

Part 2

The Boundaries of Community

Chapter 5

The Negotiation of Inclusion and Exclusion in the Westminster Infirmary, 1716–1750

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Abstract

The Westminster Infirmary, established in 1719 to offer medical charity to London's sick poor, was the world's first voluntary hospital. This chapter examines how different debates about inclusion and exclusion shaped ideas about the hospital's social and religious mission, its policies and processes regarding donors, staff, and patients, and patient admission and discharge. It shows how open the Westminster Infirmary's activities were to negotiation by its stakeholders between 1719 and 1750, but how over time new policies were introduced in attempt to curb unruly behaviour which limited scope for the negotiation of the rules and created an increasingly bureaucratic and exclusionary culture within the hospital.

Keywords: hospital; admission; discharge; Westminster Infirmary; patient; charity; medicine; religion

On 14 January 1716, a small group of eminent Anglican gentlemen met in St Dunstan's Coffee House, Fleet Street, to discuss the establishment of a 'Charitable Society for Relieving the Sick Poor and Needy'. The aim of this newly formed charity – to be funded through subscriptions and donations from elite donors – was to provide food, medical assistance, respite care, and religious

instruction to the sick poor through outdoor relief. Among those that the charity said it would assist were sick poor from within and outside the parish of St Margaret's Westminster who were unable to pay for medical care or maintain accommodation. They also agreed to care for homeless, abandoned pregnant women nearing delivery, and sick prisoners.¹ With grand ambitions to help so many, but with a limited initial fund of £10, the charity's pockets were empty by April 1716.² Within the year the charity had ceased activity.³

In 1719 the society reassembled. At this time, the charity agreed to exclude pregnant women and prisoners from accessing assistance and moved away from their outdoor model of medical relief (where financial charity, food, or services were given without the recipient needing to enter an institution). Instead, they were to focus their efforts on establishing a small hospital at a private house in Petty France, Pimlico. These decisions appear to have been strategic; made in relation to the charity's earlier financial difficulties. It seems that, in the view of the Society, its earlier failure was because elite donors were reluctant to support pregnant women and prisoners. They also appear to have viewed a hospital-based model of medical charity as more appealing to potential donors. This can only be inferred, due to lack of surviving evidence, but the historians Jonathan Barry and Colin Jones do note that hospitals were popular recipients of charity during this period because they were 'subject to rigorous and highly public rules of admission and methods of administration'. This enabled donors to 'sleep peacefully abed at night, assured that their money was being properly spent'.⁴ In a poster advertising the establishment of the Westminster Infirmary from 1719, it was stated that the hospital would relieve 'the SICK and NEEDY, by providing them with lodging, with proper Food and Physick, and Nurses to attend to them during their Sickness, and by procuring them Advice and Assistance of Physicians or Surgeons'. 'Upon this Understanding', it was

explained that ‘such sums of money have been advanced and subscribed by several of this charity’.⁵ The charity’s early turbulent period seems to have taught trustees a lesson: that to ensure a steady stream of donations they needed to be reflexive to the sensibilities of the London elite, and negotiate with them to determine how their charity was delivered and who was included or excluded as its beneficiaries.⁶ Debates concerning inclusion and exclusion were thus woven into the cultural foundations of the Westminster Infirmary.

This chapter explores exclusion as it was defined and implemented in the structures and processes of the Westminster Infirmary, and how exclusion was experienced and negotiated by various hospital stakeholders. The Westminster Infirmary is a fitting case study because it was the world’s first voluntary hospital entirely funded by donations and subscriptions. This chapter is especially interested in how the institutional culture of the Westminster Infirmary, as a new sort of ‘Enlightened’ medical institution that relied ‘largely on the enthusiasm of the local community’, evolved between 1719 and 1750.⁷ There is particular focus on the period 1735–1740; an especially turbulent time in the hospital’s history when a dispute occurred between the Board of Governors and the physicians about the site of the hospital’s relocation (which was necessary due to expanding patient numbers). While the governors preferred a location at Buckingham Gate (where the Westminster Infirmary eventually moved in 1735), another property in at Hyde Park Corner was considered as more favourable by the physicians. The physicians who lost the argument subsequently resigned their posts at the Westminster Infirmary and went on to establish St George’s Hospital at their preferred site at Hyde Park Corner. For the Westminster Infirmary, this ushered in a period of new managerial methods and approaches. It also brought with it the *en masse* enlistment of a new staff of physicians, and the creation of a new set of conditions for inclusion and exclusion.

Alongside the hospital's management and daily activities, this chapter is also interested in how the hospital's cultures of exclusion were shaped by broader changes occurring in London during this period. These developments included increasing urbanisation and migration; shifting hierarchies of social order and status; changing gender norms; new cultures of charity and associational culture; rising rates of poverty, crime, and alcoholism; and tensions surrounding religion.

In an effort to examine these big themes, this chapter does not aim to tell a detailed or comprehensive history of the Infirmary's early history; this has already been thoroughly documented elsewhere.⁸ Nor is this a history of the changing relationship between state, religious, and charitable healthcare provision, although these issues form a backdrop to the analysis.⁹ Instead, this chapter offers a social history of the Westminster Infirmary. Specifically, it explores how socio-economic developments of the period were reflected in the activities of the institution, and the experiences of people who worked for and were treated by the hospital. It shows how various people involved with the hospital – trustees, medical and auxiliary staff, patients, and patient visitors – shaped the institution and its approaches to inclusion and exclusion. Of specific interest is how the institution responded to behaviours by trustees, staff, and patients that implicitly or explicitly ran counter to both its own norms and to those of eighteenth-century society more widely. In summary, the chapter aims to detail how the Westminster Infirmary, an institution where power and authority was nebulously located in its early years, created structures, processes, and behavioural norms to deal with behaviour that it judged 'unruly' and, in so doing, created an institutional identity for itself.

Sources for this chapter include the trustees of the Westminster Infirmary meeting minutes, and print material that advertised the hospital's activities with the aim of encouraging financial donations. Detailed in these sources is information about the patients admitted to and released from the hospital, the hiring and firing of staff, debates over the creation of new orders and resolutions, and changes to the hospital's governance. Print materials produced by the Westminster Infirmary, like its proposals and reports, also played an important role in engaging the eighteenth-century urban elite in the hospital's activities and assisted in the creation of its institutional identity. These materials also culturally communicated ideas about social inclusion and exclusion that were born in the context of the hospital, and provided a blueprint for the operation of voluntary medical charity more broadly.

In its approach to this wide range of sources, the chapter focuses on moments of disagreement and cases involving unruly behaviour. These instances were largely outside the usual realms of operation for the hospital but created moments for the institution to reflect on its identity, and its approaches to inclusion and exclusion. One challenge with these sources is that they only provide information about the hospital and its patients from the perspective of the hospital's trustees and senior management. There is thus a limit on the extent to which we can access actual patient experience through such records. Another problem is that several issues around patient-hospital relations are excluded. For example, these sources provide little information about the events preceding the patients' admittance to the hospital or the experiences of patients who were turned away. To get at some of these stories, this chapter also makes selective use of cases from the Old Bailey and contemporary writing about urban life.

The first part of the chapter examines how the foundation and structures of the Westminster Infirmary reflected broader socio-economic developments and contemporary social, gender, and religious norms. Section two focuses on issues inclusion and exclusion concerning staff. Part three looks at patient experiences and the hospital's reactions to moments of unruliness, with a focus on the hospital's criteria and processes of admission, and how hospital stakeholders negotiated them. The final section examines the hospital's policies and practices concerning discharge, and how and why they evolved between 1719 and 1750. Collectively this analysis will show that issues concerning inclusion and exclusion were central to the creation of the Westminster Infirmary's habitus and identity.¹⁰ At the same time, the chapter will demonstrate that in this early period of the hospital's history, its idioms, structures, and processes of inclusion and exclusion were both explicitly and implicitly open to negotiation by hospital stakeholders.

The Westminster Infirmary and social order

In the first half of the eighteenth century, England was undergoing significant political and socio-economic transformations. Nowhere was this change felt more keenly than in London. In 1600, London's population was around 200,000, but by 1750 it had grown to an estimated 675,000.¹¹ Death rates in the city outranked birth rates for most of this period, largely caused by high rates of infectious disease.¹² London's overcrowded and unsanitary living conditions, malnutrition, and food adulteration also caused susceptibility to chronic disease among the working population.¹³ Among the first group of thirty patients treated by the Westminster Infirmary between 10 February 1720 and 13 July 1720, four were cited as suffering with 'consumption' (tuberculosis or other wasting diseases), two scurvy, two rheumatism, two fever, and three menstrual diseases. Other

cited causes of disease among admitted patients included leprosy, scrophula (also known as the ‘Kings Evil’), strains, joint problems, and asthma.

The main factor in London’s eighteenth-century population increase was rising in-migration.¹⁴ Although London’s commercial and industrial growth relied on such migration, it also provoked widespread social anxiety. A particular concern was that London was becoming a magnet for poor migrants who preyed on London’s residents for financial support. For example, in 1729, the Quaker merchant Joshua Gee – in a surprisingly un-Quakerly manner – complained:

If any person is born with any defect or deformity, or maimed by fire or any other casualty, or by any inveterate distemper, which renders them miserable objects, their way is open to London, where they have the free liberty of shewing their nauseous sights to terrify people, and force them to give money to get of them.¹⁵

Equally, many Londoners objected to seeing the ugliness of disease and poverty on London’s streets. In 1720, a correspondent to the *London Journal* complained that the people of London should not have to suffer the sight of deformed beggars wandering ‘the Streets exposing their distorted Limbs and filthy Sores’.¹⁶

Several factors compounded Londoners’ anxieties about migration, poverty, and disease. First was a recognition that the parish system of poor relief was unable to cater sufficiently for migrants or provide adequate support to London’s sick poor.¹⁷ Secondly, there was insufficiency of hospital provision in the capital. As early as 1676, the English philosopher, economist, and physician William Petty complained that one ‘cause of defect in the art of medicine is that there have not been Hospitalls for the Accomodation of sick people. Rich as well as Poor’.¹⁸ Indeed, until the

establishment of the Westminster Infirmary, London only had two hospitals that explicitly catered for the sick poor: the religious and state funded hospitals of St Bartholomew's in Smithfield, and St Thomas's in Southwark. Both of these hospitals also required a nominal fee from patients, thereby excluding the truly destitute from access. Thirdly, high rates of migration, poverty, and disease in the city were regarded as indicators of a failure in social order. This ideological correlation, as Lynn Hollen Lees suggests, resulted from a tendency, on the part of the contemporary elite, to transfer 'their hostility to the dirt, disease, and decay of early industrial society on to the figures of the dependant poor'.¹⁹

By the early eighteenth century, the London elite were becoming increasingly frustrated by lack of state action in response to London's poverty problems. They were also more articulate about what they perceived as the key issues. In the Charitable Proposal drawn up by the Charitable Society for Relieving the Sick Poor and Needy in 1716, it was stated:

amongst those who do receive Relief from their respective Parishes, many suffer extremely, and are sometimes lost, partly for want of Accommodations and proper Medicines in their own Houses or Lodgings, (the Closeness and Unwholesomeness of which is too often one great Cause of their Sickness) partly by the imprudent laying out of what is so allowed, and by the Ignorance and Carelessness or Ill Management of those about them.²⁰

In this sense, the establishment of the Charitable Society for the Sick Poor and Needy, and later the Westminster Infirmary, can be seen as an effort by London's elite to solve poverty issues for themselves. The shift in charitable focus, from merely providing relief for the sick poor towards correcting perceived social problems, was new to the eighteenth century. Among other things, this

change was connected to evolving ideas of Protestant civic responsibility and the rise of new ‘enlightened’ sensibilities among the emergent middle classes and elites, which together created a greater social commitment to philanthropy.²¹ The establishment of the voluntary hospital was thus part of the evolution of new ‘enlightened’ approaches to medical charity.

The trustees of the Westminster Infirmary used Londoners’ fears about the sick poor to promote support for their charity. In a published statement of the hospital’s aims after 1719, it was remarked that it was ‘obvious to any one that walks the Streets’ that existing frameworks of charity were ‘not sufficient to preserve great Numbers ... from Beggary, to the Grief of all good Men, and the no small Reproach of our Religion and Country’.²² Correspondingly, the establishment of the Westminster Infirmary was presented as a means of restoring social order in the city, in part by physically removing the sick poor from London’s streets. Writing about the establishment of the Royal Hospital at Greenwich in 1728, a similar sort of institution, the building’s architect Nicholas Hawksmoor proposed that that such hospitals were a necessary means of ‘rectifying the irregular and ill management of the polices of great cities’.²³ In this way, the establishment of the Westminster Infirmary and other voluntary hospitals were aligned with national concerns. This was made explicit in a printed report advertising the charity’s activities from 1723, where the Westminster Infirmary described its charity as a: ‘Blessing upon the whole Nation’, ensuring:

the Hungry being fed, the Naked cloathed, the Stranger taken in, the Ignorant instructed, the Sick visited and relieved, and many Poor industrious People, who have nothing but the Labour of their Hands to subsist upon, preserv’d from perishing miserably, or becoming a Burden to their Country, and render’d useful Members of it.²⁴

The Westminster Infirmary was an Anglican institution and, as such, sought to solve contemporary problems by ministering the souls, as well as the bodies, of the sick poor. It achieved this by providing patients with daily visits from Anglican clergymen during their hospital stay, as well as access to religious and conduct texts like Henry Hammond's edition of *The Whole Duty of Man* (1658). This dual approach was considered the best means of resolving complex social problems in a period when social ills, including disease, were interpreted as the result of moral failings on the part of individuals and society more broadly.²⁵ Through the hospital, the trustees also sought to stifle the threat of religious Dissent in the city. For example, Paul Slack has traced the roots of London's voluntary hospital movement to charitable societies such as the Society for Promoting Christian Knowledge (1699), which was set up by the Anglican Clergy in West London to address contemporary social problems and perceived 'competition from Dissent and Popery'.²⁶

Donors and staff

The establishment of the Westminster Infirmary was also part of the rise of associational culture in Enlightenment London. Historians such as Peter Clark and Ileana Baird note that clubs and societies were significant in the creation of elite social networks during the eighteenth century. This was at a time, as Peter Borsay suggests, when London experienced difficulties 'integrating a large and sometimes heterogeneous body of people into a viable community'.²⁷ The Westminster Infirmary adopted a range of approaches to engage donors and socially reward them for their charitable activity, including newspaper adverts that listed donors by name, and social events like yearly charitable sermons.²⁸ Initially, donor numbers were quite small but numbers expanded after the Prince of Wales, future George II, donated to the charity in 1721. Although many donors were

motivated by genuinely charitable intentions, sometimes the elite's involvement was viewed cynically as a means of them vainly and publicly displaying their moral and religious 'virtue', consolidating connections, and demonstrating their wealth, power, and influence. In characteristically scathing style, the physician and social commentator Bernard Mandeville wrote in the 1730s: 'Pride and Vanity have built more Hospitals than all other Virtues together'.²⁹

Evidence from donor lists shows that subscribers to the Westminster Infirmary were primarily from the aristocratic and gentry elite, and the 'polite' professional and commercial classes.³⁰ Indeed, the four founding members of the Charitable Society for Relieving the Sick Poor and Needy were the banker Henry Hoare (who provided the first financial donation of £10), the wine merchant Robert Witham, the religious author William Wogan, and Reverend Patrick Cockburn. Donor lists also illustrate that a high number of women from similar sorts of backgrounds subscribed to the charity. The active engagement of female subscribers was particularly important to the Westminster Infirmary's success. Its inclusion of women – unmarried, married, and widowed – as charitable donors, reflected women's increasingly prominent role in the organisation of sociable activities within polite society at this time.³¹ The charity also seems to have been proud of elite women's participation in their activities. In the letter the Westminster Infirmary sent to King George I in 1721, thanking him for his endorsement of the charity, it was stated that 'the voluntary contributions of several of the Nobility and Gentry of both the sexes' had enabled the hospital to preserve 'the lives of some hundreds of your Majesty's poor subjects'.³²

Female subscribers had views that were distinct to male subscribers, governors, and physicians on how the hospital should operate and who should be admitted. These women voiced their opinions

through dialogue with members of the all-male trustee board and, on occasion, by sending letters to express their views. For example, in 1738, the hospital considered at length whether to admit patients known to be suffering venereal disease. Among the evidence considered by the trustees, and recorded in the trustees meeting minutes, was a letter sent by thirty female donors opposing the proposal to admit such patients. Their objection was that this move undermined the hospital's original aim to provide care to the 'deserving' sick poor. The letter stated:

Gentlemen,

We who are subscribers to the Infirmary at St James Street Westminster having been well informed that several of the Trustees do Endeavour to introduce venereal patients into that place for cure; contrary to what we apprehended and Believed would be the practice of the Infirmary. Therefore we do think it requisite to show our great Dislike of admitting such patients, hindering the Industrious sick poor being Admitted. We therefore hope that you gentlemen, who have the liberty of attending the Gen. Board will come to such a Resolution, as will Effectually prevent the admission of all such patients.³³

This letter evidences how far donor stakeholders considered issues of inclusion and exclusion to the hospital's successful functioning. It also shows how the voluntary hospital's model of charity empowered its subscribers to have a say over the hospital's activities, some of whom – such as women – were excluded from similar sorts of decision making in other contexts. Moreover, it reveals that elite female donors had particular perceptions of the types of poor to be included and excluded from access to the hospital, and how they made their opinions known in distinct ways; largely through negotiating with male governors through bureaucratic and social means.

In terms of medical staff, the Westminster Infirmary was a highly ‘enlightened’ institution in providing care to the sick poor that was administered by physicians who held a medical degree, in addition to trained surgeons and apothecaries. It is important to note that at this time most of the population, outside of the polite commercial classes, would have been unable to afford the medical care of accredited physicians or even expert surgeons. Instead, the majority of the population would have relied on domestic medicine, and treatment or care from medically experienced neighbours, midwives, barbers, and ‘quacks’.³⁴ Essentially, the Westminster Infirmary could have just offered care to the sick poor from barber-surgeons and nurses – without the involvement of physicians – and this would have still constituted a far better level of medical care than they could financially or socially procure for themselves.

While the surgeons and apothecaries who worked for the hospital were paid a salary, the physicians offered their services for free. Physicians were attracted to these roles because they brought social prestige and networking opportunities to mingle with elite donors as potential clients. Such work also supplied them with interesting and challenging medical cases.³⁵ The hospital’s physicians, in a position of power due to their professional training and provision of free services, had considerable autonomy over patient admittance and discharge. For example, on 3 January 1721, contrary to the hospital’s standard processes, it was reported that one of the hospital’s physicians, Mr Aldis, ‘gave notice to the board that a poor man being found perishing ... with hunger and cold’, had been given by him some ‘victual’s’ and money ‘to carry him to his habitation in the country’.³⁶ This shows how physicians involved with the Westminster Infirmary felt able to bend the rules because the charity largely depended on their voluntary support to function. That said, after 1735, when many of the original attending physicians at the Westminster Infirmary left

following the dispute regarding the hospital's relocation to Buckingham Gate, such instances of rule-bending became less common. This suggests that the mass resignation of the original attending physicians from the Infirmary may have been, at least in part, to do with shifting contours of power between the established physicians and the Infirmary's governors, alongside a more general refusal to comply with changes that would have publicly suggested that their power was lesser than that of the governors.

The hospital also employed a female matron, female nurses, and other mixed-gender auxiliary staff, such as cooks (mainly women) and orderlies (mainly men). The matron's main responsibilities included the daily running of the hospital and ensuring that the hospital's rules were adhered to.³⁷ After the physicians, the matron had the most power in determining patient admittance or removal. The matron was also responsible for reporting any issues with the hospital's management to the board before trustee meetings, and it is through the matrons' reports that we learn of most of the instances of unruly behaviour in the hospital. The positioning of a woman in this considerable position of power is in some ways surprising, but nevertheless consistent with contemporary gender norms that placed women in charge of orderly household management, including management of servants and care of the sick.³⁸ Like most female heads of households, the hospital's matron also guarded and managed the hospital's keys.³⁹

Another of the matron's responsibilities was ensuring the employment of 'appropriate' nurses and auxiliaries at the Westminster Infirmary. In the hospital's early years there were no specific criteria for any of these positions and instead appointments were left to the matron's discretion. However, over time rules were introduced by the governors regarding nurses' behaviour and conduct. These

would have guided decisions over who the matron employed and how she vetted applicants. The first explicit rule regarding the employment of nurses was implemented at the Westminster Infirmary in 1742 after it was discovered that a nurse, Ann Martin, and a cook, Margaret Humphreys, were Catholics. This was a problem because the Westminster Infirmary was an explicitly Anglican institution, but also because Catholics were seen to be a dangerous threat to the social order and Protestantism more broadly.⁴⁰ The presence of these women in the hospital was thus, in many ways, seen as a Catholic plot to undermine the activities of the Infirmary, which wished to promote Protestant values. Both Martin and Humphreys were soon dismissed after these discoveries about their religion were made public. The hospital also subsequently ordered that:

none but true Protestants shall at any time hereafter be admitted to any services or employ in or about the Infirmary, and that all servants or wages who are not or shall be suspected to be Papists or Profess the Romish Religion, shall give full satisfaction and proof to the Society of their being Protestants.⁴¹

This example shows how the balances of power shifted in the period under consideration from individuals to the institution via the implementation of rules. It also demonstrates how contemporary socio-economic and political issues informed the identity, structures, processes, and practices of the hospital in its early years.

Admission

Hospital admission, or refusal of admission, represents the most explicit cultural enactment of social inclusion and exclusion in a medical context. The medical historian Guenter B. Risse suggests that the exclusion of the sick from the healthy was among the earliest aims of hospitals. Explaining the social and medical functions of hospital admission practices from the classical age

through to modern times, Risse suggests that these rites symbolise ‘the transition to patienthood’, and help social actors understand - and give social meaning to – the passage across the liminal threshold between health and sickness, and social and medical space.⁴² In this sense, hospital admission practices are meaningful to both the sick and the healthy, and facilitate the demarcation of the different social roles and expectations that are attached to individuals judged healthy or diseased.⁴³

Hospitals’ admission criteria are not historically fixed. Instead, they vary according to shifting social and institutional values, changing conceptions of disease, and alterations in attitudes towards patients’ social worthiness.⁴⁴ Historians of early modern England have noted that from the mid-seventeenth century authorities increasingly distinguished between the ‘deserving’ and ‘undeserving’ poor, and sought to ‘clarify institutional responses in the form of institutional support’.⁴⁵ Recently, however, Kevin Siena has argued that evidence from treatises penned by eighteenth-century doctors, especially those published before 1750, suggest more ‘ambiguous’ medical attitudes towards the poor, ‘with some overtly condemning the poor but others resisting that urge’.⁴⁶ As we will see, this ambiguity characterises the Westminster Infirmary’s attitudes towards the sick poor in the period between 1716 and 1750. Indeed, whether people were categorised as ‘deserving’ or ‘undeserving’ was largely determined on an individual basis, albeit with some exceptions, such as in the case of people with venereal diseases.

At the time of its establishment, the Westminster Infirmary deliberately styled itself as a more open and accessible institution than London’s other charitable hospitals. This was because it did not require any sort of fee and offered treatment to patients from any English parish, as well as

‘foreigners’. The Westminster Infirmary held true to many of its original inclusive aims throughout the period considered in this chapter. In the first year of the hospital’s operation, 17 per cent of the total number of patients admitted were described as ‘strangers’ from outside London, with a further 16.6 per cent being from parishes outside of St Margaret’s Westminster.⁴⁷ Some migrants came from much further afield. For example, in 1719 the hospital treated a Dutch ‘foreigner’, Adrien van Reyney, for consumption. Likewise, in 1721 it was recorded that the hospital had provided assistance to Ann Lolbech, ‘a stranger of Lancarts Forfshire’, in Scotland, who had been blinded by a lightning strike.⁴⁸ The Westminster Infirmary’s focus on treating patients regardless of their parish origins, was one of its most distinctive and enlightened characteristics. This was because this approach recognised, and provided a solution for, the failings of parish-based systems of charity at a time when people were increasingly mobile. This approach provided a blueprint for other London voluntary hospitals, such as St George’s Hospital (1735) and the London Hospital (1740).

Although in some respects the Westminster Infirmary was inclusive in its approach to patient admission, in others it was highly exclusionary and selective. Among the patient groups who were usually denied access to the hospital on application were non-Anglicans, people with mental illnesses, those suffering with long-term infirmity, and the dying. Indeed, from the start, the Westminster Infirmary explicitly excluded anyone who the hospital’s physicians did not believe they could treat within two months of admission. Two months of admission was also denoted as the maximum length of stay for any patient. As they were employed in practice, these criteria probably meant that, for the most part, the hospital excluded elderly patients who would have been considered likely to die during their hospital stay. Instead, preference was shown to the sick

poor who were young or middle aged with ‘treatable diseases’ like scurvy, rheumatism, colds or flu, menstrual abnormality, or injury.

The Westminster Infirmary also routinely excluded patients with contagious diseases, such as typhoid and smallpox, from admission. This was, in part, due to the infectious nature of these diseases, but also because such cases were difficult to treat. Lessons about the contagious nature of smallpox were only learned by the Westminster Infirmary over time, resulting in changing practices of admission and treatment for these patients. For example, on the 25 April 1738, it was stated in the governors’ board minutes that:

Having been represented to the Board that great Dangers and Inconveniences have attended the keeping of persons in the House that are sick of the smallpox ... for the future every person sick of the smallpox be immediately sent out of the House to a Nurse, to be provided by the Apothecary and Matron till such a time as a proper place may be found for them.⁴⁹

This shows that were occasions when the Westminster Infirmary’s governors made efforts to mitigate the exclusion of patients from hospital admission, who were excluded on the basis of general policy, by offering other forms of support, namely through outdoor relief.

Although the Westminster Infirmary’s records enable us to establish instances when the Board of Governors bent their rules to facilitate treatment for patients that might usually be excluded from the hospital, it is impossible to substantiate how many applicants were directly turned away. This is because the Westminster Infirmary did not keep records – at least that survive – that documented cases of patients who were denied admission. It is therefore difficult to establish, either

quantitatively or qualitatively, how the hospital's rules were applied to individual patients, and the reasons given for their exclusion from admission. Our best evidence to this effect comes from the admission data from the St Margaret's Workhouse Infirmary, established in 1725, that was in close proximity to the Westminster Infirmary. In his analysis, Siena suggests that thirty eight per cent of St Margaret's workhouse inmates were admitted because of illness or sickness due to their inability to pay for health care or prove their charitable case elsewhere.⁵⁰ Siena also notes that in 1734, seventy-nine per cent of the patients in the workhouse infirmary were suffering from the pox (whether it was smallpox or venereal disease is difficult to establish, partly due to the confusion surrounding its diagnosis), itch (infectious skin diseases), and fever. The St Margaret's Workhouse Infirmary data suggests that people with these diseases were routinely excluded from London's other hospitals, including the Westminster Infirmary.⁵¹

In practice, the Westminster Infirmary's processes of admission were socially and culturally complex. Siena suggests that '[g]etting into a voluntary hospital was fraught with uncertainty, and it was particularly hard for those with dubious reputations or no connections or those suffering from ailments ... that called their character into question'.⁵² To be granted admission to the Westminster Infirmary, patients required a letter of recommendation. It was stated in the hospital's policies that patients could be recommended to the hospital by a trustee, a physician, or a donor. An order of 1721 stated that the hospital would admit 'poor sick persons inhabiting the parishes of St Margaret's or others may be recommended by any of the subscribers or benefactors'.⁵³ This clause meant that a sick and poor Scot, for example, who had been previously working with or for someone who was a charity benefactor – and willing to recommend them – would be able to obtain treatment from the Westminster Infirmary. A parishioner of St Margaret's, by contrast, who had

the same socio-economic and health circumstances as the Scot, but who had no connections to a donor, could be denied access. Recommendations from subscribers and donors came in the form of letters, which were used to show that the proposed patient was deserving of medical care by the hospital and was also morally sound.⁵⁴ The ability to recommend patients suggests that one of the potential reasons for donor's involvement with the charity was that it enabled them to provide their servants with a very basic form of workplace insurance. To aid the administration of this 'recommendation' system, the hospital provided printed copies of forms which could be filled out by subscribers and benefactors to facilitate the admittance of patients.⁵⁵ The only stipulation that was put upon donors who were recommending patients from outside the parish was that they should 'oblige' themselves 'to take care of the said person upon his Recovery' and cover burial costs if the patient died.⁵⁶ On admission, the orders also stated that patients from parishes outside of St Margaret's were required to provide certified letters from their home parish which stated that, following the patient's discharge from the Westminster Infirmary they would receive necessary care and charitable support from that parish. It is ambiguous as to whether this letter was to be acquired by the hospital, on the patient's behalf, or the patient themselves.⁵⁷ Whether the hospital required such letters ahead of a patient's admission to the Infirmary is also unclear.

How patients obtained letters of recommendation from benefactors is equally unclear and not documented in hospital records.⁵⁸ All patients required this sort of letter for admission. In most cases, it is likely that recommended patients were the past or present employees of charitable benefactors, or family or friends of employees who had petitioned their employers, as subscribers of the charity, to support their claims for relief.⁵⁹ For example, in an Old Bailey case from 1742, a witness, who described himself as a Goldsmith, testified to the character of the daughter of one of

his employees, Jane Wood, who was accused of stealing. Prior to the crime being investigated, and as a way of providing a good account of her character, he explained that she had been ‘frightened into Fits some Years ago, by some Soldiers coming into the House, which took away her Senses’. Following this episode, he recounted that he had ‘got her into the Infirmary at Westminster, and she was sometime there before she was cured’.⁶⁰ This shows how people of standing were able to use their position and connections to support the admission of patients to the Westminster Infirmary.

Before admission, all patients had to be examined by a hospital physician. This examination was used to confirm the nature of the patient’s disease and establish whether they met the criteria for treatment. Risse suggests that these ‘encounters could be frustrating and deceptive, as prospective patients tried hard to tell doctors the “right” stories about their sufferings to ensure admission’, while doctors looked out for ‘symptoms or signs that clearly marked particular diseases’.⁶¹ Following this examination, applicants who were not considered to meet the hospital’s criteria for treatment were turned away directly. No reports were created, as far as is evident from the records, in relation to these turned-away applicants. On the other hand, in the case of patients recommended for admittance, the hospital’s doctors submitted reports, often no longer than a few lines, to be verified by the hospital’s board. These reports included the patient’s name and the nature of their disease, and were used for official record keeping. Sometimes, although rare, the physician’s decisions could be trumped by subscribers and donors, especially if they were particularly generous or influential supporters. For example, on 3 January 1721, Cath Stevens, who had been recommended by one of the charity’s major patrons, Lady Dodsley, the Royal governess, was said to have been ‘examined by the physicians and pronounced incurable, having the Gout’. This was

initially judged as grounds to exclude her from admission. However, the trustee board's meetings minutes noted that it was 'ordered nevertheless upon consideration of my Lady's recommendation that she be admitted for a fortnight'.⁶²

Nonetheless, when it came to recommending patients, doctors tended to have more influence than subscribers and donors. When the Westminster Infirmary first opened, neither donors nor physicians had any limit on how many patients they could recommend. Yet, in 1729, due to the rising success of the hospital and growing patient numbers, the hospital governors decreed that physicians and surgeons 'may each have two in and two outpatients'. The donors, by comparison, could only have two inpatients and one outpatient at any one time.⁶³ In this respect, the role of doctors in the admission process enabled the Infirmary to function like a proto-accident and emergency hospital. For example, in 1750 one of the physicians was brought to the Old Bailey to testify in the case of William Riley who was accused of murdering Samuel Sutton with a clothes hanger. Soon after the crime had been committed, the mortally wounded victim had been brought by his friends to the hospital in an effort to save him, and was admitted by one of the attending physicians, John Pile. Pile, testified:

I am surgeon to the Westminster Infirmary. The deceas'd was brought there on Saturday was seen in the evening. I found he had a wound on the left side of the belly, near the navel, where the intestine came out; he languish'd till Monday morning, and then died. It was about an inch long. The gut was not cut, but there was a large quantity of it out; and all that was out mortified. That was the occasion of his death.⁶⁴

Alongside failure to produce a letter of support or meet the requirements of admission, there were numerous other factors that could cause patients to be turned away by the Westminster Infirmary. Quite frequently the hospital was full, especially in the early years when the hospital resided in the locations of, firstly, Pretty France, Pimlico (which accommodated ten beds), and secondly, St Bartholomew's, Smithfield between 1720 and 1724 (accommodating eighteen beds). On the 6 September 1724, both Jane Farrant and Jane Belcher were given outpatient care until the hospital had space for admission.⁶⁵ Financial difficulties and the poor state of the rented buildings used to house the hospital at different stages in its early history also caused challenges. For example, on the 19 November 1729, it was decreed that 'in consideration of the present low state of this Infirmary', no patients should be admitted 'till a General Board is called'.⁶⁶ The hospital moved again in 1735 to a new residence at Buckingham Gate which accommodated ninety-eight beds. Debates over this relocation caused an irreconcilable split between the managing trustees of the Westminster Infirmary and its attending physicians, causing the physicians to separate themselves from the charity and establish their own hospital, St George's Hospital, at their preferred site at Hyde Park Corner.⁶⁷

The inclusion or exclusion of particular patient groups, especially venereal patients, was a subject of debate between hospital governors, benefactors, physicians, and patients throughout the period 1716 to 1750. It involved all these key stakeholders because it was perceived by some to fundamentally alter the institution's essential charitable mission, and the overall ability of the Westminster Infirmary to support the sick and deserving poor. Before the 1730s, there is little mention of the issue of venereal disease in the Westminster Infirmary's records. This suggests the sick poor with these diseases were not deliberately excluded. Interestingly, however, there is also

no record of patients with this type of illness being admitted for treatment. Yet, after 1735, the new hospital administration and team of doctors seem to have regarded the issue of whether to admit venereal patients as a particular challenge. This might have been because of increasing numbers of applications of patients with such diseases, maybe as a result of overcrowding in London's other hospitals. But it also might suggest that the earlier staff body of physicians for the Westminster Infirmary, who left in 1735, may have been more willing to overlook these issues and/or deceive the board about the nature of the complaints of the patients they admitted. Either way, in 1738 the Westminster Infirmary trustees ordered the establishment of a committee to consider:

what persons are properly objects of this charity, to enquire into the methods hitherto followed both amongst us and at other hospitals on the choice of patients to be Admitted, and to draw up a report of what method shall appear to them the most satisfactory to the subscribers, most for the Good and Safety of patients, and most for the peace and prosperity of the society.⁶⁸

Upon considering the issue, the committee recommended that venereal patients should not be admitted to the hospital for treatment in the future. The stated reasons for this decision were manifold, including the previously mentioned objections of the female donors and the apparent lack of precedent for the admission of such patients, as evidenced in the Infirmary's patient records. Yet, the main reason for their exclusion, according to the committee, was that venereal patients could not be considered eligible for admission because: 'persons infected with venereal disease do generally bring it upon themselves by their own lewd and vicious habits'. It was also proposed that by allowing these patients access, the hospital would be causing 'the exclusion of many more deserving objects'.⁶⁹

Discharge

In comparison to admittance, described in detail by historians such as Risse, the history of patient discharge has received limited historical attention. The reasons for this are unclear, but it is likely because the structures, processes, and practices of patient discharge are more nebulous than admission and tend to be more deeply intertwined with individual patient treatment and case histories. Indeed, at least in relation to the Westminster Infirmary, practices of patient discharge tended to be reactive to individual cases rather than planned processes, meaning that they are less well documented in formal institutional records. The standard evidence of discharge we have from the surviving records is a few lines stating the name of the patient and when they were discharged, whether or not they had been cured, or if they had died. In a few more exceptional cases, there is evidence of potentially controversial reasons why a patient was discharged without cure.

Practices of discharge are worth studying because they are highly revealing of institutional cultures, shifting pressures within and outside institutions, and because of their symbiotic relationship with rules of admittance. In terms of the Westminster Infirmary in the period considered, practices of discharge reveal how the 'rules' were negotiated between various hospital stakeholders. They also indicate some of the methods used to maintain social order in the hospital, and ways in which the hospital responded to challenges caused by London's social problems. There was also a close relationship between instances of patient discharge and structures of admission. For example, after dealing with particular cases of unruly behaviour, it was common practice for the hospital to pass new rules of admission to prevent similar instances arising in the future. This approach to the development of admission rules was significant because it increasingly made the hospital a more exclusive space.

Numerous factors could lead patients to be discharged from the Westminster Infirmary after admission. The most common cause of patient discharge, it is important to note, was cure. For example, in a public account of 1734, it was reported that in the period December 1719 to March 1734, 228 patients had left the hospital 'cured', in comparison to 10 discharged for irregularity and 24 discharged incurable.⁷⁰ To be discharged, patients had to have their leave of the hospital agreed by the physicians and trustees. Successful cure of patients was something that the hospital celebrated as evidence of its social value and impact, and to encourage ongoing and increased support for the institution. This explains why the hospital regularly published figures on the numbers of successfully treated patients. After 1721 it was also ordered that 'everyone discharged cured from this infirmary be enjoined by the chairman to give publick thanks in their parish churches'.⁷¹ This was a further means of promoting the charity and publicising its good deeds across London, England, and beyond. In addition, this practice served to reaffirm the hierarchical distinctions between the givers and receivers of charity. Records of who had, and who had not, given thanks to the charity were recorded in the trustees' meeting minutes, with those who failed to provide thanks being denied future access to care by the hospital.

Patients could also be discharged prematurely from the Westminster Infirmary following discoveries about the nature of their disease during treatment. For example, on 30 March 1721, Robert Pight was discharged due to mental illness. The physician attending his case noted: 'this House is not the proper for the care of Robert Pight him being a lunatic. Ordered to be discharged'.⁷² The Infirmary's exclusion of patients with mental diseases was consistent with London's other medical hospitals in the same period. The mentally ill were routinely shunned from

such institutions because of their behavioural unpredictability, and difficulties relating to their treatment. At the same time, they problematised clear patient categorisation, which was challenging in institutions such as the Westminster Infirmary where such categorisation was central to the hospital's effective operation. On a deeper level, mental illnesses often provoked concern in medical institutions and society more broadly because there was a recognition that 'its definitions, its boundaries, its meanings' were 'a distorted mirror of shifting social order'.⁷³ The founding ethos of the Westminster Infirmary was to restore order, and in this sense it is easy to see how the treatment of the mentally ill was problematic within this context. Consequently, the only institutionally based treatment option for the mentally ill in London in this period was Bethlem Hospital, described by Allan Ingram as 'where madness went to hide its face'.⁷⁴

Another cause of early patient discharge was failure on the part of patients to uphold decent behaviour. The hospital's rules were generally policed and reported to the board of trustees by the hospital's matron. Early in the years of the hospital's operations the trustees were confronted with a difficult case which seems to have taken them by surprise, as evidenced by the extensive discussion that was devoted to it in their meeting minutes. On 17 August 1720, it was reported that Rob Winnington, a patient, had 'behaved himself in a very rude and scandalous manner'. Among his crimes were 'motioning quickly' – a euphemism for masturbation – 'cursing and swearing', and 'having abused Matron and servants at this Infirmary with cursings and threatings of every language'. Mr Winnington was subsequently brought before the board to explain himself, where he stated that his behaviour was caused by drunkenness. The board declared that Mr Winnington should immediately be discharged.⁷⁵ No rules were put in place following this case, but this was

the beginning of the hospital's long-standing and complicated challenge in dealing with alcohol consumption by patients.

From the 1720s, there were escalating problems with gin consumption within the hospital and in society at large. Gin drinking was on the rise during this period due to its lack of licensing, ease of distillation, cheapness, and its popularity among London's poor and working classes on account of its alcoholic strength. Roy Porter notes that gin was widely 'sold in workhouses, prisons, brothels and barbers' shops'. Evidence in the Westminster Infirmary's records suggests that it was also sold in hospitals.⁷⁶ For example, on 21 March 1721, Dr Wasey reported to the board that a patient, Sam Moor, was cured and should be immediately discharged, but on discharge should be reprimanded by the chairman of the trustees for 'attempting to introduce a scandalous custom of extorting money from fellow-patients upon admission to the house for ... drinking money'.⁷⁷ While this money might have been for beer, it was more likely to have been collected for gin, as the hospital provided a weekly allowance of beer for each patient. On 21 February 1721, it was ordered that 'the matron take a strict care that no strong liquor be brought into this infirmary from any publick house'.⁷⁸ As the poor were unlikely to have been able to afford any strong liquor other than gin, it seems that this was another reference to London's gin issue as encountered by the hospital. Indeed, this rule appeared around the same time that the authorities were considering legal steps to curb the consumption of gin. In 1721, the Middlesex magistrates complained that gin was 'the principal cause of all the vice and debauchery committed among the inferior sort of people'.⁷⁹

Issues with gin consumption among patients continued throughout the period between 1720 and 1760. In the 1730s, the Westminster Infirmary sought to collaborate with other local hospitals to address the social and moral challenge presented by gin. On 22 July 1735, the trustees established a committee to look into developing a coordinated response with the ‘Governors and Trustees of Bartholomew’s, St Thomas’, Guy’s Hospital and the Hospital of Hide-Park Corner’. The aim of this collaboration, the Westminster Infirmary’s trustees wrote, was ‘to prevent the Entertaining of any patients that have contracted their Distempers by drinking Gin or other spiritous Liqueurs, and if so desire them to cooperate with this society in discountenancing that most pernicious practice’.⁸⁰ At this stage it was also ordered that ‘whatever patient or patients be discovered to drink gin or any other spirituous liquors that they be forthwith expelled from this house’. The new rule also stated that ‘any nurse or servant’ who was ‘found guilty of suffering or knowingly to permit any patients of this infirmary to drink the said liquors’ would ‘immediately be discharged’. This stands as testament to the ubiquity of gin consumption among the working classes in London at this time.⁸¹

Theft was another major problem for the Westminster Infirmary, and a cause of early patient discharge in several cases. Incredibly, it was only after fifteen years of operation that the hospital introduced a specific rule about what to do in cases of theft by patients. This came about due to an incident involving one of the hospital’s in-patients, Mary Pearce, who in 1735 was spotted by one of the hospital’s religious visitors entering a ‘genever shop’ (small premises where gin was sold and consumed). After following Pearce into the shop, the anonymous hospital visitor searched Pearce to find that she was carrying a cap and apron belonging to the Infirmary. On questioning by the board, Pearce revealed that she intended to sell these items, and had already sold another

apron belonging to the house, to buy gin. Perhaps surprisingly, the hospital chose not to prosecute her, whether out of genuine sympathy of Pearce's situation, or to avoid bringing ill repute on the institution. They may also have been concerned about the severity of her punishment if the case was taken to the Old Bailey, which would have most likely been hanging. Pearce's ability to show contrition seems to have been a deciding factor. The minutes recorded: 'upon her humble subscription and begging pardon, no further punishment be inflicted on her but only that she is expelled from the house'.⁸² For future cases, however, it was determined that any theft would result in both expulsion of the patient and their prosecution, thereby preventing the trustees to show the same level of leniency as they had to Mary Pearce.

Conclusion

The historian David Sabean suggests: 'What is common in community is not shared values or common understanding so much as the fact that members of a community are engaged in the same argument, in which alternative strategies, misunderstandings, conflicting goals and values are threshed out'.⁸³ This chapter has argued that for the Westminster Infirmary, debates, and negotiations between the hospital's various stakeholders – centring around particular moments of inclusion and exclusion, and instances of unruly behaviour – served to create a distinct identity and sense of community for the hospital; albeit one where stakeholders' values and goals remained distinct.

This chapter has shown that in its establishment, the Westminster Infirmary deliberately styled itself as an inclusionary institution; offering medical care and support to the sick poor who were unable to access treatment by other means. Yet, despite these aims, the establishment of the

hospital was largely connected to a perception among the social elite about the need to remove the sick poor from the streets and to restore a sense of social order in the city. Social changes such as urbanisation, migration, changing patterns of social organisation, shifting gender norms, the rise of associational culture, religious conflict, as well as rising poverty, crime, and alcoholism, all played roles in shaping the Westminster Infirmary's culture.

The chapter has also evidenced numerous ways in which the hospital's stakeholders were touched and impacted by the socio-economic changes taking place in London during this period, and how they used the hospital to achieve their own ends in relation to these developments. The collective dialogue around poverty and disease, and the structures, processes, and practices produced by the Westminster Infirmary – information about which was spread through the hospital's print materials and the social networks of benefactors and recipients of charity – produced new discussions and alternative strategies for resolving the challenges of social organisation, poverty, and disease management. As evidenced by the subsequent rise of the voluntary hospital movement across Britain in the eighteenth century, many seem to have viewed the Westminster Infirmary's voluntary model of medical charity as an effective method of solving some of the issues wrought by socio-economic change that created benefits for the elites, emergent middle classes, and the poor alike.⁸⁴

What has also been illustrated by this chapter is that in its first thirty years, the activities of the Westminster Infirmary were open to negotiation by various stakeholders. Various examples have been provided of how donors, trustees, physicians, and patients negotiated the structures, rules, and processes of the hospital for their own purposes. Nevertheless, access to involvement in the

hospital was always denied to excluded groups, like Catholics, as well as some of the most vulnerable members of society, including patients who were labelled infectious, mad, or sexually deviant. Equally, over time new structures and rules were introduced in response to specific instances of unruly behaviour. This created a more firmly established habitus of inclusion and exclusion across different levels of the hospital's administration. Ultimately this served to curtail the stakeholders' powers of negotiation, and created a more bureaucratically focused approach to the delivery of voluntary charitable relief as it evolved over the eighteenth century.

Notes

¹ London Metropolitan Archives, City of London (hereafter LMA), H02/WH/A/01/001, 'Minutes of the Trustees', vol. 1 (1716 January–1724 June), 3–4.

² John Woodward, *To Do the Sick No Harm* (London: Routledge, 1974), 11.

³ For further discussion of the Charity's early financial difficulties see Joseph Graeme Humble, 'Westminster Hospital: First 250 Years', *British Medical Journal*, 15 (1966), 156.

⁴ Jonathan Barry and Colin Jones (eds), *Medicine and Charity Before the Welfare State* (London and New York: Routledge, 1994), 7.

⁵ LMA, H02/WH/A/01/065, 'The First Proceedings of the Trustees', July 1720.

⁶ Woodward, *To Do the Sick No Harm*, 17.

⁷ *Ibid.*, 17.

⁸ Joseph Graeme Humble, *Westminster Hospital 1716–1974*, second edition (London: Pitman Medical Publishing Company, 1974); Walter George Spencer, *Westminster Hospital. An Outline of its History* (London: H. J. Glaisher, 1924); John Langdon-Davies, *Westminster Hospital. Two Centuries of Voluntary Service, 1719–1948* (London: John Murray, 1952).

⁹ For further discussion on this historiography see Jonathan Andrews, 'History of Medicine: Health, Medicine and Disease in the Eighteenth Century', *British Journal for Eighteenth Century Studies*, 34 (2011), 503–515; Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (Oxford: Oxford University Press, 1999), 8.

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- ¹⁰ Pierre Bourdieu defines habitus as the mental frameworks that inform how individuals perceive the world in which they live. Pierre Bourdieu, *Outline of The Theory of Practice* (Cambridge: Cambridge University Press, 1977), 72–3.
- ¹¹ Roy Porter, *London: A Social History* (London: Penguin Books, 1994), 98.
- ¹² Edward Anthony Wrigley, *Population and History* (London: Weidenfield and Nicolson, 1969), 70–4.
- ¹³ Leonard Schwarz, *London in the Age of Industrialisation: Entrepreneurs, Labour Force and Living Conditions, 1700–1850* (Cambridge: Cambridge University Press, 1992), 133–5 and 141; John Landers, *Death in the Metropolis: Studies in the Demographic History of London, 1670–1830* (Cambridge: Cambridge University Press, 1993), 353–5.
- ¹⁴ Schwarz, *London*, 127–8; Edward Anthony Wrigley, *English Population History from Family to Reconstitution, 1580–1837* (Cambridge: Cambridge University Press, 1997), 204; Wrigley, *Population and History*, 70–4.
- ¹⁵ Joshua Gee, *The Trade and Navigation of Great Britain Considered* (London, 1729), 38–9.
- ¹⁶ C.W. Bradley, *The London Journal*, no. 602 (13 February 1720).
- ¹⁷ Woodward, *To Do the Sick No Harm*, 4, 8.
- ¹⁸ Marquis of Lansdowne (ed.), *The Petty Papers: Some Unpublished Writings of Sir William Petty* (2 vols, New York: A. M. Kelley, 1967) ii. 176.
- ¹⁹ Lynn Holden Lees, *The Solidarities of Strangers: The English Poor Laws and the People, 1700–1948* (Cambridge: Cambridge University Press, 1998), 23.
- ²⁰ Westminster Infirmary, *Annual Report*, 3 January 1721–2 to 16 January 177–3, ‘An Account of the Proceedings of the Charitable Society for Relieving the Sick and Needy at the Infirmary in Petty-France, Westminster’. Quoted in Woodward, *To Do the Sick No Harm*, 11–2.
- ²¹ Donna Andrew, ‘Two Charities in Eighteenth-Century London’, in Barry and Jones (eds), *Medicine and Charity*, 82.
- ²² Quoted in Anon., ‘The Origin and Evolution of the 18th Century Hospital Movement’, *Hospital* (17 January 1914), 429.
- ²³ Paul Slack, ‘Hospitals, Workhouses and the Relief of the Poor in Early Modern England’, in Ole Peter Grell and Andrew Cunningham (eds), *Health Care and Poor Relief in Protestant Europe 1500–1700* (London and New York: Routledge, 1997), 229.

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- ²⁴ Westminster Infirmary, *An Account of the Proceedings of the Charitable Society for Relieving the Sick and Needy at the Infirmary in Petty-France Westminster* (London, 1723), 3–4.
- ²⁵ Penny Roberts and William Naphy (eds), *Fear in Early Modern Society* (Manchester: Manchester University Press, 1997), 3.
- ²⁶ Slack, 'Hospitals, Workhouses and the Relief of the Poor', 239.
- ²⁷ Peter Clark, *British Clubs and Societies 1580–1800: The Origins of an Associational World* (Oxford, 2000); Richard J. Morris, 'Voluntary Societies and British Urban Elites, 1780–1850', *The Historical Journal*, 26 (1983), 95–118; Ileana Baird (ed.), *Social Networks in the Long Eighteenth Century: Clubs, Literary Salons, Textual Coteries* (Newcastle upon Tyne: Cambridge Scholars Publishing, 2014); Peter Borsay (ed.), *The Eighteenth-Century Town: A Reader in English Urban History* (London, 1990), 12.
- ²⁸ Andrew, 'Two Charities in Eighteenth-Century London', 83.
- ²⁹ Bernard Mandeville, *The Fable of the Bees: Or Private Vices, Publick Benefits*, second edition (London, 1723), 269.
- ³⁰ Paul Langford, *A Polite and Commercial People: England 1727-1783* (Oxford and London: Clarendon Press, 1998), 61-65.
- ³¹ Sylvana Tomaselli, 'The Enlightenment Debate on Women', *History Workshop Journal*, 20 (1985), 101–124; Katharine Glover, *Elite Women and Polite Society in Eighteenth-Century Scotland* (Woodbridge: The Boydell Press, 2011), 4.
- ³² LMA, H02/WH/A/01/001, 'Minutes of the Trustees', vol. 1 (January 1716–June 1724), 218.
- ³³ LMA, H02/WH/A1/005, 'Minutes of the Trustees', vol. 5 (April 1738–June 1740), 180.
- ³⁴ Michael Stolberg, *Experiencing Illness and the Sick Body in Early Modern Europe*, translated by Leonard Unglaub & Logan Kennedy (Basingstoke: Palgrave Macmillan, 2011), 58-64.
- ³⁵ Woodward, *To Do the Sick No Harm*, 23.
- ³⁶ LMA, H02/WH/A/01/001, 'Meeting Minutes of the Trustees', vol. 1 (January 1716–June 1724), 160.
- ³⁷ Woodward, *To Do the Sick No Harm*, 29–30.
- ³⁸ Amanda Vickery, *The Gentleman's Daughter: Women's Lives in Georgian England* (New Haven and London: Yale University Press, 1998), 127–160.
- ³⁹ *Ibid.*, 133.

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- ⁴⁰ Gabriel Glickman, *The English Catholic Community, 1688–1745* (Woodbridge: The Boydell Press, 2009), 2.
- ⁴¹ LMA, H02/WH/A/01/007, ‘Minutes of the Trustees’, vol. 7 (April 1742–November 1743), 33.
- ⁴² Risse, *Mending Bodies*, 8.
- ⁴³ Talcott Parsons, *The Social System* (London: Routledge, 1951), 428–433.
- ⁴⁴ Woodward, *To Do the Sick No Harm*, 41.
- ⁴⁵ Andrew Spicer and Jane L. Stevens Crawshaw (eds), *The Place of the Social Margins, 1350–1750* (London and New York: Routledge, 2016), 4.
- ⁴⁶ Sienna, *Rotten Bodies*, 13.
- ⁴⁷ LMA, H02/WH/A/01/065, ‘The First Proceedings of the Trustees’, July 1720.
- ⁴⁸ LMA, H02/WH/A/001, ‘Meeting Minutes of the Trustees’, vol. 1 (January 1716– June 1724), 149.
- ⁴⁹ LMA, H012/WH/A1/005, ‘Minutes of the Trustees’, vol. 5 (April 1738– June 1740), 14.
- ⁵⁰ Kevin Siena, ‘Contagion, Exclusion and the Unique Medical World of the Eighteenth-Century Workhouse’, in Jonathan Reniarz and Leonard Schwarz (eds), *Medicine and the Workhouse* (Woodbridge: The Boydell Press, 2013), 20.
- ⁵¹ *Ibid.*, 24.
- ⁵² *Ibid.*, 22.
- ⁵³ LMA, H02/WH/A/001, ‘Orders Relating to the Recommending of Patients’ in ‘Minutes of the Trustees’, vol.1 (January 1716–June 1724), 424.
- ⁵⁴ For further discussion of this process see Risse, *Mending Bodies*, 232–5.
- ⁵⁵ H.W. Hart ‘Some Notes on the Sponsoring of Patients for Hospital Treatment under the Voluntary System’, *Medical History*, 24 (1980), 446–60; H.W. Hart, ‘The Conveyance of Patients to and from the Hospital, 1720–1850’, *Medical History*, 22 (1978), 397–407.
- ⁵⁶ LMA, H02/WH/A1/001, ‘Orders Relating to the Recommending of Patients’, in ‘Minutes of the Trustees’, vol.1 (January 1716–June 1724), 424.
- ⁵⁷ *Ibid.*, 425.
- ⁵⁸ Siena, ‘Contagion, Exclusion and the Unique Medical World of the Eighteenth-Century Workhouse’, 22–3.
- ⁵⁹ Risse, *Mending Bodies*, 232–3; Siena, ‘Contagion, Exclusion and the Unique Medical World of the Eighteenth-Century Workhouse’, 22.

⁶⁰ *The Proceedings of the Old Bailey – London’s Central Criminal Court, 1674–1913: Old Bailey Proceedings Online* (www.oldbaileyonline.org, version 8.0) (hereafter *OBP*), 21 October 1742, trial of Jane Wood (t17420909-38).

⁶¹ Risse, *Mending Bodies*, 235.

⁶² LMA, H02/WH/A/001, ‘Minutes of the Trustees’, vol.1 (January 1716–June 1724), 157.

⁶³ LMA, H02/WH/A/002, ‘Minutes of the Trustees’, vol. 2 (June 1724–November 1729), 489.

⁶⁴ *Old Bailey Proceedings Online*, 12 October 1750, trial of William Riley (t17500912-61).

⁶⁵ LMA, H02/WH/A/01/002, ‘Minutes of the Trustees’, vol. 2 (June 1724–November 1729), 23.

⁶⁶ *Ibid.*, 1008.

⁶⁷ Humble, ‘Westminster Hospital’, 57.

⁶⁸ LMA, H012/WH/A1/005, ‘Minutes of the Trustees’, vol. 5 (April 1738–June 1740), 120.

⁶⁹ *Ibid.*

⁷⁰ Westminster Hospital, *An Account of the Proceedings of the Charitable Society for Relieving the Sick and Needy* (London, 1734), 3.

⁷¹ LMA, H02/WH/A/001, ‘Meeting Minutes of the Trustees’, vol. 1 (January 1716–June 1724), 149.

⁷² *Ibid.*, 172.

⁷³ Andrew Scull, *Anglo-American Psychiatry in Hospital Perspective* (Berkeley, CA: University of California Press, 1989), 8.

⁷⁴ Allan Ingram with Michelle Faubert, *Cultural Constructions of Madness in Eighteenth Century Writing* (Basingstoke: Palgrave Macmillan, 2005), 7.

⁷⁵ LMA, H02/WH/A/001, ‘Minutes of the Trustees’, vol.1 (January 1716–June 1724), 116-7.

⁷⁶ Porter, *London*, 181.

⁷⁷ LMA, H02/WH/A/001 Minutes of the Trustees’, vol.1 (January 1716–June 1724), 256.

⁷⁸ *Ibid.*

⁷⁹ Quoted in Porter, *London*, 181.

⁸⁰ LMA, H02/WH/A/004, ‘Minutes of the Trustees’, vol. 4 (November 1734–March 1738), 231.

⁸¹ *Ibid.*

⁸² *Ibid.*

⁸³ David Sabean, *Power in the Blood: Popular Culture and Village Discourse in Early Modern Germany* (Cambridge: Cambridge University Press, 1987), 29.

⁸⁴ Woodward, *To Do the Sick No Harm*, 36.