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Accounting and the moral economy of illness in Victorian England: the Newcastle Infirmary

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Abstract

Purpose – This paper aims to examine the Victorian attitude to the poor by focussing on the health care provided at a large provincial hospital, the Newcastle Infirmary.

Design/methodology/approach – The archives of the Newcastle Infirmary are reviewed alongside the local trade directories. These primary sources are examined in conjunction with the writings of contemporary social theorists on poverty.

Findings – At a time when poverty was seen as a sin, an act against God, it would be easy to assume that the Victorians faced no moral dilemma in dismissing the poor, particularly what were seen as the "undeserving poor", out of hand. Yet, the paper observes how accounting was used both to persuade the wealthier citizens to contribute funds and to enable the hospital to exercise compassion in treating paupers despite this being prohibited under the hospital's rules. Such a policy conflicted with the dominant utilitarian view of society, which emphasised the twin pillars of economic expediency and self-help.

Research limitations/implications – More case studies are needed of other hospitals to ascertain how typical the Newcastle Infirmary was of the voluntary hospital sector as a whole.

Originality/value – Although many histories of British hospitals exist and some have examined how accounting was used to manage within these institutions, the concern has not been with accounting as a moral practice.

Keywords Hospitals, Ethics, Victorian Britian, Poverty, Social accounting

Paper type Research paper

Introduction

In the management of modern British hospitals which form part of the National Health Service (NHS) matters of finance are not normally expected to be elevated above the relief of suffering. The overriding qualification for assistance is that of need. In the nineteenth century, the need of patients who could not afford to pay for their treatment, however pressing, was but one possible consideration in determining whether the

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impoverished sick were admitted to hospitals, most of which were entirely dependent for their meagre resources upon the charitable giving of affluent citizens. The tension between financial constraint and the provision of free hospital care was a key issue for the new wave of voluntary hospitals, such as the Infirmary for the Sick and Lame Poor of the Counties of Newcastle-upon-Tyne, Durham, and Northumberland (hereafter the Newcastle Infirmary)[1] established throughout Britain from the mid-1700s. The solution to this insistent and enduring problem for most voluntary hospitals was to apply a moral qualification for allocating the hospitals' precious resources amongst those seeking help by distinguishing between the poor who were "deserving" and "undeserving" of care. Although the improvement in medical knowledge and technology during the nineteenth century which allowed an increased range of conditions to be susceptible to medical intervention lead to a demand for treatment from a "superior class" of wealthy patient (1886 Annual Report, p. 5), most of the demand at Newcastle continued to come from the impoverished masses whose numbers rose rapidly during the industrial revolution. Between 1760 and 1850 the population of the region tripled, placing severe pressure on the hospital's resources (McCord, 1979, p. 25) which, until 1887, came entirely from voluntary contributions. How to ration the care which the Newcastle Infirmary provided became a fundamental issue, in which the role of the financial accounts was especially prominent, hence the focus of this study.

Although there is an abundance of histories of British hospitals, both provincial and in London (for example, see Anning, 1963; Eade, 1900; Haliburton-Hume, 1906; Hall *et al.*, 1987; Harris, 1922; Jacob, 1951; Robb-Smith, 1970; for an extensive bibliography of hospital histories see the bibliography in Woodward, 1974), the interest of accounting historians is only recent and remains scarce. Notable exceptions include Berry (1997), Jackson (2004) and Jones and Mellett (2007). The latter examined the evolution of hospital accounting in Britain from the nineteenth century to the creation of the NHS while Berry (1997) sought to explore the relationship between economic pressures and policy making through an examination of the accounts of provincial hospitals in the second half of the nineteenth century. Jackson (2004) focused on the use of the annual accounts of the Royal Edinburgh Infirmary as a means of engaging with the subscribers to command their support.

Following Scott *et al.* (2002, pp. 104, 108) and Jones and Mellett (2007), this paper adopts an extended historical perspective to "evaluate relationships and provide interpretations" (Previts *et al.*, 1990, p. 2) at the Newcastle Infirmary. The use of case studies, such as the Newcastle Infirmary, was defended by Previts *et al.* (1990 p. 149; see also Scott *et al.*, 2002, p. 108) on the basis that it allows "the researcher to look at problems as a whole and to take into account a multiplicity of variables". A multiplicity of variables is particularly noticeable in the history of hospitals where the convergence of the financial, political and moral can be most obvious, at times tragic but also to admit compassion. Thus, the concerns of the present paper are less with the details of the accounting practices themselves and more with how the deployment of accounting information either reflected or challenged pervading social beliefs, derived from Church teachings and moral philosophy, about how the poor should be assisted when in extreme need.

The study concentrates on the period c. 1840-1888 during which time there were huge advances in medical knowledge, including the introduction of anaesthetics and antiseptics, and in the treatment of illness, with Florence Nightingale pioneering

advances in nursing care. Newcastle itself went through a period of rapid industrial growth, based on coal and engineering, as well as population growth. Add into this mix cholera epidemics (1848 and 1853), a huge explosion in the city in 1854, and changing attitudes towards the poor with the introduction of the New Poor Law, then it is unsurprising that the Newcastle Infirmary was severely stretched in terms of both physical capacity and finance and the moral foundations upon which the institution was built.

In carrying out this study, the annual reports of the Infirmary were reviewed through to 1888. A cut-off of 1888 was chosen because this is when the hospital reformed its funding and admissions policy to allow free access to all. The minutes of the House Committee, Medical Committee, and Special Finance Committee, Statutes and Regulations and building reports contained within the Newcastle University Library and Tyne and Wear Archive Service were also examined together with the local trade directories, where available. The latter provide an insight into the professional expertise and social background of the hospital managers.

Accounting historians have long recognised accounting practices as an overt manifestation of social, political and economic values as well as being their agent (e.g. Lyons, 1993; Walker, 1998; Davie, 2000; Neu, 2000; Walker and Llewellyn, 2000; Funnell, 2001; Fleischman and Tyson, 2004; Fleischman *et al.*, 2004). Maltby (1997 p. 85), for example, argued that accounting "commanded conviction" in nineteenth-century Germany precisely because it reflected the established "schema" of middle-class morality. Miller (1990, p. 1) argued that accounting is "intrinsic to, and constitutive of social relations, rather than derivative and secondary". The present study demonstrates that it was in the provision of treatment for the sick that the socially constructed and constitutive nature of accounting and the roles that it performed can be seen in particularly bold relief. Accounting by Victorian hospitals was both a means of recording economic phenomena and a technology of entitlement; a means by which the moral and economic criteria determining access to medical attention could be reinforced in a situation where access to treatment for the poor depended upon satisfying society that they were "deserving" of help.

However, there was also a more compassionate side to Victorian moral virtue in dealing with the sick poor in extreme cases. In contrast to the rigid enlistment of accounting as a technology of entitlement ushered in by the Poor Law Amendment Act (Walker, 2004), and in the provision of relief to the desperate poor during the Irish famine (Funnell, 2001), the present paper shows that accounting was also used to justify providing relief on compassionate grounds to those who were morally "undeserving" of help. The Newcastle Infirmary was a Christian foundation, and the annual accounts frequently espouse the example of Jesus. Thus, even in parsimonious Victorian Britain the strict dictates of economy and efficiency were forced to yield to compassion in the treatment of the sick poor. Indeed, at the Newcastle Infirmary there was an expectation gap between the stated aims of the hospital and what took place on the ground, which both the hospital authorities and funding providers proved willing to tolerate, given that the numbers and types of patients treated were made clear to them repeatedly in the annual accounts. By allowing the construction of discursive formations that moderated society's perceptions and treatment of the poor, accounting practices were thus implicated in and essential to endeavours to give relief to the needy. Moreover, the paper will describe how accounting, by throwing back responsibility for these lapses onto the

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subscribers, was implicated in the tacit understanding subsisting between subscribers and authorities that the admission rules of the hospital could be broken. The hospital management were thereby enabled to follow their religious conviction in exercising compassion to the poor without overtly challenging the social order premised on the belief that property was both the evidence and source of virtue. Thus, the paper supports Jacobs and Walker (2004) and Jacobs (2005) in challenging the idea that accounting and religious values are inevitably "antithetical" (Jacobs, 2005, p. 189).

The paper continues firstly with a discussion of social attitudes towards the sick and the poor, before moving on to consider how these attitudes played out in the voluntary hospitals through their moral imperative, management and admissions policy, with particular reference to the Newcastle Infirmary. Discussion then moves to the role of the financial accounts in engaging with the local community and its effect on the treatment of the "sick and lame poor".

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The moral economy of poverty: the virtuous sick poor in Victorian society

The discourse of poverty

During the first half of the nineteenth century, hospitals in Britain were used only by those who were unable to pay for medical assistance. Those who could afford to pay were expected to be treated at home (Berridge, 1990, p. 203; Scott *et al.*, 2002, p. 111). Indeed, only the destitute were likely to seek succour in hospitals, so malodorous was their reputation. In 1844, *The Lancet* authoritatively described the hospital system in England as "essentially bad" (Rivett, 1986, p. 15). When determining the eligibility of the poor for even these uncertain benefits, British society distinguished between two main categories of those in need, the category in which an individual was assigned determining the type of medical institution from which they might receive medical attention. Those defined as the "sick poor" were the deserving poor, labouring men and women who were normally in employment but due to unforeseen illness or accident required medical attention to return them to gainful employment. Paupers, on the other hand, were the "undeserving poor", those who did not work, either because they were unable to find a job or because they did not wish to work (See Himmelfarb, 1984, pp. 77, 79, 161, for a detailed discussion of the stigmatisation of poverty in Victorian England).

Although the poor had always been regarded with some suspicion and disapprobation by English society, prior to the nineteenth century poverty was regarded as something which was inherent to the existence of humankind: "the poor are always with us" (Jesus' words quoted from Matthew 26, 11; see also Smiles quoted in Black, 1971, p. 371). Instead of attempting to eradicate poverty, society was to accept that this was impossible for the poor were a part of God's creation. The poor fulfilled a divine purpose in that they were a natural, unavoidable accompaniment to the social order ordained by God. Society and the poor themselves were to accept that the poor were but one component in a society ordered into classes, each with obligations towards others either above or below them. Most especially, the existence of the poor allowed the prosperous to demonstrate their piety and God's favour by showing charity to the less fortunate (Briggs 1955, p. 126).

With the onset of the industrial revolution in England in the late eighteenth century, the long-standing acceptance of the poor began to change, reaching its moral nadir during the middle decades of Victoria's reign, the period of most concern in this study of the Newcastle Infirmary. It marked an era in which the state gradually took from the

Church responsibility for the poor, in which poverty was secularised and the "moral economy" of society was replaced by Adam Smith's market economy (Himmelfarb, 1984, p. 63). This was a scientific age where measurement and rationalism increasingly supplemented religion in determining cause and effect in society, the economics of public health and poor relief being a prime example.

Reflecting a change in emphasis in religious teaching consistent with a more materialistic age, the Victorians took a far more judgemental view of the poor in their midst. Poverty was characterised and condemned as a vice in and of itself as well as the result of vices. Instead of the poor being accepted as part of God's unblemished, infallible plan they became an offence to this plan, each of the poor betraying a purposive rejection by them of the life of provision that God had ordained in His perfect plan for everyone. To descend to the level of pauperism was to live a life of sin and spiritual death of which the dependence of the able-bodied upon charity was among its most obvious manifestations. Accordingly, poverty in the nineteenth century was not to be accepted but to be vigorously overcome and morally stigmatised.

With increasing conviction throughout Queen Victoria's reign (1837-1901), poverty was denounced as the consequence of licentious behaviour, a life characterised by intemperance, idleness and immoral behaviour. Poverty was essentially a question of choice rather than circumstances (Clark-Kennedy, 1963, p. 3; Eyles and Woods, 1983, p. 34). Thus, in 1866 the Chaplain at the Newcastle Infirmary (Annual Report for 1866) blamed improvidence and drunkenness for the poverty which caused the "disease [which] [. . .] sends many of its victims to this house [. . .]". Reflecting strengthening social attitudes which condemned poverty and maligned the poor, in 1816 the Archbishop of Canterbury, John Sumner, encouraged the poor to live a life of discipline, the result of which is "a moral character formed, tried and confirmed previously to their entering upon a future and higher state of existence" (quoted in Dean, 1991, p. 93; see also Tawney, 1980, p. 265). Of course, not everyone was as severe in their judgement of the poor. Notably, Florence Nightingale condemned the way in which "a sick man, woman or child is considered *administratively* to be a pauper, to be repressed and not a fellow creature to be nursed to health" (quoted in Ayers, 1971, pp. 8-9, emphasis added). Classical economists, however, were as one in their denunciation of the evil of poverty and the necessary remedies.

The poor in classical political economy

The writings of Thomas Malthus, David Ricardo, Jeremy Bentham[2]. Adam Smith and Sir Francis Eden[3] which constitute much of the cannon of classical political economy, were frequently preoccupied with matters of poverty but especially the correspondence between morality and economics. So persistent are these concerns that Dean (1991, p. 111) refers to "the plethora of moral statements concerning the poor in classical political economy". Thus, Ricardo (1772-1823) criticised the Elizabethan Poor Laws for directing money away from productive pursuits and removing the incentive for work. Referring to the certain, unbending injurious effect of the Poor Laws he noted how "the principle of gravitation is no more certain than the tendency of such laws to change wealth and power into misery and weakness [. . .]" (Ricardo 1817, p. 108). The Poor Laws could never hope to improve the condition of the poor but rather to "deteriorate the condition of both poor and rich" (Ricardo 1817, p. 106; Harris, 2004, p. 33).

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Famously, Thomas Malthus, writing in his *Essay on Population* in 1798, warned that God had ordained a natural balance between the providence of the earth and the population that it could sustain. If the poor were not given material support they would see their children and possibly themselves die out. Accordingly, for Malthus poverty without relief was essential to human happiness by keeping numbers down by a natural process of elimination in which society and its institutions should not interfere; it was the natural order of things. To interfere in this natural balance would place all in peril and question God's divine plan. Ricardo (1817, p. 107) maintained that those who provided entirely for their own needs from their labour could be expected to promote the population control necessary to retain this balance, for they would know how many children that their material wealth would support and, therefore, of their own volition and without any outside intervention they would limit the size of their family. In fatal contrast, the poor, but especially paupers, who were provided for from the endeavours of others, had no such inducements to control their tendencies to procreate. Notoriously, Herbert Spencer (1820-1903), a firm advocate of eugenics, later followed closely Malthus' lead when he argued that the culling of the poor, the idle, the old and sick was a "stern discipline" of nature and an act of "far-seeing benevolence":

> [. . .] Under the natural order of things society is constantly excreting its unhealthy, imbecile, slow, vacillating, faithless members (Spencer, 1851, p. 323 see also Mencher 1967, p. 63).

There was also wide agreement between political economists, notably Smith (1776) and Ricardo (1817), that there should not be any attempt to improve the state of the lowest paid workers by interfering with the market processes that determined wages. Most famously, Ricardo's "iron law of wages" portrayed wage levels as the manifestation of a natural law (Ricardo, 1817; Rodgers, 1949, p. 6). Any attempts to interfere with this eternal law of economics would ultimately end in failure as immutable, natural and unrelenting forces would eventually see a return to an enduring homeostasis but only after causing great harm to individuals and to the nation (see also Tawney, 1980, p. 265).

Salvation for the poor was therefore only possible through individual initiative or "self-help". Harrison (1957, p. 160) and Himmelfarb (1984, p. 24) link this concept to Protestant teachings that promoted the virtues of "moral restraint, unremitting labour, self-discipline, self-reliance, independence and foresight" (Dean, 1991, p. 92). Briggs (1955, p. 127) describes the writings of Spencer and Smiles which espoused the self-help doctrine as part of the "success literature" of the mid-nineteenth century. Smiles' *Self-Help*, the "Gospel of Work" (Harrison, 1957, p. 162) published to coincide with the Great Exhibition in 1851, from the first edition proved to be very popular and influential in conditioning social attitudes about wealth and dependence (see Fielden, 1968). Charles Dickens' (1995, pp. 126-7) Mr Bounderby epitomised this pride in mastering circumstance, to be able to say like Mr Bounderby that those who redeem themselves "may shake hands on equal terms. I say equal terms, because although I know what I am, and the exact depth of the gutter I have lifted myself out of [. . .] I am as proud as you are". According to Smiles (1883, pp. 1, 3, 5), not only did individual well-being depend upon self-reliance but so did the future of the nation which, after all, was merely the agglomeration of individuals whose energetic pursuit of their self-interest was the foundation of moral character (see, for example the Annual Report of the Manchester Royal Infirmary 1777-1778, cited in Cherry, 1980, p. 72). Accordingly,

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Ricardo (1817, p. 107) saw the world as divided into those who save and provide the means by which society advances and those who are their slaves, the improvident and the wasteful. There were no excuses for falling into poverty and dependence; even the humblest working man by being careful could be the master of his destiny, never to rely upon the charity of others and take from them their rightful entitlements (Smiles, 1883; Black, 1971, p. 370).

Poor-relief and "efficacious assuagings of distress"

The reform of the Elizabethan Poor Laws with the Poor Law Amendment Act in 1834 provided statutory recognition of society's changing attitudes towards the poor. Dean (1991, p. 98) refers to a "massive change" thereafter in attitudes towards the able-bodied poor. After the reforms poverty became much less a matter of economics and more a matter of morality. The New Poor Law was about "moral discrimination on grounds which were pure Malthusian" (Dean, 1991, p. 99). Most importantly, the reforms created a clear and enforceable distinction between the "indigent" poor and the destitute paupers. Indigence was defined by the Poor Law Commission as "the state of a person unable to labour or unable to obtain in return for his labour the means of subsistence" (quoted in Mencher 1967, p. 93). Paupers, on the other hand, were categorised as those who were able to work but who chose not to do so. They would have to locate themselves and their families into workhouses where living conditions were deliberately set at levels just below those of the lowest paid workers, and life comprised a daily toil of disciplined work. Thus, the reforms consecrated work by ensuring that the able-bodied destitute were provided for in a manner which encouraged them to regain their independence, supposedly the original purpose of the Elizabethan statutes (Briggs 1955, p. 125; Ayers, 1971, p. 2; Dean, 1991, p. 97; Abel-Smith, 1964, p. 46).

The same shift in emphasis can be seen in attitudes towards charity for the poor. Whereas charity prior to the nineteenth century was more readily regarded as materially beneficial to its recipients and spiritually beneficial to those who gave – God had ordained poverty not to inflict punishment and misery but, reminded Robert Eden famously in 1760 in his influential book *Harmony and Benevolence*, to provide the means by which his faithful servants could perform his will and assure them of salvation (see Eden in Rodgers, 1949, p. 9) – increasingly during the nineteenth century charity was portrayed as creating far greater vices and suffering than those which it sought to relieve. Walter Bagehot (1826-1877) was but representative of a pervading antipathy to providing for the presumably improvident when after recognising that philanthropy may be able to do good in some ways, also believed that it could do "great evil" by "augmenting vice" and "multiplying suffering" (Bagehot quoted in Owen, 1965, pp. 167-8). Similarly, Samuel Smiles portrayed as true patriotism the charity which provided the means for those in need to establish their independence sufficiently to be able to provide for themselves. Any other form of charity would destroy initiative and the opportunity to live a life of virtue (Smiles, 1883, p. 3). Mr Gradgrind in Charles Dickens' (1995) grim depiction of the English working class in his novel *Hard Times* epitomised this Victorian judgement of the poor.

For the Victorians, if assistance could not be entirely avoided then private charity was always to be preferred to state sponsored assistance. So malicious for Spencer (1851, p. 320) were the effects of state provision that he believed that "there could hardly be found a more efficient device for estranging men from each other, [. . .] than

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this system of state-almsgiving". Whenever the state took property from one section of society, Spencer's "good for somethings", to give to others in need, the "good for nothings", it contravened Spencer's fundamental law of the state propounded most famously by John Locke whereby the state is "to take care that every man has freedom to do all that he wills, provided he infringes not the equal freedom of any other man [...]" (Spencer, 1851, p. 311; for very similar sentiments see Smiles, 1883, p. 2).

Irrespective of the urgings of moralists such as Smiles and Spencer, however, there were still powerful motives for giving to those in need in the eighteenth and nineteenth centuries, prompted most especially and enduringly, but not exclusively, by the teachings of the Church (Berridge, 1990, p. 204; Woodward, 1974, pp. 19, 20; Gorsky *et al.* 1999, p. 467). Owen (1965, p. 164) refers to the nineteenth century as a humanitarian age, an age when the act of charity continued to assume some importance. Also reflecting the tenor of mid-Victorian society, the *Westminster Review* (1853) dismissed the mid-nineteenth-century English as "foolishly soft, weakly tender, irrationally maudlin, unwisely and mischievously charitable [...]. We are kind to everyone except society".

The impulse to be charitable was not entirely selfless. From the very top of society, with the royal family especially notable for lending its name and association to many charitable organisations, good works were the mark of social standing and virtue. Being associated with charitable works provided opportunities to have one's name linked with the nobility, even royalty (Owen, 1965, p. 165; Woodward, 1974, p. 20). Charles Dickens showed with Mrs Jellyby in *Bleak House* that charitable works had become a fashionable activity, but especially for middle and upper class women. Charitable works allowed them to escape from the suffocating strictures of domestic confinement by engaging in an activity which in these pious times attracted considerable social approval (Rodgers, 1949, p. 19, Harrison, 1957, p. 160).

The results of charitable impulses in Victorian Britain were no more clearly evident than in the formation and maintenance of voluntary hospitals, of which the Newcastle Infirmary was an outstanding example. But as the paper will describe, it was a charity couched in "self-help" terms resulting a difficult dilemma for hospital management between the relief of suffering and denying care to those most in need.

The Newcastle Infirmary

Voluntary hospitals and the foundation of the Newcastle Infirmary

Throughout the eighteenth and nineteenth centuries, sick paupers received medical attention in infirmaries which were part of the workhouse in which they were living while the needs of the sick indigent poor were increasingly provided for by "voluntary" hospitals. Essentially the workhouse infirmaries were state hospitals, although concerted state intervention in the provision of hospitals did not occur until 1867 with the Metropolitan Poor Act (Abel-Smith, 1964, p. 4). From the early eighteenth century in larger metropolitan centres such as London, a small number of hospitals were established by generous bequests from wealthy businessmen or members of the British aristocracy. Guy's hospital in London, for example, was established by Thomas Guy, a London businessman. Most hospitals, however, were known as "voluntary hospitals" where, as the name suggests, all funding until the latter part of the nineteenth century came from the interested public who committed themselves to regular subscriptions.

Until 1887, the Newcastle Infirmary was entirely dependent on voluntary contributions.

The first voluntary hospital, St Bartholomew's, was established in London in 1123, although most were founded after 1700. Thus, 20 voluntary hospitals were established between 1735 and 1775, including one at Liverpool in 1745, Manchester in 1752, Birmingham in 1766 and Leeds in 1767. The greatest expansion occurred between 1861 and 1891 when the numbers of such institutions rose from 130 to 385 (Abel-Smith, 1964, p. 4; Woodward, 1974, pp. 47-8; Berridge, 1990, p. 204; Berry, 1997; Gorsky 1999, p. 465; Jones and Mellett, 2007).

The foundation of the Newcastle Infirmary in 1751 was prompted by a letter appearing in a Newcastle newspaper which suggested the need for an infirmary (Account of the Rise, 1751, p. iv). A public meeting was subsequently convened after which subscriptions were collected with the first meeting of subscribers held on 22 February 1751. At a meeting on 21 March 1751 it was decided to rent a house at Gallowgate to initially accommodate 23 patients. The hospital, which a 100 years later had grown to be the largest hospital in the north of England, opened soon after on the 23 May 1751 as a Christian charity with a Christian mission supported by the Church of England and other Christian denominations (Account of the Rise, 1751; Annual Report 1854, p. 8). From the outset, one of its main features was that it became a specialist centre for surgery owing to the high concentration of industry in the region, and the concomitant number of accidents. A report in 1874 described Newcastle in the following terms:

> It should not be overlooked that Newcastle is surrounded by numerous coal-pits, rolling mills, ship building yards, factories, and a network of railways, each contributing its particular casualties; the Infirmary therefore becomes the receptacle of a class of accidents, which for complication and frightfulness can hardly be paralleled in the three kingdoms (Report of the Committee of Governors on the Resignation of Mr Jeffreson, Assistant Surgeon).

Although it was most common for each voluntary hospital to be independent from other hospitals and for each to be entirely responsible for the management of its affairs, with its own detailed rules and regulations which covered all aspects of the operations, including accounting practices, there was a remarkably consistent approach to management practices and principles between voluntary hospitals throughout England and Wales (see Berry, 1997, p. 2), which were only too willing to learn from each other. Anning (1963, p. 56), for example, observes that the Leeds Infirmary borrowed its manual of regulations from the Manchester Infirmary. The drive for consistency was no more clearly seen than in the moral imperative which determined that only the deserving sick should be admitted for medical treatment.

Admissions and the moral imperative in determining eligibility for assistance

Jones and Mellett (2007) describe the voluntary hospitals as "bastions of communitarianism within a society dominated by laissez-faire market forces". Hospitals, more than any other charitable institution, trod a very narrow moral line, for in attending to the physical well-being of the poor they must not achieve this at the expense of encouraging "idleness and improvidence" through making them dependent on "the bounty of others" (Introduction to Loon Faucher's Manchester in 1844, quoted in McCord, 1974, p. 93). There was therefore a tension for a Christian foundation such as the Newcastle Infirmary between following Christ's example of extending compassion

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towards the sick and outcasts of society and the strong desire to concentrate resources only on those who were deserving of help, i.e. those who had been incapacitated through no fault of their own, and who through hospital intervention could be helped back towards fulfilling a useful economic role in society (Rivett, 1986, p. 28; Jones and Mellett, 2007; Account of the Rise, 1751, p. iii). One can see this from the accounts. Hence, the hospital's 1856 Annual Report extolled the "voluntary offerings of benevolent individuals, who claim no privileges in return, feeling sufficiently repaid by the consciousness of having aided in alleviating the sufferings of their fellow creatures", and the one for 1885 posed the question: "Have we in good times of commercial prosperity acted the part of the Good Samaritan?" However, these comments were tempered by a published report of the Special Committee commissioned in 1887 to investigate the past management and financial position of the Infirmary which opined that:

> Indiscriminate medical charity is not only injurious to the poor themselves, by weakening their sense of independence, and encouraging improvidence and unthrift, but tends, probably to create and develop the physical ailments which it is meant to heal by affecting the state of mind (p. 23).

The largest part of voluntary hospital revenues came from annual subscriptions provided by socially prominent members of the local community. In some areas, including Newcastle, subscriptions were also obtained from trades unions and town councils (McCord, 1974, p. 97; Woodward, 1974, p. 38). The tradition of Newcastle employers in the area providing welfare arrangements for their employees can be traced back to the eighteenth century when the records of the major coal-owners reveal that they paid pensions to the widows of pitmen killed in accidents, and established a fund "towards relieving such pitmen and their families as shall happen misfortunes" (Levine and Wrightson, 1991, p. 365). In the first year of the Newcastle Infirmary's operations three of the largest coal-owners in the region, Bowes, Blackett and Ravensworth, contributed £50 each in addition to providing free coal towards the heating costs of the institution (Report of the State of the Infirmary 1753). One hundred years later when the local economy had been transformed with a huge expansion in the numbers and range of employers and size of the working population, large employers like William Armstrong still showed themselves willing to make good the Infirmary's funding deficits on a regular basis. The main subscribers in 1878, for example, were the major industrial enterprises of Armstrong and Co., the Consett Iron Company, Leslie and Co., the North Eastern Railway Company and Stephenson and Co. (1878 Annual Report).

Other sources of income at Newcastle included legacies, interest on investments, annual dinners, sermons, benefit plays, concerts and the poor box placed in local churches (Annual Report, 1854, p. 5). An indication of the relative importance of each source of income can be seen in the Table I, which was originally printed in the 1854 Annual Report of the Newcastle Infirmary.

The table does not include special donations for capital projects. Especially, lucrative were sermons delivered in churches encouraging the faithful to donate to the hospital (Woodward, 1974, p. 18; Anning, 1963, p. 8). However, by far and away the most important source of income were the annual subscriptions. As we shall see, engaging with the subscribers in order to ensure their continued support was the main focus of the hospital's published accounts.

Table I.
Analysis of income

	1752-1761	1802-1811	1842-1851
Annual subscriptions	£1,394	£1,608	£2,158
Interest	79	450	565
Donations less than £20	40	58	75
Sermons	46	130	49
Annual dinners	48	7	6
Benefit plays	60	35	12
Poor Box	12	5	8
Benefactors greater than £20	287	164	290
Legacies	116	60	169

Until late into the nineteenth century, each subscription of one guinea to the Newcastle Infirmary entitled the subscriber to recommend one outpatient per year and two guineas provided for two outpatients or one inpatient per year[4]. For any amount subscribed over two guineas, the proportion of outpatient to inpatient was the same as for two guineas (Annual Report 1850, p. 27; Statutes and Rules 1855; Annual Report 1867, p. 3). Hospitals would publish lists of subscribers along with the amount that they had donated. If a subscriber fell behind in their financial commitments this was usually indicated next to their name, a form of social shaming (Rivett, 1986, p. 31). In addition, any subscriber who had fallen behind was not permitted to vote on any policy issues of the hospital, such as the appointment of new physicians and members of the House Committee.

Patients to be admitted to the hospital would present a letter of introduction from their sponsor in order to gain admission. The letter of introduction not only verified that the patient had a financial backer but, possibly just as important, that the subscriber sponsoring them believed the patient to be eligible and worthy of being admitted to the hospital; that is, they were part of the labouring poor and, therefore, "a proper object of charity". This was to be confirmed upon admittance at Newcastle when each supplicant was required to "appear to the Committee and *receiving* Physician and Surgeon to be *curable,* and *real* Objects of the Charity [. . .]" (Statutes, Rules and Orders 1751, p. 1, emphasis in the original; Statutes and Rules, 1801, pp. 13-14, 28).

The effectiveness of voluntary hospitals was to be measured by increasing the number of patients who were restored to health and useful employment, which explains the exclusion of those who were incurable as well as paupers (Abel-Smith, 1964, p. 39; Robson, 2003, p. 102). Financial pressures meant that the chronically ill, or those approaching death, were not to be admitted; hospitals were not to be places of refuge for the incurably ill. Hence, under no circumstances was anyone supposed to be admitted to the Newcastle Infirmary who was suffering from, cancer, consumption, "in a dying state" or from the effects of old age. In 1876, the Annual Report stated that:

> [. . .] to send patients in an advance stage of mortal disease is an act of cruelty to the sufferer, great unkindness to patients in the House and injustice to the Hospital whose death rate is thus causelessly aggravated.

People suffering contagious diseases were also kept out because of the risk they posed to other patients (Account of Origin, 1801, p. 24; Statutes and Rules, 1801, Section 6; Annual Report 1867, pp. 18-21). Pregnant women too were excluded as were the insane and children under seven years of age. Both the high mortality rate amongst children

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and the costs that would be associated with the need to accommodate members of their family to stay with them while receiving treatment in hospital precluded young children from being admitted, while pregnancy was regarded as a natural event and not an illness. Domestic servants could be admitted only if they had broken a limb or needed major surgery as their medical needs were expected to be the responsibility of their employer (Statutes, Rules and Orders 1751, Rules Concerning the Admission of Patients, pp. 9-10; Statutes and Rules, 1801, p. 15)[5].

Finally, those whose illness was a result of immoral behaviour were usually also excluded from voluntary hospitals (Abel-Smith, 1964, p. 37). Thus, anyone suffering from sexually transmitted diseases in most instances would not be eligible for admission, although provision was sometimes made for "fallen" women or prostitutes in specialist Lock Hospitals. In this respect the Newcastle Infirmary appears untypical, in that its new Statutes and Rules in 1801 officially allowed married women of good character to be admitted who, through no fault of their own, suffered from "a certain distemper, which originates in vicious indulgence", that is syphilis. This merely formalised what had been happening for some time for "such patients, from the imperious dictates of humanity, have always gained admission [. . .]" despite the undiminished social and moral stigma of the disease.

As for those who technically should have been excluded under the hospital's rules, it was recognised in Statutes that, "[. . .] false names had been frequently affixed to this distemper, to prevent enquiry into the violation of the rule [. . .]" (Statutes and Rules, 1801, Section 6). In later years, the Statutes contained the following proviso, presumably to assuage the feelings of those subscribers against the admission of such cases:

> Females labouring under syphilitic complaints shall be admissible [. . .] by permission of the House Committee without letters of recommendation. But, if in the opinion of the House Committee, the funds of the hospital shall at any time be inadequate to provide for such patients in addition to the other patients of the Institution, the House Committee shall be at liberty to order the exclusion of female syphilitic patients applying without letters of recommendation, or restrict the number of admissions, to such an extent as they may deem necessary or expedient (Statutes and Rules 1883, General Rules XXVIII part 2).

In the case of male sufferers, a male lock ward for treating venereal disease was maintained in contravention of the rules until 1885, when moral disapprobation finally demanded its closure (Report of the 1887 Special Committee, p. 19).

It is evident from the above that what occurred in practice at the Newcastle Infirmary was a lot laxer than the rules. The hospital was also tolerant in its attitude to inebriation. Thus, the 1874 Annual Report (p. 5) referred to the large number of patients admitted to the hospital following injuries resulting from "intoxication", 367 of whom were still in a drunken state at the time of admission. Cholera patients should in theory not have received treatment, yet during the calamitous cholera epidemic in Newcastle and Gateshead in 1853 the Infirmary remained open at all times to help those who presented themselves (Annual Report 1854, p. 5). The "dictates of humanity" demanded that such patients receive treatment. Upon discharge each patient was to be encouraged to return to their church and give thanks to God and to their benefactors for their recovery (Statutes, Rules and Orders 1751, Admission Rules, p. 11).

One of the main difficulties with the letter system was its abuse by the governors and medical staff in order to administer treatment to individuals who needed the help

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but did not qualify. By 1887 it had become unworkable and was abandoned. While it may have been usual in most voluntary hospitals to admit only patients who came with a recommendation letter there were some, such as the Metropolitan Free Hospital founded in London in 1837, which would receive any sick poor regardless (Rivett, 1986, p. 27). Increasingly throughout the nineteenth century, this approach to those who were ill characterised the work of the Newcastle Infirmary. Despite the seemingly unyielding nature of hospital's rules, in practice the governors very often were unable to deny the sick the help that they would beseech from the hospital, irrespective of their entitlement to it. The first report of the Newcastle Infirmary in 1751 established the, albeit bounded, compassionate intent of its founders by allowing anyone who had suffered a serious accident or was in immediate, urgent need of assistance to be admitted at any time and without the usual letter of recommendation required from a subscriber (Report of the State of the Infirmary 1753, p. 2). Officially, these concessions remained unchanged throughout the eighteenth and nineteenth centuries. At all other times "only such Persons who are recommended by a Subscriber [. . .]" were meant to be admitted. However, the Newcastle Infirmary's Annual Report in 1850 (p. 5) confirmed that in a great many cases this rule was relaxed for "casual patients" whose treatment was justified on the grounds that these were "indigent persons" unable to obtain the necessary letter of recommendation at the time of their urgent need. Not all of these patients were "indigent", however. Providing additional allowance to take account of downturns in the local economy that would have thrown people out of work was a repeated theme in the annual reports (e.g. 1878, 1879, 1887 reports). The report for 1886 (p. 7) likewise referred to the "considerable numbers" of children of the "destitute" prone to "a variety of diseases" through poverty who had always received treatment. According to the report, these were "a class of patients peculiarly deserving in sympathy" irrespective of what the hospital rules may have said. This made it clear that when a decision had to be made between cost and compassion the supplicant, invariably, would be treated. Such compassion for the unemployed and destitute would not in theory have been permissible under the 1834 Poor Law Amendment Act.

To some extent the treatment of non-qualifying individuals was institutionalised by the creation of an outpatients department for treating "casuals", the numbers so dealt with disclosed in the accounts. The Annual Report for 1880 justified their treatment as "a good thing" on the grounds that it prevented smaller problems becoming serious and preventing the poor from working. Similarly, the 1856 Annual Report described treating casuals as a "necessary augmentation" to the letter system. However, inpatients were also admitted inappropriately. Indeed, the number of times that this practice was referred to in the annual reports suggests it became a regular occurrence, prompting regular reminders by the hospital governors of the correct procedure. The Annual Report for 1781, for instance, noted a resolution of the general court that the committee of governors "be desired to stick closely" to the hospital's admission rules. Ninety years later, the 1870 Annual Report was again upbraiding the governors for wrongly issuing letters of admission. At the same time, the 1870 report (p. 5) acknowledged the moral dilemma in denying admission to non-qualifying patients where there was a desperate need. Although the report urged the governors "not to give letters to such persons", it suggested that in some cases there was in reality no alternative, as "to turn back such patients is to consign them to death upon the streets". At the anniversary meeting in April 1870, the problem was highlighted with the giving of letters to people with

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consumption who had often travelled many miles to get to the Infirmary, often arriving in a dying state. If these people were not admitted, there would be an outcry of cruelty. The rule to exclude, therefore, was very hard to carry out in practice.

The following section will establish that, indeed, the distressing needs of those in need were the overriding determinant of access to the healing of the Infirmary, not its financial capacity at a point in time to meet these needs, and that management of the Infirmary was directed by these priorities. Nowhere was this more obvious than in the form of the annual reports published by the Infirmary and the purposes they served in facilitating its moral mission.

Accounting for sickness at the Newcastle Infirmary

Management and the process of financial reporting

Achievement of the spiritual and temporal aims of voluntary hospitals with the, usually, meagre resources available, required that subscribers were heavily involved in their governance and management. Thus, final authority in all matters pertaining to hospital management resided with a Board of Governors selected from the subscribers, overwhelmingly men of high social standing. Indeed, it was a mark of social status to be a hospital governor. Subscribers of two guineas or more a year at Newcastle were entitled to be governors while benefactors of more than £20 were made governors for life. Day-to-day management of each hospital was usually delegated by the Board of Governors to House Committees consisting of subscribers, medical staff and hospital employees (Abel-Smith, 1964, pp. 32, 33; Berry, 1997, p. 2). In this regard, the governance and management arrangements at the Newcastle Infirmary were typical of most hospitals. At Newcastle the Statutes of Government in 1751 required a House Committee of Governors consisting of 36 governors, 12 each from the governors representing the three counties of Durham, Northumberland and Newcastle (Statutes, Rules and Orders 1751, p.viii)[6]. In later years, it was agreed that the House Committee should elect a sub-committee of 12 governors charged with looking after the routine business of the Institution.

Table II gives an indication of the constitution and occupation of the House Sub-Committee for two years in the period under review.

As can be seen, the committee comprised a mixture of professional people (clergy, solicitors, physicians), trades people (corn-merchants, fitters, tanners, etc.), as well as "gentlemen", or persons of independent means. In all cases, they were respected members of the local community.

The House Committee, and later the House Sub-Committee were to meet each Thursday to admit and discharge patients, decide upon any necessary expenses and other matters related to the running of the infirmary, including the appointment of doctors and hospital staff. The weekly board was also required to examine the accounts for the past week and to approve payment of bills by the treasurer (Statutes, Rules and Orders 1751, Rules and Orders Concerning the Government and Conduct of the House, Article 3).

The treasurer and auditors, both of whom performed their duties in an honorary capacity, were selected from the governors[7] (see, for example Statutes of the Newcastle Infirmary, 1910). The local trade directories suggest that the treasurers came from a financial background. William Boyd, treasurer from 1817-1844, was a supervisor in the Excise Office of Newcastle (Richardson Directory of Newcastle and

Committee named in 1851 Annual Report		Committee named in 1860 Annual Report	
Name	Occupation	Name	Occupation
The Reverend Vicar of Newcastle	Clergy	P.G.Ellison	Solicitor
P.G. Ellison	Solicitor	W. Beaumont	Gentleman
A.L. Potter	Coal-fitter	J. Taylor	Unknown
G. Clementson	Gentleman	G. Bargate	Tanner
Sir J.L. Lorraine	Post-master	M. Wheatley	Iron-merchant
J.D. Weatherley	Captain	J. Pollard	Corn-merchant
E. Jackson	Gentleman	W. Kell	Unknown
G.T. Dunn	Gentleman	R. Swan	Unknown
S. Stokoe	Wine and spirit merchant	G. Philipson	Physician
J.B. F alconer	Unknown	J. Blackwell	Unknown
J. Fenwick	Unknown	J. Falconer	Unknown
T. Burnet	Gentleman	R. Walters	Land-agent

Sources: Ward Trade Directory of Northumberland and Durham 1850; Whellan Directory of Northumberland 1855; Ward Directory of Newcastle 1865

Table II. Composition of the house sub-committee

Gateshead 1838); and Matthew R. Bigge, treasurer in the 1850s, was a director of the District Bank (Whellan Northumberland Directory 1855). The honorary auditors, for their part, needed to be men of impeccable social standing. Thus, two "gentlemen", Robert Henderson and Robert Robson, occupied this role in 1883 (Ward Directory of North and South Shields, Jarrow, Sunderland, Newcastle and Gateshead 1883-84). In some hospitals, and in most towards the latter decades of the nineteenth century, a salaried lay Secretary or House Governor progressively assumed the duties previously exercised by the Honorary Treasurer and Governors. The role of House Governor was created at Newcastle in 1878. According to the 1887 Statutes and Rules, this official had "Supreme authority in the House". The first incumbent was R.R. Redmayne. Although his background is uncertain, the 1879 Annual Report (pp. 7-8) makes it clear that he was a high status individual whom the hospital were prepared to pay the huge salary of £300 p.a. in expectation of future offsetting cost savings.

As charities, voluntary hospitals were expected to keep accurate and detailed accounts to allow their stewardship to be vouchsafed. The books of account, demanded the Newcastle Infirmary's, 1751 Annual Report, were to "lie constantly open for inspection". Responsibility for maintaining accounts at the Newcastle Infirmary and providing these for inspection rested solely with the secretary until 1883 when it devolved to the accountant (Statutes and Rules 1883, General Rules, Section XXIII). According to the Statutes and Rules pertaining in 1801 (see also Statutes, Rules and Orders 1751, Rules to be Observed by the Steward), the secretary was required to maintain accounts for all hospital expenditures, "to keep the books and accounts in a methodical manner", and to accept responsibility for the accounts kept by the House Surgeon and the Matron who was required to keep a daily account of all provisions and necessaries used and to provide this account to the House Committee at its regular Thursday meetings (See, for example Rules to be Observed by the Matron, Statutes, Rules and Orders 1751). These duties varied little over the course of nearly 150 years.

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The first accountant to be employed by the Infirmary was Arthur Tranah in 1859. Little is known regarding his background. The trade directories listed his occupation as an agent, which may imply that the Infirmary was not his sole employer. His salary in 1860 was £10 which compares unfavourably with £130 for the House Surgeon, £25 for the Assistant House Surgeon, £42 for the Secretary, £60 for the Dispenser, and just over £49 for the Matron (1860 Annual Report). Either he was not highly regarded, or perhaps more likely, he had other employment. Interestingly, in the Statutes and Rules of 1883 there are rules concerning the qualifications of honorary staff and paid officers, but there is no mention of any qualification necessary for the accountant. Tranah stayed in the post for the next 35 years and retired in 1894, when his replacement was W.F. Allden A.C.A. The employment of a professional accountant shows the progression of the Infirmary towards a business orientated entity, as well as reflecting the growth of the profession towards the end of the century.

While each voluntary hospital in the nineteenth century had their own form of accounts, there were many similar characteristics. The most obvious similarity between hospital accounts nationwide was the almost exclusive reliance upon cash accounting, the simplicity of which made the accounts understandable by all subscribers, thereby recognising the significance of their role as accountability mechanisms[8]. Consistent with the nature of unsophisticated cash accounts, rarely would hospital accounts separate current and capital items; certainly it would have been unusual to revalue or depreciate hospital assets (Berry, 1997, p. 6). Thus, large expenditure on furniture and surgical equipment was effectively written-off alongside the expenses at the Newcastle Infirmary, and it was not until 1905 that the first balance sheet was produced in the annual report.

General Courts of Governors, when all governors were expected to attend, were to be held four times a year, on the first Thursday in January, April, July and October, to "receive the reports of the House Committee, to inspect the accounts, and to transact such other business as shall be brought before the Court" (Annual Report 1867, p. 4; Statutes, Rules and Orders 1751, p. 3; for an account of a coincident regime of control at the Leeds Infirmary see Anning, 1963, p. 57). At the Anniversary Court in April the treasurer was further required to give "a full account of the capital stock [. . .] and of his money transactions" and conduct an annual inventory of household goods and furniture (Annual Report 1867, pp. 31, 32, 37).

Accounts covering the full year of activities were published in annual reports presented from the first year of operation of the Infirmary to the Governors at the Annual Court. The structure of the annual reports changed very little from the foundation of the Infirmary in 1751 to the late nineteenth century, although they did gain in sophistication in their presentation and in the range of information presented. The first report which ran for the first two years of operations up to 13 April 1753 was a one page, two-sided document. By the mid-nineteenth century the year end had been regularised at 31 March, and the annual report was in booklet form. The 1753 report contained an introductory paragraph summarising the rules; a receipts and payments account; an abstract of cases treated by the Infirmary, inpatients and outpatients, listed by disorder, and showing the outcome of treatment; a list of officers; and a list of subscribers (Report of the State of the Infirmary 1753). By the mid-nineteenth century these items had been consolidated into a list of officers; an Infirmary Report compiled by the House Committee reviewing the operations of the hospital during the year and assessing its future prospects; a Report of

the Medical Board providing details of the types of illnesses treated and the outcome of their treatment; an Abstract of the Infirmary Accounts for the year on a receipts and payments basis; a General Alphabetical List of Subscribers by name with the amounts paid; a similar General Alphabetical List of Benefactors; Extracts from the Rules; and a Chaplain's Report. The Infirmary and Medical Board reports contained the most information, both in narrative and statistical form. For example, in 1878 these reports included extensive schedules analysing the numbers of inpatients and outpatients treated, the number of patients treated who had suffered serious injury from accidents, the number cured or "relieved", the average cost of the inpatients, the average daily number of patients, the average length of stay in hospital of the inpatients, the number of deaths and the death rate, all with prior year comparatives and compared to a 12 year average. The prime purpose of this information was to demonstrate efficiency to the subscribers. As far as the Abstract of Accounts was concerned, it remained in the same format throughout the period, except that the number of expense headings increased. Thus, in 1878 expenditure was analysed over 52 categories compare to 36 in 1850. Finally, a signed audit report was added in 1877. From 1871 to 1876, it was the accountant who had signed the accounts, and prior to that they were unattested by anyone (Annual Reports 1850-1878).

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Publicising the need for funds

The Newcastle Infirmary's annual reports, reflecting its voluntary status and dependence on the beneficence of subscribers, were preoccupied with the need to raise subscriptions and to be accountable to subscribers. Essentially, the annual reports were instruments of persuasion. By exposing shortfalls in funding, the accounts provided a means of persuading the public in the region to increase their financial support of the hospital, particularly in the form of subscriptions. At the same time, and befitting an age when abstemious economy was a moral imperative and a sign of virtue (see Funnell, 2004), using accounts to demonstrate to the subscribers the ability of management to achieve value for money was also important. Taking the 1864 Annual Report as an example, the installation of a Turkish bath was referred to in the following terms:

> The [Turkish] bath is in use three days per week and the economy tending its working will favour its adoption in similar institutions where the chief aim is to realise the greatest amount of good by the simplest and least costly means.

Such comments, together with the inclusion of schedules analysing the numbers of inpatients and outpatients treated as well as the cost, were intended to demonstrate efficient use of resources. The accounts were also written with the knowledge that they would be reviewed by other charitable hospitals in the country. Death rates were often published as were the major causes of illness and injury during the year.

Jackson (2004) saw the annual reports of voluntary hospitals, with their published lists of subscribers, as a mechanism for holding the subscribers accountable for the moral responsibility they owed to their local community in supporting these institutions. Such charity was not entirely selfless, as the publication of the names and the amounts subscribed also enabled the individuals concerned to demonstrate moral superiority in their local communities. Other tactics employed in the Newcastle annual reports to convict prominent members of the community to either become a subscriber

or to maintain their subscriptions included publishing tables showing the relative number of patients treated from the various localities in the hospital's catchment area. The 1850 Annual Report, for example, used this information to demonstrate that the level of contribution by the employers of County Durham was disproportionately small compared to the amount of benefit they were deriving from the hospital. The relevant extract from the Annual Report is included in Table III.

This document is noteworthy because it shows the Infirmary keeping detailed records tracking its admissions which it could then relate to subscriptions. At this time, transport of patients unable to walk would generally be by horse drawn conveyance, although railways could have played a part. Most of the patients seem to have come from within about a 20 mile radius of the hospital, although the admission of patients from "more distant localities" suggests trains may have been used.

It was the explicit intention of the Newcastle Infirmary to attempt to cover its total expenditure with "ordinary income", made up of subscriptions and income from rents, interest and dividends. Hence, the infirmary's published accounts distinguished ordinary income, which was balanced against expenditure, from legacies and donations. The consequence of this accounting practice which kept ordinary income separate from other income was that the infirmary appeared to be continually in deficit,

Localities	Patients received by letter	Accidents	Lock patients
Parish of All Saints	304	333	41
St Andrew	96	69	16
St Nicholas	123	144	9
St John	216	428	23
Borough of Tynemouth	82	14	36
From within 15 miles round Newcastle	158	18	11
From more distant parts	82	11	5
Borough of Gateshead	156	99	5
Borough of South Shields	106	5	22
From within 15 miles round Gateshead	176	33	24
From more distant parts	69	4	10
From other counties of UK	59	24	35
Foreigners	34	13	–
Total	1661	1195	237

Notes: From this table, it will be seen that numerous patients have been admitted from the surrounding towns and more distant localities; and it has been thought a worthy subject of investigation to ascertain whether the charity is supported by the nobility and gentry of each locality in a relative proportion to the number of patients sent by such district. The result of the enquiry proves that the counties of Newcastle and the county districts of Northumberland bear a much greater proportion of the expense of the charity in proportion to the number of patients received from them, than the surrounding towns or the county of Durham; and to this important fact we would wish to call the attention of clergymen and other influential personages of such districts that due support may be received from them for the desired enlargement of the Institution and a proportionate increase of yearly collections and subscriptions for the carrying out of the benevolent objects of the extended charity. We would also remark that the number of accidents received from adjacent manufacturers and the extensive railway undertakings exceed in proportion the amount of their subscriptions and we hope that such gentlemen connected with such works will not fail to remember the claims of the charity which so largely contributes to the relief and safety of their workmen
Source: 1850 Annual Report

Table III.
The relative number of patients received from certain localities

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a fact that was invariably highlighted in the narrative to the annual report (1879 Annual Report, p. 4; 1881 Annual Report, p. 4). The beneficial impact of this practice in inducing support from subscribers was evident by the ability of the hospital to survive and thrive through even the most difficult times. Indeed, it was not unusual for governors of voluntary hospitals to conspire to report a deficit to emphasise the dire need of the hospital in order to loosen the purse strings of subscribers (for example, see Abel-Smith, 1964, p. 39 and Berry, 1997, p. 9). In terms reminiscent of accepted, indeed expected, practice the annual reports for 1877 and 1878, for example, referred to the "serious financial condition of the Infirmary", and noted that a finance committee had been set up to ascertain how best to "render equal the income and outlay" (Annual Report 1877, see also 1879 Annual Report, pp. 3-4).

The reality of the situation was somewhat different, however, in that in none of the years under examination was the infirmary unable to cover its expenditure, notwithstanding the need to periodically draw on its reserves through the utilisation of bequests or the sale of investments (1879 Annual Report, p. 4; 1881 Annual Report, p. 4). For instance, in 1853 about a half of benefactions was used to meet the costs of the Infirmary and the remainder invested (Annual Report 1853, p. 6). Furthermore, the infirmary showed little appetite for cutting services in order to reduce costs, as the 1863 Annual Report explained:

> The Committee, as they have frequently stated, would much wish to be placed in such a position that they could fund [invest] all sums received for legacies and life governorships, but so long as the demands for medical aid continue to be as numerous and urgent as they are at present, they do not feel justified in curtailing their expenditure by the rejection of applicants *for the mere purpose of saving money* (1863 Annual Report, p. 6, emphasis added).

Indeed, the opposite was true. Throughout the period in question, the House Committee at Newcastle showed little hesitation in regularly committing itself to additional heavy expenditure on capital improvements (e.g. Annual Reports 1855, 1859, 1863, 1867, 1876, 1878, 1880, 1885). The confidence of the hospital in its benefactors is illustrated by the comments of the House Committee in the 1853 Annual Report. Whilst the Committee as usual expressed anxiousness about the future state of funds given the proposed enlargement of the hospital, it stated that:

> Records of the past evince that where extraordinary appeals have been made in a good cause they have always been met with a ready response [...] [and] the committee indulge a confident hope that present age will not be found less inclined to acts of charity.

Hence, the balancing of total expenditure against ordinary income had a propaganda value in creating a picture of financial distress for the subscribers that was unwarranted by events.

This interpretation is confirmed by events in 1838. At a meeting of the House Committee on 29 November, a motion was passed to write to the clergy of Newcastle, Durham and Northumberland, and ministers of dissenting congregations, to request an annual sermon be delivered to raise funds for the Infirmary. The following letter was sent:

> I am directed by the House Committee of the Governors of the Infirmary of Newcastle upon Tyne, Durham and Northumberland to transmit a copy to you of the resolution passed this day, your kind compliance with which may prove the greatest benefit to an excellent charity. I am also ordered to add that there appears to be a deficiency of near £600 per annum,

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> a circumstance the House Committee cannot view without the greatest concern, as an evil which, unless a speedy remedy can be applied, must inevitably occasion the destruction of an institution which in the space of 87 years has cured upwards of 19,500 of the sick and lame poor of these counties – a large proportion of whom without such aid would in all humane probability have miserably perished and have been an equal loss to their families and their counties.

The appeal was successful to the tune that donations from churches increased from £156 in the 1838 accounts to £1,357 in 1839, resulting in a net surplus at the end of the year of £528 5s 9½d (Annual Reports 1838, 1839). However, the Infirmary sought to downplay the situation with the following statement in the Annual Report, just below the surplus income figure:

> The balance [. . .] has arisen as a result of the urgent appeal made to the public on behalf of the charity. It will therefore be obvious that such a sum cannot be permanently calculated upon [. . .] the regular expenditure of the Institution exceeds the regular income by the sum of £623 10s 11d.

In short, the annual reports of the Newcastle Infirmary were utilised as a publicity vehicle for engaging with the hospital's supporters in order to convince them of the hospital's need and their moral obligation as part of a social elite to support it. Providing the hospital could demonstrate good value for money to its supporters the management felt no compunction in asking for extra support. Therefore, it is hard to see how the hospital could have demonstrated good value for money given the publication in the annual accounts of its treatment of non-qualifying individuals. The explanation of this paradox lies in the complex nature of the accountability subsisting between the subscribers and hospital management.

Establishing accountability between the subscribers and hospital management

Good stewardship involved more than acting honestly and diligently. It also entailed achieving value for money by providing evidence of patients restored to society in productive good health. This was almost certainly true of the sector as a whole, something observed by Jones and Mellett (2007; see also Rivett, 1986, p. 17 and Berry, 1997, p. 16). By reinforcing the pervading social beliefs about the deserving poor discussed earlier, expeditious restoration to health and gainful employment was regarded as a key measure of the financial responsibility and proficiency of the hospital's governors, medical staff and management; an indication that the very limited financial resources which had been placed in their trust as a result of the generosity and goodness of the hospital's benefactors had been used wisely and without being needlessly dissipated on hopeless cases (Harris, 2004, p. 96; Berry, 1997, p. 3). The Newcastle governors were keenly aware that to admit such patients would be regarded as poor stewardship of a hospital's scarce resources and denial of the hospital's moral mission. Thus, the scarce funds available were expected to achieve the maximum benefit for society (Cherry, 1980, p. 71; Woodward, 1974, p. 40; Account of Origin, 1801, pp. 23-4; Newcastle University Library, Hospital Archives, 43).

It follows that no matter what the reality of the situation was with regard to treating the "undeserving" poor, the hospital management could not afford to accept responsibility for any waste of resources in the annual reports. In an Account of Origin of the Newcastle Infirmary, written in 1801, the governors sought to confirm the financial responsibility and propriety required of them to ensure that they were not

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betraying the trust placed in them by God and man for the welfare of their fellow citizens by making it clear that:

> [. . .] the express design of an Infirmary [. . .] (including that at Newcastle) is to afford relief to the indigent sick, who cannot be treated with success at their own houses. If [. . .] improper objects be received, the funds of the charity will be injudiciously wasted, and those patients excluded, for want of room, whose diseases can only be treated with advantage in the house (Account of Origin, 1801, p. 23).

These sentiments were still dominant much later when in the 1882 Annual Report concern was expressed that:

> [. . .] the beds in the Infirmary are sometimes occupied by persons of the pauper class, to the exclusion of those who only require restoration to health to enable them to resume their work. Those who, when medicine has done all for them that it can, have no recourse to the Work House, had better be at once referred to the Work House Hospital.

If Jackson (2004) is correct that the names of the subscribers were included in the annual reports for the express purpose of enabling them to demonstrate their moral superiority in the community, it would have been important for the hospital to have been seen to be acting in a moral way itself. Thus, the annual accounts provided the necessary rhetoric about the "deserving" and "undeserving" poor. In doing so, the accounts were contributing to the stigmatisation of paupers much in keeping with the tenor of the New Poor Law.

However, the 1882 Annual Report also highlights the tension, which had endured from the foundation of the Newcastle Infirmary, between the need to ensure that funds were used according to expectations of society and benefactors and also the hospital's inescapable spiritual obligation to help those who sought relief from their suffering. Thus, if the moral imperative of the infirmary, as explicitly stated in the governing rules, was to heal those who were capable of regaining their health and useful employment, this was very often shown in the reports of the Infirmary to have been inconsistent with actual practice overseen by the governors for whom, ultimately, extending the hand of compassion to those not considered deserving was an expression of the Infirmary's spiritual mission. Accordingly, the annual reports which contained lists of the number of patients treated with and without letters provided both a measure of how seriously the governors took their moral responsibilities by admitting those considered by society as deserving help and a measure of the compassion extended to the supposedly undeserving.

If the moral imperative of the infirmary was to heal only the useful members of society, how then did this square with the inconsistency identified in the paper between the hospital's rules and who in practice received treatment? The answer lies in the two-way accountability highlighted by Jackson (2004), by which the annual reports of a voluntary hospital served to render the subscribers, as well as the management, accountable for their relationship with the hospital. How the hospital's resources were utilised was seen to be largely the subscribers' responsibility. It was they who issued the letters of introduction which allowed the patients to be admitted and it was they who made up the House Committee, which met every Thursday to admit and discharge patients. It was up to the House Committee and receiving medical staff to ensure that only the proper objects of charity appearing before them were admitted. Yet, the way the House Committee habitually phrased its section of the annual report was to

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abrogate all personal responsibility for admitting non-qualifying patients, preferring instead to blame the anonymous and, therefore, personally unaccountable body of subscribers for sending ineligible needy individuals. Hence, the publication in the annual reports of statistical and other financial information exposing breaches in the hospital's admission rules and exhortations to the subscribers to desist from such activity. However, the annual reports also tended to excuse the unnamed subscribers for these lapses on the basis that they were "playing the part of the Good Samaritan" (Jackson, 2004, 1885 Report, p. 12). Thus, it could be argued that the annual reports provided a mechanism by which the hospital was enabled to treat the "undeserving" poor, by diverting responsibility onto the general body of members, whilst at the same time providing them with justification on the grounds that had acted humanely in keeping with Christian principles. In this way, the accounts helped the hospital authorities to ameliorate the harsher dictates of the "self-help" doctrine and principles of moral economy in the treatment of the sick without the need to overtly reject them.

Conclusion

The paper provides an interesting corollary to previous accounting studies that have emphasised the ways in which accounting has been enlisted by social elites as an implement of social and moral control over the lower orders of society. Throughout the eighteenth and nineteenth centuries, the vast majority of patients who were treated at the Newcastle Infirmary came from the lower orders of society and were therefore unable to pay for their treatment. Yet, it has been observed how accounting was used to persuade the wealthier citizens to contribute funds and to enable the hospital to exercise compassion in treating the "undeserving" poor. Such a policy conflicted with the dominant utilitarian view of society, which emphasised the twin pillars of economic expediency and self-help.

This apparent beneficence towards the poor conflicts with the findings of previous studies relating to poor relief in Victorian Britain. Thus, Walker (2004) was able to show how reform of the accounting arrangements in the parishes under the Old Poor Law was seen as key to making the system more efficient. For example, publishing the identities of claimants in the localities was intended to act as a stigma and discourage claims. In this way, accounting became a manifestation and implement of prevailing social morality and, thus, the means of reinforcing extant power structures in local communities. Similarly, under the workhouse regime established by the New Poor Law in 1834 accounting processes were actively deployed to stigmatise the inmates and reconstruct their identities as "spoiled" individuals (Walker, 2008). Such psychological pressure reinforced the perception amongst the poor that claiming help from the authorities was truly a matter of last resort.

Probing the motives behind the different stance taken by the Newcastle Infirmary is problematic. Altruism was not the main motivating force for the employers on Tyneside who were the hospital's main supporters. Primarily they were capitalists who sought to increase their profits, utilising management accounting information to assist them in controlling costs and capital investment decisions (Fleischman and Parker, 1997, pp. 117-139; Fleischman and Macve, 2002). The period examined coincided with the region's main period of economic expansion during which large fortunes were made. Economic progress depended on the availability of an able-bodied labour force. In this light, it could be argued that it was in the interests of employers to maintain the

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health of the working population, including those people temporarily thrown out of work as a result of economic downturns, notwithstanding that technically they were deemed "undeserving" by the New Poor Law.

However, economic self-interest cannot explain the treatment proffered to those permanently disabled through industrial accidents or those suffering incurable ailments who would never work again. The paper has alluded to certain factors that might be relevant. The first is the industrial-relations culture of the region. Tyneside effectively had two industrial revolutions, the first in the early to mid-eighteenth century when it became the first region in Britain to industrialise on a significant scale – the seeds of this were sown in the seventeenth century (Oldroyd, 2007, pp. 2-3); and the second during the Victorian period when the region achieved massive growth. According to Levine and Wrightson (1991, p. 366), industrial relations in the earlier period were grounded in estate practice and were essentially paternalistic. This was the time when the Newcastle Infirmary was founded (1751). Landowners such as the Bowes and Londonderry families were still major players in Tyneside industry during the nineteenth century, and it is possible that the tradition of paternalism endured. Second, there is the influence of religion. The Newcastle Infirmary was founded as a Christian institution and the connections with the Church remained strong, not just in terms of the rhetoric in the accounts, but also the financial support it received from church congregations. The annual reports were prone to refer to the example of Jesus by way of justification for bending the hospital's eligibility rules; and for believers, this was not merely lip-service. Finally, denying treatment to the "undeserving" poor was not just a theoretical question of moral economy. The admissions officials were forced to deal in person with the sick and dying importuning them for help; and one cannot underestimate the moral difficulty they faced in turning away ineligible cases when confronted face to face with extreme suffering. Whatever the reasons for the inconsistency between practice and rules, the paper illustrates the need for more case studies of other hospitals to ascertain how typical the Newcastle Infirmary was of the voluntary hospital sector as a whole. It also demonstrates the dangers of forming conclusions about the treatment of the poor by social elites based solely on what was meant to happen in theory. Apart from the hospitals, the New Poor Law is the other example that might benefit from more work in that respect.

Notes

1. In 1905, the hospital was granted royal recognition, whereupon it became the Royal Victoria Newcastle Infirmary.
2. Bentham promoted his panopticon as equally suited to the management of hospitals for the poor as for prisons (Himmelfarb, 1984, p. 78).
3. Sir Frederick Eden was well known in the late eighteenth century for his views on the causes and consequences of poverty. His book *The State of the Poor: Or a History of the Labouring Classes in England, from the Conquest to the Present Time* (Eden, 1797) was a highly influential text.
4. The General Rules of 1883 allow subscribers of one guinea to nominate six outpatients which two guineas allowed 12 outpatients or one inpatient and higher amounts in these proportions.
5. If an employee was admitted under such circumstances, the rules require the Secretary to send a letter to the employer requesting the submission of a letter of admission. If the

employer had already used his letters, or was not a subscriber, then the Secretary would inform the employer of the annual subscription fee (Statute of Rules of the Infirmary 1855, rule 21).

6. The House Committee numbers remained unchanged until 1896 when their number was increased to 37.
7. The first Statutes of Government for the Newcastle Infirmary in 1751 specified that the treasurer, as at most infirmaries (see Anning, 1963, p. 57), was required to enter into a bond with two people "for the due accounting for and paying the Money, which shall be paid into his hands [. . .]" This served the purpose of protecting the contributions of donors but also it provided an effective means of excluding social inferiors from senior and socially prestigious offices.
8. Cash accounting also dominated in hospitals throughout British colonies. At the Royal North Shore Hospital and St Vincent's Hospital in NSW, cash accounting operated undiminished from the founding of the hospitals in 1837-1935.

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