half (13:28) of all the provincial hospitals, for more than half (13:24) of the hospitals in borough towns, and for over a third (13:34) of the most politically-active boroughs. See Frank O'Gorman, *Voters, Patrons, and Parties: The Unreformed Electoral System of Hanoverian England, 1734-1832* (Oxford, 1989), PP. 350-6.

[26] Langford, *Public Life and the Propertied Englishman, pp. 128-30*

[27] See my `A Critical Portrait of Social History', in *Rethinking Social History: English Society, 1570-1920, and its Interpretation, ed.* Wilson (Manchester, 1993), PP-9-58.

[28] Porter, `The Gift Relation'; Langford, *Public Life and the Propertied Englishman,* pp. 128-30.

[29] *Northampton Mercury, to* Mar. 1743-4. I thank Mike Woodhouse for this reference.

> I am persuaded (from the present general harmony, owing, perhaps, to our frequent amicable meetings at the late summer-evening entertainments, contriv'd by the ingenious Mr Spires[30]) we may now put the ... plan into immediate execution ... I have ... at last obtained the benevolent author's permission to print the aforesaid plan ...

The `rancour of party' in I741 was hardly surprising in an election year, particularly in a borough as often contested as Coventry. (As it happened, 'W.H.' proved too sanguine, for his attempt to revive the Coventry dispensary scheme was unsuccessful.) The point to notice is the suggestion that the successful launching of a hospital (or in this case, a dispensary) required *a pre-existing* political harmony - precisely the inverse of the usual claim.

Thus eighteenth-century testimony can be used to suggest that the putative eirenic associations of hospitals ran in either direction, or in both. But such testimony was by no means disinterested. On the contrary, it was a standard trope of political rhetoric to present a particular interest as the general interest, a party move - particularly in the realm of charity - as an anti-party initiative.[31] Thus contemporary claims that hospital foundation either reflected or promoted a spirit of party cooperation, a burying of political hatchets, ought to be treated with at least a measure of suspicion. Further, it has to be admitted that the eirenic picture as a whole still rests on a mere handful of such rhetorical claims: a general case has been made from only a few examples, and it remains to be seen whether these can be generalized. (We know that Joseph Priestley supported the Leeds General Infirmary in 1768, but did he back the Birmingham General Hospital in the I780s?)[32] In short, if we are to assess the accuracy of the prevailing picture, it will be necessary both to move beyond such rhetorical testimony, and to use a more systematic method than the mere assembling of examples.

One possible way of approaching this task is to use the incidence of contests at general elections as an index of political conflict, and to set this against the presence or absence of infirmaries in the relevant county and borough constituencies.[33] Admittedly, the frequency of electoral contests will supply at best only an oblique measure of political tension, since, as O'Gorman has stressed, `the absence of contested elections does not allow us to conclude that party conflict was absent'. In some constituencies contests were avoided simply because support for the two parties was known to be equally balanced; further, there were many `aborted contests' - elections where a poll was avoided when informal canvassing established in advance what the result would be.[34] Nor were electoral contests, when they did occur, necessarily affairs of party: on the contrary, from the 1740s to the I760s (a period in which over half the hospitals were founded) such contests were more commonly stimulated by dynastic rivalry in the counties and by such issues as oligarchic control in the boroughs.

Despite these ambiguities, it will still be worth comparing the pattern of hospital foundation with the incidence of electoral contests. For it is only if we *fail* to find the `expected' association between hospitals and (apparent) political quietude that these considerations will come into play. If it turns out that hospitals *were* associated with a relatively low incidence of electoral contests, this will also suggest that, despite the qualifications just mentioned, the frequency of contests reflected, to some extent at least, the intensity of political conflict in the various constituencies.[35] And only by attempting the exercise can we discover whether this was the

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[30] This doubtless refers to the concerts of vocal and instrumental music at Spires's Spring Garden. See Peter Borsay, *The English Urban* Renaissance: *Culture and Society in the Provincial Town, 1660-1800* (Oxford, *1989), PP- 333, 351* •

[31] Wilson, 'The Politics of Medical Improvement', *pp. 7-8.*

[32] Porter, 'The Gift Relation', pp. *163-4;* I find no mention of Priestley in this connection in Money, *Experience and Identity.* Priestley moved to Birmingham in *1780:* William Hutton, *An History of Birmingham* (2nd edn., Birmingham *1783), p. 117*

[33] The authorities cited below also list contested by-elections; but I have excluded these, since it is not clear whether the absence of a by-electoral contest (which was the usual state of affairs) indicates no contest (as with general elections) or simply no by-election. Thus the incidence of by-electoral contests is not formally comparable with the incidence of general-election contests.

[34] O'Gorman, *Voters, Patrons, and Parties, pp.* 342 (and cf. p. 341), 111-12.

[35] In addition, Paul Langford notes (personal communication) that the frequency of contests might not capture the putative effects of hospitals, for a new, extra-party arena might conceivably have been created without necessarily reducing partisan activity in its traditional domains of parliamentary elections and corporation politics. The same applies to this as to the issues raised in the text: it will make a `negative'

case. Let us therefore proceed to compare the frequency of contests in constituencies with and without a hospital, and to ask how this related to the moment of hospital foundation.[36] If local political calm was the precondition for hospital foundation, then we would expect that `hospital constituencies' experienced a relatively low rate of contests *before* the moment of hospital foundation. Conversely, if hospitals promoted political harmony, we would expect this to emerge *after the* respective hospitals were founded. In view of the hospitals' associations with both town and county, we need to pursue this investigation both in the counties and in the boroughs. In each case the definition of comparable `hospital' and `non-hospital' constituencies is not quite straightforward.[37]

Relevant county constituencies: I have used England, less Monmouthshire, as the sphere of comparison. Nineteen of the thirty-nine counties (identified by asterisks in Table 1) belonged to the `hospital' category, i.e. they acquired before 1800 a hospital named as a county infirmary or at least situated in the county town. Fifteen counties belonged to the 'non-hospital' category, in that they did not acquire a county infirmary before 1800. Five counties had to be excluded from the comparison. Middlesex, where a hospital was founded in *1745,* has been excluded because both its electorate and its hospital were effectively part of London, and it is thus not comparable with other counties.[38] Northumberland and Durham were jointly served by a single hospital, the Newcastle Infirmary; as a result this hospital could not be associated with a specific county constituency, nor could these counties be assigned to the 'non-hospital' category.[39] Finally, Lancashire and Warwickshire were special cases of a different kind. Lancashire was served by the Manchester Infirmary, founded in *1752* (though not by the Liverpool Infirmary, established three years earlier, which was restricted to the town and drew the great bulk of its support from urban subscribers).[40] Yet the basis of the Manchester Infirmary was not so much the county as the region, that is 'eastern Lancashire and Cheshire' - at least until the Chester Infirmary was created in *1755*[41] Similarly in Warwickshire, the Birmingham General Hospital *(1779)* was designed to serve 'the populous county about it' as well as Birmingham itself; but this may have referred to the town's practical hinterland, which cut across county boundaries, embracing parts of Worcestershire and Staffordshire, but excluding much of Warwickshire itself.[42] (The parallel between these two hospitals was no accident: both towns were rapidly growing centres of manufacture, situated near the geographical edges of their respective counties.) It may well be that after closer examination, either or both of the hospitals at Manchester and Birmingham should be regarded as county hospitals; but in the

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finding difficult to interpret, but will not affect a 'positive' finding.

[36] Just two hospitals were founded in election years. The Devon and Exeter Hospital (23 July 1741) *post-dated* the election of that year (19 May): see Romney Sedgwick, *The House of Commons, 1715-1754* (z vols., London, 1970), i. 46, and John Caldwell, 'Notes on the history of Dean Clarke's *Hospital, 1741-1948', Reports and Transactions of the Devonshire Association for the Advancement of Science, Literature and Art, civ* (1972), 175-92, at 175-6. Although the Salop Infirmary opened in 1747, its inaugural meeting *pre-dated* this election by some years (Mike Woodhouse, personal communication).

[37] Constituency characteristics were taken from the Appendix tables given in Sedgwick, *The House of Commons, 1715-1754;* Sir Lewis Namier and John Brooke, *The House of Commons, 1754-1790 (2* vols., London, 1964); and R. G. Thorne, *The House of Commons, 1790-1820* (2 vols., London, 1986). Contests were identified from John Cannon, *Parliamentary Reform, 1640-1832* (Cambridge, *1973),* App*. 3 (PP. 276-89)*--

[38] Since Middlesex was removed from the 'hospital' counties because of its association with London, it might be argued that Essex, Hertfordshire and Surrey should be excluded from the 'non-hospital' counties for the same reason (I thank John Cannon for drawing my attention to this point). The analyses reported below were therefore repeated with these three counties excluded; this lowered the rate of contests in the 'non-hospital' counties (see Fig. *2),* but otherwise did not affect the findings.

[39] Hume, 'The Origin and Early History of the Infirmary of Newcastle upon Tyne', *78;* Wilson, 'Urban Culture and Political Activism', PP- *173, 176*

[40] McLoughlin, *A Short* History *of the Liverpool Infirmary, passim;* Wilson, 'Urban Culture and Political Activism', *p. 174.*

[41] J. V. Pickstone, Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region, 1752-1946 (Manchester, 1985), p. 13 (quoted); cf. William Brockbank, Portrait of a Hospital, 1752-1948 (London, 1952), pp.11-12, and id., 'The Manchester Public Infirmary, Lunatic Hospital and Dispensary', Manchester University Medical School Gazette, xxvi (1947), 131-5, and xxvii (1948), 31-5, at 134

[42] Money, *Experience and Identity,* p. *9.*

first instance, their counties cannot clearly be allocated to either the 'hospital' or the 'non-hospital' category.

Relevant borough constituencies: Of the twenty-eight voluntary hospitals founded before 1800, twenty-four were situated in towns which enjoyed a borough franchise.[43] But that franchise took several different forms - freeman, burgage, corporation, scot and lot, householder - and was associated with electorates of very different sizes, which behaved electorally in different ways. Thus if we are to compare `hospital boroughs' with 'non-hospital boroughs' we must restrict attention to some comparable type or types of constituency. In fact, seventeen of the twenty-four `hospital boroughs' had large electorates (1,000 voters or more), either for all of the period in view (fifteen cases) or at least from before the respective hospitals were founded (the remaining two cases).[44] Of these seventeen, sixteen were freeman boroughs and the remaining one, Northampton, had a householder franchise. Thus the simplest way of making a valid comparison between `hospital' and 'non-hospital' boroughs is to restrict attention to boroughs with a freeman or householder franchise, whose electorates were or became `large' during the eighteenth century. This means that we have eleven 'non-hospital boroughs'[45] for comparison with seventeen `hospital boroughs' (the latter are identified by asterisks in Table 1).[46]

Figures 1 and 2, treating the boroughs and the counties respectively, display the frequencies of electoral contests in 'non-hospital' constituencies and in `hospital' constituencies, both before and after these acquired their hospitals. Here the period from 1716 to 1806 has been divided into five phases, each spanning three general elections. (Some such aggregation is required because the small numbers of county contests make for random fluctuations in the apparent rate of contests if a single-election focus is used. The five-phase division used here is arbitrary, but is largely justified on political grounds.) The first result of this exercise is to suggest that the frequency of contests may indeed have reflected not only such contingent influences as dynastic rivalry, but also the underlying state of political relations in the various constituencies. For both in the boroughs and in the counties, `hospital constituencies' experienced fewer electoral contests than did 'non-hospital constituencies' - just as we were led to expect. But the form of this association, and its clarity, differed between the boroughs and the counties. In the boroughs (Figure 1) the pattern was clear-cut: before obtaining their hospitals, `hospital boroughs' experienced the same rate of contests as did 'non-hospital boroughs', whereas after hospital foundation they had proportionately fewer contests. Thus, in line with Langford's argument, it appears that hospitals tended to promote a degree of political peace in the boroughs; but contrary to what 'W.H.' suggested in 1744, it did not require a pre-existing harmony in the borough for a hospital to be founded.

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[43] The four exceptions were Manchester, Leeds, Birmingham and Sheffield.

[44] The electorates at Lincoln (county infirmary *1769)* and at Kingston upon Hull (town infirmary *1782)* expanded from 'medium' to 'large' at mid-century. On electoral sizes I have followed the various volumes of *The House of Commons*.

[45] *All* these eleven were freeman boroughs. The electorates in six of these boroughs were 'medium' until *1747*, but 'large' from *1754:* Bedford, Carlisle, Maidstone, Dover, Evesham and Beverley. The remaining five were 'large' throughout the period: Durham, Colchester, Lancaster, Bridgnorth and Coventry. Strictly speaking, Preston (a householder borough) should have been included, since its electorate eventually expanded from 'medium' to 'large'; but this occurred so late (c. *1790)* that it was thought best to exclude Preston throughout.

[46] The hospital boroughs excluded were Winchester, Cambridge, Shrewsbury and Stafford, with freeman franchises and 'small' electorates; Bath and Salisbury, with corporation franchises and 'small' electorates; and Taunton, with a householder franchise and a 'medium'-sized electorate.

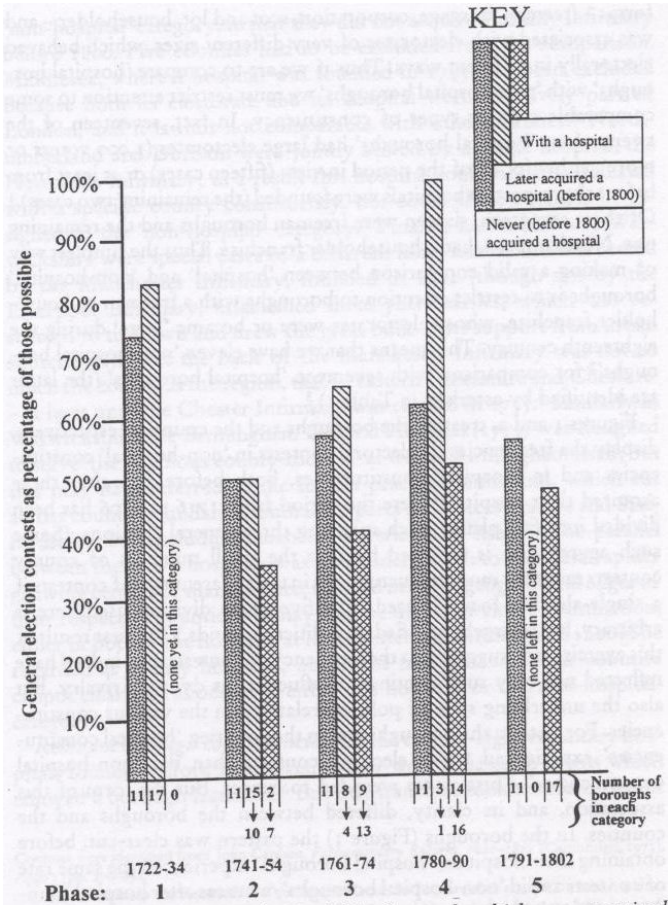


Fig. 1. Borough contests: distinguishing boroughs which never acquired a hospital from those which later acquired one.

Yet the claim of 'W.H.' was at least partly borne out by the counties. For we see from Figure 2 that even before the moment of hospital foundation the `hospital counties' tended to experience a lower incidence of contests than did 'non-hospital counties'. Admittedly, this tendency was reversed in the (pooled) elections of 1741, 1747 and 1754 - when contests were infrequent in counties of all types - and was slight in the 1780s. But in the (pooled) elections of 1761-74 the disparity between the two groups of counties was sufficiently strong to suggest that a real effect was at work.[47] In addition, it appears that the frequency of contests fell after the moment of hospital foundation, once again in agreement with Langford's argument.

In the boroughs, then, it seems that hospitals promoted political peace rather than reflecting it; whereas in the counties there obtained to some extent a reciprocal relationship between political peace and the founding of infirmaries. Yet the pattern in the counties is not entirely clear, perhaps because the various hospitals were founded across a wide time span - from the 1730s to the 1790s - during which the incidence of electoral contests fluctuated considerably. In order to clarify this issue we may approach the matter from a different angle. In each 'hospital constituency' we can compare the incidence of electoral contests before and after the moment of hospital foundation. A suitably broad `window' for this purpose will be ten general elections:

[47] At these three (pooled) elections, the 'hospital counties' which had not yet obtained a hospital experienced only 2:23 possible contests, whereas 'non-hospital counties' experienced 28:49 possible contests. The probability that this disparity could occur by chance is less than 1 in 100 (0.0096) by Fisher's exact-probability test, for which see Sidney Siegel, *Nonparametric Statistics for the Behavioural Sciences* (New York, 1956), pp. 96-104. A more conservative assessment can be obtained by deriving the chance probability that such a disparity could occur in *any* of the five relevant comparisons; even this attains conventional 'statistical significance', i.e. a probability of under 1 in 20.

four preceding and six succeeding the year in which the given hospital was founded. We can then pool the results from all the hospitals into a composite `window' having ten `cells', representing the numbers of contests in 'hospital constituencies' at distances of (-4, -3, -2, -1, +1,+2, +3, +4, +5 and +6) general elections from the moment of hospital foundation. A `control' pattern can be derived from the frequency of contests in the `non-hospital constituencies'. For each cell in the `window', the 'control pattern' will show the number of contests which *would have* occurred in the pooled 'hospital constituencies', *if* these had shown the same incidence of contests as the 'non-hospital constituencies'. This will allow for any possible distortion arising from the changing incidence of contests throughout the period. Further, the 'control pattern' will enable us to compare the incidence of political contests in the two classes of constituency, independently of the dates at which hospitals were founded.

The results are shown in Figure 3 for the boroughs, and Figure 4 for the counties. The pattern in the boroughs confirms that *here* the hospitals promoted harmony rather than reflecting it. Before the creation of a hospital, the incidence of contests in `hospital boroughs' was effectively identical with the rate in `non-hospital boroughs' (in fact, for the first three elections in the `window' it was slightly higher, though not significantly so). After the creation of a hospital, the frequency of contests was reduced by almost one-third: in the next three elections pooled, where the `control pattern' would suggest about twenty-eight contests in all, we find only twenty. However, the effect was temporary, for in subsequent elections the frequency of contests rose again, becoming the same as the `control pattern'. Thus the hospitals' apparent soothing effect on borough constituencies lasted for just three general elections, i.e. for no more than twenty years.

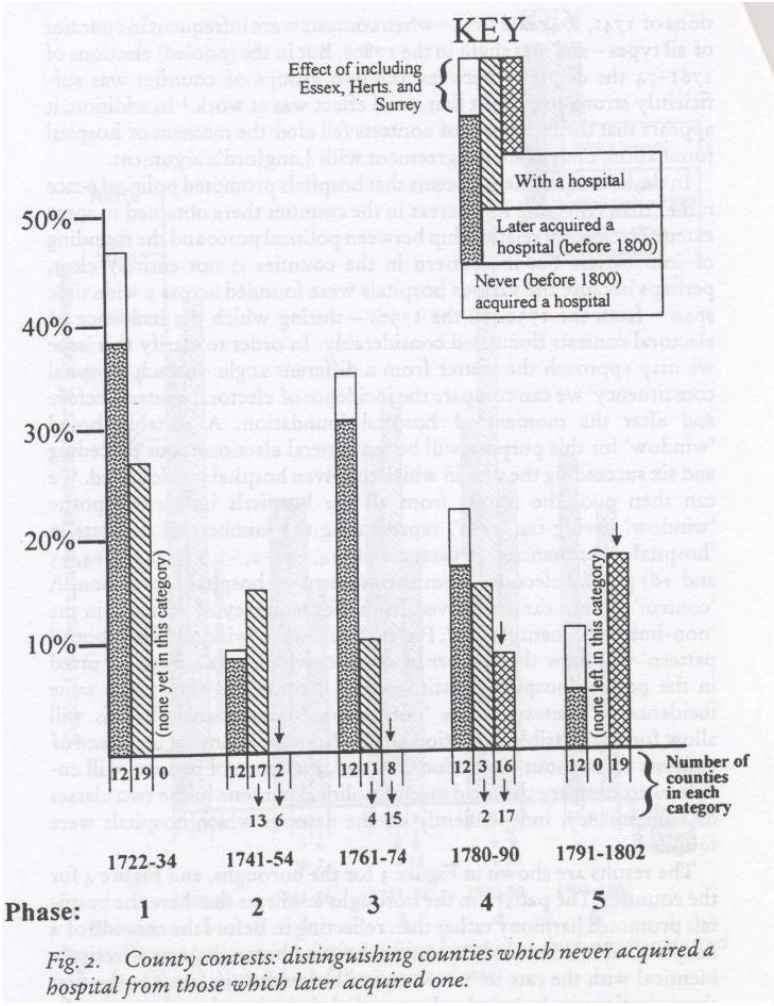


Fig. 2. County contests: distinguishing counties which never acquired a hospital from those which later acquired one.

In the counties (Figure 4) the results are more complex. On the one hand it is confirmed that hospitals both reflected and promoted county political harmony. In the combined four general elections *preceding* the moment of hospital foundation, contests in the `hospital counties' were about half as frequent as in the 'non-hospital counties'; in the combined three general elections *after* hospital foundation, this proportion fell to about a quarter. Overall it seems that the two underlying phenomena - political harmony promoting hospital foundation, and the converse - were roughly equal in strength.[48] The effect of the hospitals on the county constituencies was slightly greater than their impact on the boroughs, reducing the frequency of contests by one-half as against one-third. However, it was similar in duration, apparently lasting for about three elections, since in subsequent elections the rate of contests in the `hospital counties' seems to have been returning towards the level (in relation to the `control pattern') that had obtained before the hospitals were founded.[49] On the other hand, we also find an unexpected anomaly: the election *immediately preceding* the moment of hospital foundation saw a peculiarly large number of contests, which uniquely attained the level of the `control pattern'. That is, six county infirmaries - almost a third of such hospitals - were founded in the wake of general-election contests in the respective counties. As Table 2 shows, the six cases in point were spread across the entire period in view, from the *1730s* to the *I790s* - which explains why our earlier analysis (Figure 2) did not detect this phenomenon. This apparent association between contested elections and hospital foundation might be a coincidence, but the odds are against it: it is much more likely that some systematic effect was at work.[50]

The exercise of linking the foundation of hospitals with electoral contests has uncovered three findings. First, the eirenic effect of the hospitals, posited by Langford, was indeed felt in the arena of electoral politics. Though this impact was rather brief, disappearing after three general elections, it was strong while it lasted - reducing the incidence of electoral contests by one-third or more - and was seen in both the

[48] In the combined four elections preceding hospital foundation, contests in the hospital counties were *0.47* times as frequent as the `control' estimate. Supposing, for the sake of argument, that the effect of the hospitals was as great again, we would expect the corresponding ratio in the subsequent three elections to be *.47 x .47,* i.e.. 0.22. This would mean that in the hospital counties there were *3.6* contests in these three elections pooled, or *4* rounded; and there were in fact *4* such contests.

[49] Pooling the final three cells in the window, we would expect 8 contests (rounded) if the incidence of contests (in relation to the `control pattern') returned to the level that had obtained before hospital-foundation, and only *4* contests if this continued to follow the pattern that had obtained in the first three elections after hospital-foundation. In fact there were *7* contests.

[50] Had we expected to find such a concentration of contests in the preceding election, the probability of its occurring by chance would have been about 1 in *66,* easily attaining conventional statistical significance. Given that we did not anticipate this phenomenon, we ought perhaps to assess the probability that such a concentration of contests could occur by chance in *any* of the elections in the `window': this turns out to be about 1 in *7 (.1416).* The latter, more conservative estimate does not attain statistical significance, but the odds are still against a chance explanation of the pattern. See further *infra, p.616,* n.1. This calculation has used binomial probability, for which see Murray R. Spiegel, *Probability and Statistics* (New York, *1975), P.108.*

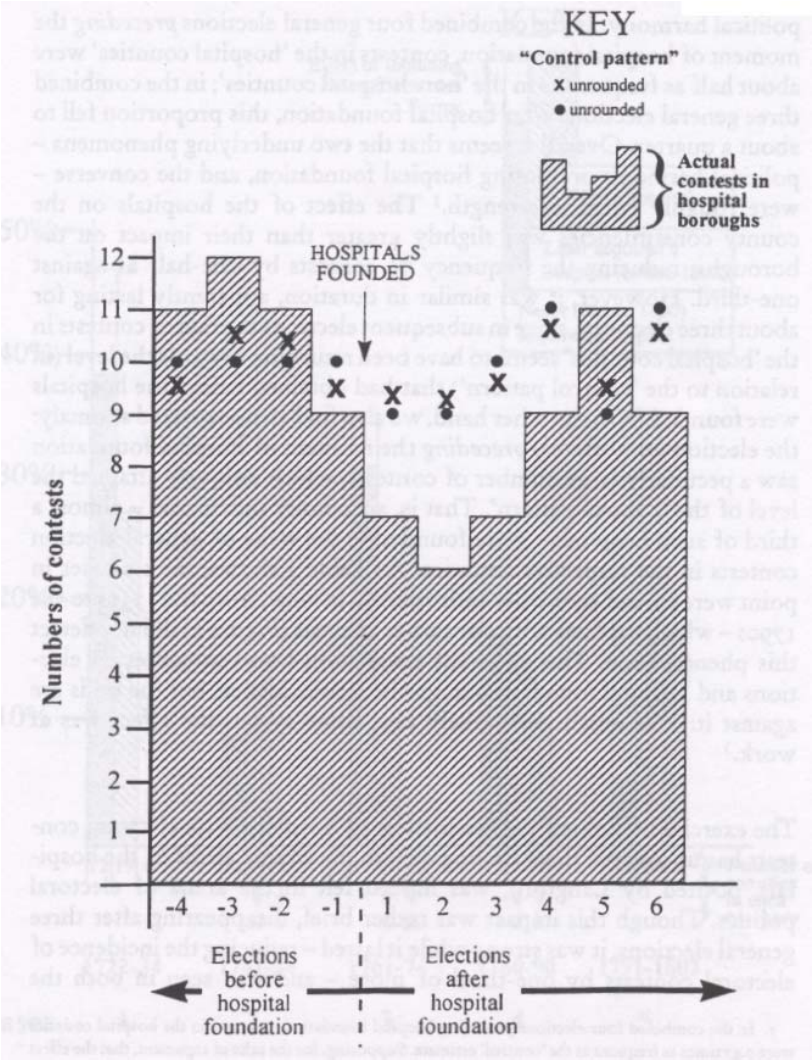


Fig. 3. Seventeen `hospital boroughs': numbers of contests before and after hospital foundation, compared with `control pattern'.

boroughs and the counties. Second, in the counties, though not in the boroughs, there was also an equally strong influence working in the opposite direction: that is, it was counties which already had a relatively low incidence of contests which tended to obtain hospitals. But third, and cutting across this, several hospitals were founded after contested county elections. We must now assess the meaning of this unexpected pattern.

In fact, it was not simply a contested county election which tended to precede the foundation of a hospital.[51] Rather, it was a run of two (or more) *uncontested* elections followed by a single *contested* election: this was the pattern in all the six cases listed in Table 2.[52] It is precisely for this reason that the last election before the moment of hospital foundation stands out in Figure 4. When the matter is viewed from this angle, a chance explanation becomes the more improbable.[53] In some of these six cases (though not in all[54]) a contested election, coming after a

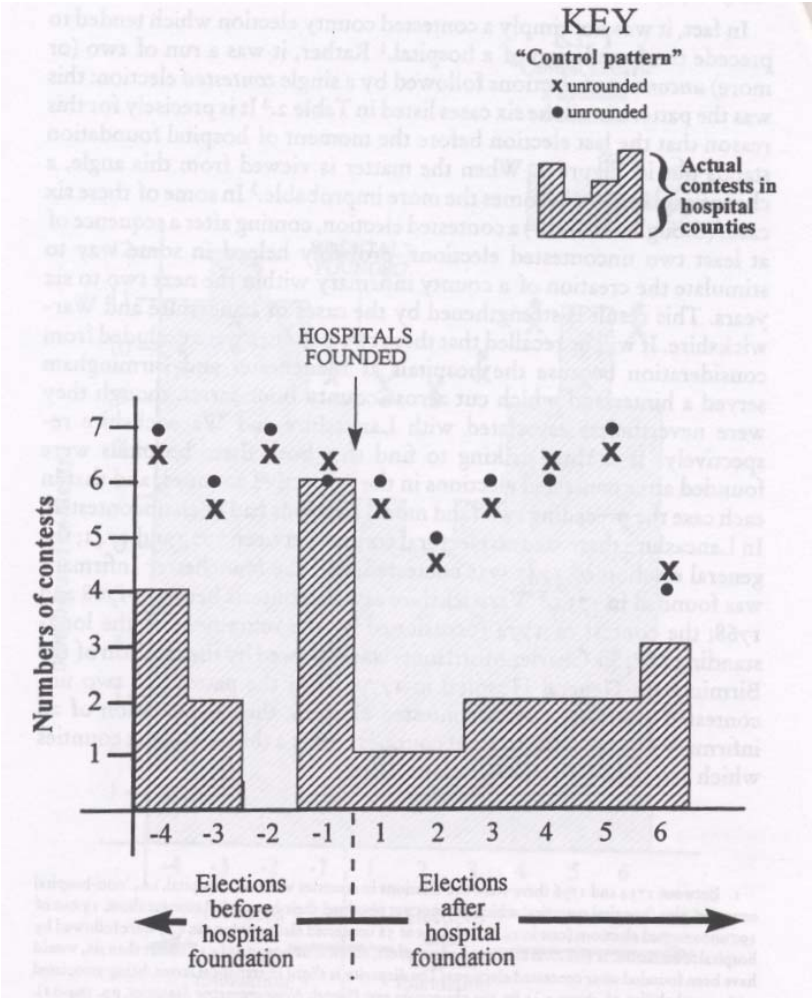
[51] Between 1734 and 1796 there were 242 elections in counties without a hospital, i.e., 'non-hospital counties' plus `hospital counties' which had not yet obtained their hospital. Amongst these, 13 out of 190 uncontested elections (one in 14.6) and 6 out of 52 contested elections (one in 8.7) were followed by hospital foundation. If electoral contests had no effect, about four hospitals (4.1), rather than six, would have been founded after contested elections. The disparity is slight in statistical terms, being associated with a probability of about 0.45 by the chi-square test (Siegel, *Nonparametric Statistics,* pp. I04-11).

[52] The two cases of contests in the second cell of the `window' arose from the counties of Staffordshire and Oxfordshire, not from the counties experiencing a contest in the fourth cell (the latter are listed in Table 2).

[53] Between 1722 and 1790 there were 242 three-election sequences in counties without a hospital (i.e.. 'non-hospital counties' plus `hospital

sequence of at least two uncontested elections, probably helped in some way to stimulate the creation of a county infirmary within the next two to six years. This result is strengthened by the cases of Lancashire and Warwickshire. It will be recalled that these two counties were excluded from consideration because the hospitals at Manchester and Birmingham served a hinterland which cut across county boundaries, though they were nevertheless associated with Lancashire and Warwickshire respectively. It is thus striking to find that both these hospitals were founded after contested elections in the respective counties, and that in each case the preceding two (and more) elections had been uncontested. In Lancashire there was no electoral contest between 1727 and 1741; the general election of 1747 was contested, and the Manchester Infirmary was founded in 1752.[55] Warwickshire saw no contests between 1708 and 1768; the contest of 1774 (occasioned by the retirement of the longstanding MP, Sir Charles Mordaunt) was followed by the creation of the Birmingham General Hospital in 1779. Thus the pattern of two uncontested elections, then a contested election, then the creation of an infirmary now extends to eight counties - over a third of all the counties which acquired infirmaries before 1800.

Fig. 4. Nineteen `hospital counties': numbers of contests before and after hospital foundation, compared with control pattern'.



counties' which had not yet obtained their hospital). Some 33 of these sequences took the form (no contest, no contest, contest); six of these were followed by hospital-foundation, i.e.. one in 5.5. Of the remaining 209 sequences, 13 were followed by hospital foundation, i.e. one in 16.1. This difference is statistically significant by the chi-square test.

[54] The frequency of hospital foundation after all other electoral sequences combined (i.e. one in 16.1: see previous note), applied to the 33 instances of the sequence (no contest, no contest, contest), would produce just two hospitals. This would suggest that the sequence played a part in triggering the foundation of four of these six hospitals.

[55] The Liverpool Infirmary was mooted in 1748 and founded in 1749, also fitting the pattern. Even though this hospital did not serve the county (see *supra*, p. 608, n. 3), its foundation may also have been triggered by the 1747 contest.

It is most unlikely that this pattern was a coincidence;[56] but a statistical association of this kind does not demonstrate a concrete connection. In order to discover whether hospital foundation was actually stimulated by an electoral contest coming after two uncontested elections, as this finding suggests, detailed local research will be required. Certainly in the

Table 2. County hospitals founded after a contested election

County	Date of contested election	Date of foundation of county infirmary
Hampshire	1734	1736
Yorkshire	1734	1740
Worcestershire	1741	1746
Norfolk	1768	1771
Herefordshire	1774	1776
Kent	1790	1793

case of the Birmingham General Hospital there are good grounds for suspecting that its successful re-launching in the *1770s,* reversing an ignominious failure of the *1760s,* was indeed assisted by the Warwickshire electoral contest of *1774.*[57] This suggests that it will be worth investigating whether such was the case in any of the other seven hospitals founded in the wake of such contests. Here we have a starting point from which to address the explanatory puzzle posed by the foundation of provincial infirmaries. How might county elections have played such a role? By way of conclusion, I shall sketch two alternative hypotheses.

What we may call the 'eirenic hypothesis' might run as follows. As is well known, members of the county elite deeply disliked electoral contests in the eighteenth century: not just because contests were personally expensive for the candidates and their backers, but more particularly because they were held to disturb `the peace of the county'.[58] And contests may have appeared especially troubling against a background of previous harmony. Thus an electoral contest occurring after a sequence of no contests could have led to a special concern to restore the pre-existing political quiescence. Perhaps this stimulated men such as Alured Clarke to propose an infirmary, with the deliberate aim of smoothing over party differences; perhaps it simply strengthened their hand, disposing the local gentry and aristocracy to back them. In either case, this conjuncture tended to favour the creation of an infirmary: for instance the Winchester County Hospital, the *very* first county infirmary, was founded at Clarke's behest just two years after the election *of 1734,* which had seen Hampshire's first contest for over twenty years.[59] If

[56] If Warwickshire and Lancashire are added, then the chance-probabilities given *supra,* p. 613, n. 3, become 1 in 554 (.0018) instead of 1 in 66, and 1 in 55 (.0179) instead of 1 in 7. Even the more conservative of the two now attains conventional statistical significance.
[57] Adrian Wilson, `The Political Origins of the Birmingham General Hospital' (paper in preparation). See also Money, *Experience and Identity, pp.* 9-11, and Conrad Gill, *History of Birmingham* (3 vols., Birmingham, 1952-74), i. 130-1.
[58] O'Gorman, *Voters, Patrons, and Parties, pp.* 60, 112-13; Langford, *Public Life and the Propertied Englishman, pp.* 122-4; Money, *Experience and Identity,* p.213, quoting Sir Roger Newdigate (here notice also Samuel Aris using the phrase `the peace of the town', in 1790; *cf. infra,* p.618, n.4.

[59] Clarke, who had been a prebendary at Winchester since 1723, made his first known moves towards the Winchester hospital in the summer *of* 1736: Carpenter Turner, *History of the Royal Hampshire County Hospital, p.*3. (Hampshire's previous contest had been in 1713: Cannon, *Parliamentary Reform, p.* 278.)

this was indeed the motive behind the founding of some infirmaries, it had the desired effect, though only for about a generation (the next three general elections). As a bonus, the hospitals also had a similar soothing effect on the local borough electorates.

An alternative explanation, which may be termed the `agonistic hypothesis', can be derived from the case of Warwickshire. In that county, at least, the 'eirenic hypothesis' is poorly supported by the available evidence. For at the 1780 election, held a year after the re-founding of the Birmingham General Hospital, what prevented a contest was not peace in the county but, on the contrary, the self-assertiveness of the Birmingham freeholders, who had shown their electoral muscle in support of Sir Charles Holte in 1774 and now `applied to Sir Robert Lawley' to stand on their behalf. (Holte had decided to retire as MP; Lawley was being invited to serve as his replacement.)[60] The move achieved instant success, for it persuaded the `county' candidate William Holbech not to stand, with the effect that Lawley was returned unopposed (along with Holbech's fellow `county' candidate, Sir George Shuckburgh). This was a classic `aborted contest' (one of several at the 1780 election), that is, a trial of strength conducted in advance.[61] Here, then, the `peace of the county' was secured at the price of a major political concession, attesting not to the absence of conflict but rather to the equal balance of contending forces. What part did the founding of the Birmingham General Hospital play in this process? Certainly the Hospital provided a link between the town's leaders and Sir Robert Lawley;[62] perhaps it also helped to unite the Birmingham freeholders into a formed 'interest'.[63] This would give a political edge to the strong civic meaning which Money has rightly stressed for the hospital.[64] The `agonistic hypothesis' would be that it was forces of this kind which were at work in the foundation of infirmaries.[65] Hospitals would thus be expressions of particular interests, in ways which may well have varied from place to place. It might then emerge that county consensus was the public mask of local conflict.

Whichever of these interpretations one favours (and in different counties, both may perhaps be true), our findings suggest that politics and charity were reciprocally related, and thus that the eighteenth-century infirmary falls within the purview of the political historian. With twenty-eight provincial infirmaries founded before 1800, there is a vast wealth of material here to explore. In up to seven further counties (Hampshire, Yorkshire, Lancashire, Worcestershire, Norfolk, Herefordshire, Kent), hospital foundation may have been stimulated by an electoral contest, as it very probably was in Warwickshire; but this possibility needs to be tested by local research. And in the rest of the kingdom we do not yet know why hospital schemes came to be conceived, nor how they were brought to fruition. Why was the idea put forward before 1800, so far as we know, in only about half the counties of England? Why did hospital initiatives succeed in some counties, such as Hampshire, but fail in others, such as Berkshire? Our starting-point must be the successful attempts, and these left ample documentary traces. In most cases, the initial lists of hospital subscribers have survived; it will often be possible to link these with poll-books, and thus to reconstruct the political and social profile of hospital founders.[66] Equally important was the precise local political conjuncture, together with the network of

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[60] Namier and Brooke, *The House of Commons, 1754-1790, i.* 399-400.
[61] O'Gorman, *Voters, Patrons, and Parties,* pp.111-12.
[62] Money, *Experience and Identity, p. to* (and cf. pp. 176-7); Birmingham Central *Library,* MS 1423/2 (Birmingham General Hospital Committee of Trustees Minute Book, 1766-1784), 19 June 1777.
[63] Hence the fact that Samuel Aris could write of `the peace of the town' in 1790 (cf. *supra, p. 617, n.2).* By the latter date Birmingham had become a sphere of interest and contest in its own right
[64] Money, Experience and Identity, ch. 1.
[65] This has been suggested for Norwich by Wilson, `Urban Culture and Political Activism', pp. 181-2.
[66] The subscribers were listed in the printed annual reports, produced by all provincial infirmaries; I am in the process of compiling a list of surviving reports. In many cases local newspapers also printed lists of subscribers, particularly at the moment of foundation. Printed poll-books (though not manuscript ones) are listed in John Sims (ed.), *A Handlist of British Parliamentary Poll Books* (University of Leicester History Department/University of California Riverside Occas. Pub. no.4, 1984).

institutions both old (such as cathedral chapters and town corporations) and new (assembly rooms, debating societies)[67] Here we have an inviting field for research, covering a wide canvas. Perhaps this theme can serve as a focus through which to connect the politics of boroughs and counties. Certainly it bids fair to act as a bridge between local and national issues - and between historians of society and historians of the State.

[67] The cathedral chapter played an important part at Winchester: see Carpenter Turner, *History of the Royal Hampshire County Hospital, p.* 4. On new cultural initiatives, see Borsay, *The English Urban Renaissance.*