Medical History

The "Radcliffe" hospitals, Oxford

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The Radcliffe Infirmary was opened 209 years ago, in 1770. The money for building was provided by the trustees of the will of John Radcliffe, who was educated in medicine at Oxford and made his fortune in London, where he died in 1742, leaving about £140 000. Provision was made for building the library, now known as the Radcliffe Camera, and, after various legacies and annuities, the remainder was divided equally between University College, Oxford, and his trustees. The principal charitable purposes to which the trustees subscribed were the building of the infirmary and the observatory.

Initially there were 36 beds at the infirmary, rising to 72 after three months, but the full complement of 121 was achieved only some years later. Admission to these beds was controlled by the admitting surgeon or physician of the week, before whom the patients were required to attend with a recommendation from a governor. Admission could be for a maximum of six weeks. This system may have ensured that beds were occupied by patients who were proper "objects of charity," but, in spite of groups such as parishes setting up as subscribers so that their head officer, who had the same rights for admission as a governor, might in due course speak for one of their number, the most needy or acutely ill were not always cared for. If a bed were available a recommendation for an urgently ill patient could sometimes be obtained after admission. In 1834 the medical staff advocated that the poor should find it easier to procure medicine as outpatients. The next year outpatients were officially recognised, Oxford residents being required to attend at 11.00 am on Tuesdays and others at 11.00 am on Saturdays. The growth of the outpatient department was rapid, partly because the city doctors had ceased seeing poor patients free between certain hours—although prescribed medicines had to be paid for at the doctor's shop—and partly because medicines were obtainable free at the infirmary. Outpatient attendances continue to increase, and in 1978 about 148 000 patients were seen.

The new hospital

For the past 145 years, therefore, the Radcliffe Infirmary has provided inpatient and outpatient care for the acutely ill. From July of this year this responsibility passes from the infirmary to the new 470-bedded John Radcliffe Hospital, which also contains a considerably enlarged outpatient department. In addition, there are the academic departments of medicine, surgery, anaesthetics, paediatrics, and pathology; a large library; and the administrative offices of the medical school. The first phase of the John Radcliffe complex—the maternity hospital with its academic unit—opened in 1972.

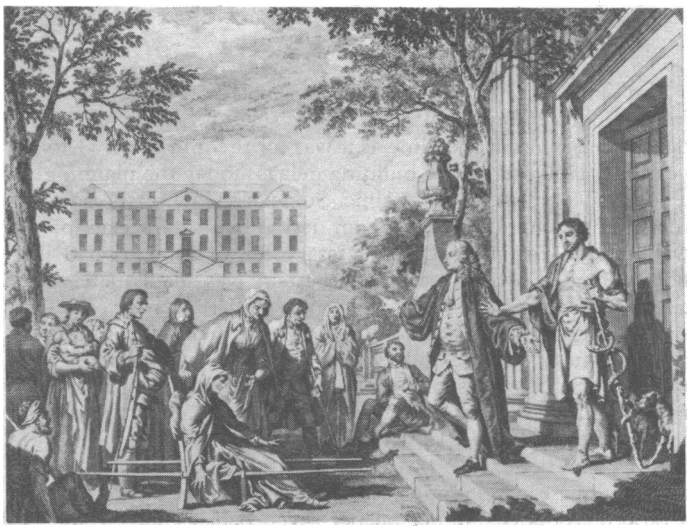

FIG 1—Reproduced from the Oxford Almanack of 1760, showing the original architectural design of the frontal elevation of the proposed Radcliffe Infirmary (courtesy of the Bodleian Library).

The John Radcliffe Hospital has been built high on Headington Hill to the east of the City of Oxford, on land previously owned by the board of governors. It forms a prominent—some would say too prominent—part of the Oxford architectural scene. The site is very different from that originally donated for the infirmary, among farmland and gravel pits to the north of the city proper in the parish of St Giles. At that time the population of Oxford was about 8000—today it is about 350 000 and the population for which certain regional specialist departments in the hospitals are responsible—for example, neurosurgery and neonatal surgery—numbers about 2½ million.

In 1758 the trustees appointed the Surveyor to St Paul's Cathedral, named Stiff Leadbetter, as architect. He had already built Gloucester County Hospital (since replaced by the new Gloucester Royal Hospital), which the infirmary resembled. History was repeated when Yorke, Rosenberg, and Mardell were chosen as architects for the John Radcliffe Hospital, for they had already designed the new St Thomas's Hospital, which the John Radcliffe Hospital resembles. Leadbetter's proposals were accepted in 1759 and a contract was signed for £5692, the hospital to open in 1764. The first patients were eventually admitted on 18 October, 1770. Costs continued to rise, the trustees providing another £1300 by 1776, and their total contribution had risen to £12 791 by 1779.

The building contract for the second phase of the John Radcliffe Hospital was for £12m. Postcontractual work will cost about £½m. Fully equipped and serviced, the total cost nears

The John Radcliffe Hospital, Oxford
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FIG 2—The Radcliffe Infirmary entrance, 1978 (courtesy of the *Oxford Mail and Times*).

£25m. The new hospital has been completed on time, although, interestingly, the interval between the start of the planning and occupation is about the same as it was for the infirmary, 11 to 12 years. In 1760 there were building delays; today the planning of a hospital complex takes the time. Some of the increased costs of the infirmary building arose from design faults—for example, a wall around the infirmary (necessary for protection) had not been included and the drainage system was inadequate. The site did, however, include a brew house. There were two brews: small beer for the patients and ale for the staff—including the nurses. The staff were collectively known as "the family," and for the first 50 years or so of the infirmary's existence "the family" numbered about seventeen—the apothecary, the matron, the apothecary's assistant, the porter (responsible for brewing), five constant nurses, three female household servants, an assistant nurse, a night nurse, and three part-time washerwomen: a ratio of roughly one person per seven beds. There would be little benefit in trying accurately to assess the ratio today, but, with a non-medical staff (including nurses) numbering about 1152, it is about two persons per bed. The apothecary and four physicians and four surgeons of 200 years ago have been replaced today by 125 consultants and 301 junior medical staff (both including honorary appointments).

The first clinical professor was appointed in 1780, this date therefore marking the start of the clinical medical school.

Lessons from the past

Alas, there is no brew house at the John Radcliffe Hospital—there is, in fact, not even a residents' mess. Modern managerial and planning concepts seem to assert that, as most junior medical staff are married and live out of hospital when off duty, a mess is not necessary. It has also been suggested in the course of discussion about this deficiency (as many see it) that junior medical staff cannot and should not expect priority over any other form of staff in the provision of a mess. The fact that for many junior doctors the hospital represents their home for much of their 6- to 12-month appointment has not received the emphasis it deserves. A hospital mess with proper facilities should provide an important forum for the exchange of social and medical news and views, among all staff, and in so doing should play a large part in creating and maintaining good morale—to the benefit of patient care. The "family" concept of 200 years ago, and practised until recently, should be remembered.

The early physicians and surgeons visited the hospital infrequently. They might see their patients once a week and one physician and one surgeon were responsible for the take-in of each week. Additionally, the surgeon would be called to care for fractures and accidents. Operations were not often performed. Between 1840 and 1854, for example, only 150 operations are recorded, mainly amputations (97) and lithotomy (26)—averaging 10·3 a year, with a mortality of 12%. Present-day discussions about medical audit are brought to mind by one of the original rules of the infirmary, laid down by the governors in 1775: "No amputation or principal operation be performed in the Infirmary without a previous consultation of all the physicians and surgeons belonging to it, except in some sudden accident." This rule was reaffirmed in 1838. Each operation had to be preceded by a consultation, the colleagues to deliver their opinion to the surgeon before the operation, in a room apart from the patient, and then sign the consultation book which was to be provided by the house surgeon. The purpose of this consultation, as the quarterly court of 1859 reiterated, was "to guard against relieving the operator from responsibility" and "to secure as far as possible that the opinions of his colleagues shall have due weight in fixing his decision." In 1889 the governors once more had formally to emphasise the need for joint consultation preoperatively, but in the following years, after the adoption of Listerian principles had reduced the incidence of infection (commonly erysipelas), the consultation system lapsed.

Past and present work load

It is difficult to make an effective comparison between past and present surgical work load at the infirmary. The accident and emergency department, with a staff of four orthopaedic consultants and 12 junior surgical staff, cared for about 3370 inpatients and 49 567 outpatients in 1978. There are five general surgical firms. In the same year, that headed by me and Mr M G W Kettlewell cared for 1738 inpatients and 4814 outpatients (1465 new and 3349 for follow-up). Twice each week the two consultants, two registrars, and three preregistration house surgeons conduct a ward round, and, in addition, there is a weekly morbidity and mortality survey. Collective responsibility, in 1770 conceived for the protection of the patients, has returned in an altered guise. Again, it brings benefit to the patient, for these rounds enable the house surgeons—each on a on-in-three night duty rota—to be acquainted with all the patients: additionally these rounds and meetings are invaluable for postgraduate instruction, at all levels.

Probably few now working at the infirmary will make the move in the second week of July without some feeling of regret. Anticipation of being able to provide better care for the commun-

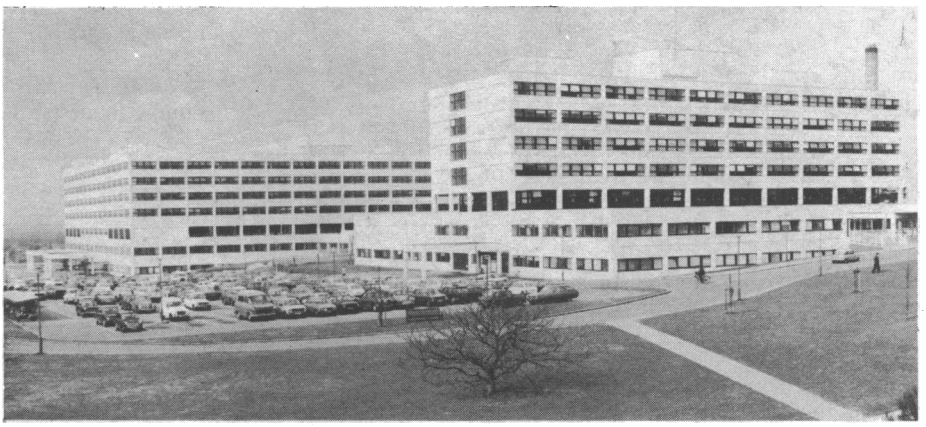

FIG 3—The John Radcliffe Hospital 1979, showing the Maternity Hospital (phase 1) in the foreground with phase 2, which is to be opened in July 1979 (courtesy of the *Oxford Mail and Times*).

ity remains, however, in spite of expectations having had to be modified by the financial restrictions of the last two or three years. The necessity for new hospital facilities in Oxford was officially accepted in 1964. The increasing local population, more specialisation within medicine, the need for a larger medical school, and inadequate resources for the care of patients at the infirmary made the need obvious. More beds and more specialist departments were eagerly awaited, and from about 1973 developments at the infirmary itself were slowed, if not halted. It was therefore particularly frustrating that about two years ago the increase expected in the regional budget to allow the John Radcliffe Hospital to be opened, while maintaining most of the existing beds in the area hospitals, did not materialise. This economy has brought an immense amount of administrative work to a relatively small group of doctors and administrators charged with the task of effecting what has come to be known as "level transfer"—namely, that the new hospital might open only if there were no increase in the number of beds or facilities. Even allowing for this condition, the additional annual revenue needed is said to be in the region of £750 000. It might be asked why, with modern designs and techniques, it should cost so much more to do the same task in a new building.

To open the John Radcliffe phase 2—at which about 80-85% of admissions will be acute—has therefore meant planning the closure of other hospitals in the area. Such closures have been resisted, sometimes vigorously and usually with the support of the local community health council. It is greatly to the credit of the working party, and others who have been reorganising the local hospital services, that ways have been found to assuage both annoyed medical staff, whose departmental plans have been curtailed, and some local communities, who understandably have felt more concerned about social services and care of the aged than what they incorrectly see as an expensive "scientific" hospital and medical school.

The administrative changes brought about by the introduction of the National Health Service in 1948 made the Radcliffe Infirmary part of the "United Oxford Hospitals," and the more recent reorganisation, which incorporated it into the less sympathetically sounding "area health authority (teaching)," are now followed by an appreciable change in its clinical responsibilities for the people of Oxford. At one stage in planning the new hospital services—in about 1972—the infirmary was to be closed as a hospital. Economic factors mainly—but perhaps also a less easily defined feeling among those who might have been required to supervise its closure—put an end to this plan. The Radcliffe Infirmary will continue, I hope without some of its older "temporary" buildings, as an important hospital in the area but will be occupied mainly by patients undergoing elective care, many of them elderly. May its reputation continue to prosper.

The views expressed here are personal: the historical facts have been gleaned from two books which I have enjoyed reading again—*The Radcliffe Infirmary* by A G Gibson (1926), Oxford University Press; and *A Short History of the Radcliffe Infirmary* by A H T Robb-Smith (1970), Church Army Press.

Reading for Pleasure

Other people's lives

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Sometimes the effluent of directives, circulars, and discussion papers threatens to swamp us all. It is then that we should gratefully take Dr Johnson's advice: "A man ought to read just as inclination leads him, for what he reads as a task will do him little good." For me, those inclinations lead to biography. It is not that I dislike fiction: it is more that I am fascinated by how real people are driven by compassion, humour, good luck, excitement, ambition, or even sheer lust for power. There is much to be enjoyed in a well-written life, be it of statesman or politician, saint or sinner.

Inclination for biography

By their very nature contemporary political autobiographies are vulnerable. Statesmen write their memoirs in old age, when time and partiality may cloud the issues and judgments of earlier days. Politicians often write their memoirs when the complacent euphoria of power softens self-criticism, or when the rancour of electoral defeat hardens bias.

While listening to Harold Macmillan on the eve of his 85th birthday in conversation with Robert McKenzie recently, I was reminded of my enjoyment of his five-volume autobiography, which is refreshingly free from these pitfalls. These memoirs are written in the grand style in which the formative influences of his literary background are clearly evident. He points out the difficulties of contemporary reporting by aptly quoting Horace Walpole's complaint: "It is one of the bad effects of living in one's own time that one never knows the truth of it till one is dead." To read these five books in sequence would be a major undertaking, but taken piecemeal there is much to relish. A debater may savour Mr Macmillan's urbane riposte to Khruschev's interruptions at the United Nations; a historian may dissect his analysis of world crises; and even an apprehensive speaker may gain comfort that the Prime Minister could not face lunch before Parliamentary questions.

My first introduction to the late Sir Alan Herbert's poetic talent was a solemn recitation of his "Lines on a Book Borrowed from the Ship's Doctor" by a distinguished professor of obstetrics at a rugby club dinner some 25 years ago. Since then I have enjoyed his less salacious verse, and his autobiography, *APH—His Life and Times*, is sheer delight. This entertaining story was written to celebrate his 80th birthday and reflects his talents as poet, playwright, lawyer, humorist, waterman, theatrical producer, and Member of Parliament. In this last

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