

The Ethel Hedley Orthopaedic Hospital for Crippled Children¹, Calgarth Park, Windermere

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‘There is little knowledge of the disease (poliomyelitis), of how to prevent it, and as a consequence public anxiety’.²

When the Ethel Hedley Hospital opened in 1920 it was one of the first hospitals in England and Wales for the management of poliomyelitis and other crippling diseases. It was founded in the wake of outbreaks of poliomyelitis in Westmorland and neighbouring counties during the previous decade and at a time when there was a growing belief that crippling diseases of childhood were both preventable and amenable to treatment.

Treatment involved lengthy immobilisation of diseased joints and bed rest, often in open-air – typically for up to two years. This paper charts the hospital’s 50-year history, the wider factors which influenced its establishment, the types of cases it treated and includes recollections of treatment methods of former patients and staff. It also shows how changes in disease incidence and the pattern of hospital provision led to the hospital’s closure in 1970.

Introduction

THE early twentieth century witnessed a growing belief that crippling diseases of childhood, hitherto regarded as incurable, were both preventable and amenable to treatment. This changed attitude toward the crippled child plus the emergence of orthopaedics as a distinct medical speciality stimulated the establishment of hospitals for the medical treatment of children so afflicted; also the incidence of poliomyelitis worldwide, which was increasing and arousing growing alarm, was an added influence in this development.

Between 1910 and 1920 Cumberland, Westmorland and the Furness part of North Lancashire experienced sporadic outbreaks of acute poliomyelitis.³ The recognition that there was a mass of neglected cases for whom adequate treatment facilities were not available provided the impetus to open the Ethel Hedley Orthopaedic Hospital for Crippled Children at Calgarth Park, Windermere in 1920.⁴ It was one of the first hospitals in England and Wales for the management of poliomyelitis and other crippling diseases.

This article charts the Ethel Hedley Hospital’s 50-year history, the wider context within which it was founded, the range of cases it treated, and shows how changes both in the incidence of disease and the pattern of hospital provision led to the hospital’s closure in 1970. Treatment methods were characterised by immobilisation of diseased joints and lengthy bed rest requiring one to two years’ hospitalisation, and in some instances repeated stays over numerous years. This is not a statistical analysis of clinical outcomes (records are not available that would allow this); rather the paper includes personal recollections from former patients and staff which offer their perceptions of

the treatment regime and hospital routine that could not be derived from statistics alone.

Background

Ethel Hedley Hospital opened as a direct response to local outbreaks of poliomyelitis and an outline is provided of the disease, the development of treatment methods used at Ethel Hedley Hospital and of the range of deforming diseases treated there.

The term ‘crippled child’ encompassed children suffering from diseases including poliomyelitis (infantile paralysis), tuberculosis of bones and joints, rickets, and a range of congenital deformities and for whom medical interest, as part of a broader concern for child welfare, emerged in the late nineteenth century.⁵ Support for afflicted children was primarily humanitarian, through voluntary agencies, and by educational provision. Permissive legislation in 1899 allowed local authorities to provide for the education of children suffering from physical defects. Then the 1918 Education Act made it compulsory for local authorities to provide for the medical treatment of ‘physically defective’ children and for the establishment of state-approved schools and hospital schools.⁶ By then it was estimated that between 30,000 and 60,000 children in England and Wales were affected.⁷

At the beginning of the twentieth century much of the treatment of deforming diseases was undertaken by general surgeons in general and children’s hospitals. The founding of the British Orthopaedic Association in 1917 marked the emergence of orthopaedics as a distinct medical specialty, attributable both to experience gained in reconstructive surgery during World War 1 and to earlier pioneering activity undertaken in North West England by Hugh Owen Thomas, Robert Jones and Agnes Hunt.⁸

Hugh Thomas was a general practitioner in Liverpool. His approach to treatment was largely conservative, being primarily concerned with manipulative rather than open operative surgery (which he believed resulted in many limbs being amputated), and the prevention of deformity. His mantra – ‘alignment and enforced, uninterrupted and prolonged rest’ – became one of the fundamental principles of orthopaedic surgery.⁹ He designed his own (Thomas) splints for the immobilisation of diseased joints, which were used extensively during World War I and the process of gradual traction or manipulation, with retention by plaster or special splint, which long remained the method of choice in Britain.¹⁰

Thomas’ work was continued by his nephew, Robert Jones, regarded as the creator of modern orthopaedic surgery. Initially a general surgeon, he gained early experience in the treatment of accidents as Consulting Surgeon during construction of the Manchester Ship Canal during the 1890s.¹¹

During World War 1, as Director of Military Orthopaedics, he set up special military orthopaedic centres across England for the treatment of skeletal or neuromuscular injuries. By 1918 these centres housed some 30,000 beds.¹² One centre was at Ancoats Hospital, Manchester under the directorship of Captain Harry Platt who was to become

Medical Director at Ethel Hedley Hospital and a figure of national and international importance.¹³ He would develop orthopaedics as a surgical specialty in the North West region, opened the first fracture clinic in the country, at Ancoats Hospital in 1917, and became President of the Royal College of Surgeons in England.¹⁴ He pioneered treatment for numerous conditions, including congenital deformity of the hip, which resisted manual reduction.¹⁵

Robert Jones had developed an interest in the care of chronically ill children in during the 1890s. He recognised the necessity of long-term treatment which was not available in general hospitals from where many children were sent home prematurely. He believed that there were few children so incurable that they could not become well if placed in a proper healing environment and in 1898 rented beds in Liverpool for this purpose.¹⁶ He also collaborated with Agnes Hunt, a trained nurse, disabled by tuberculosis of the hip, who in 1900 had established the first country orthopaedic hospital for cripples at her home at Baschurch in Shropshire. Her empathy with fellow sufferers guided her care of the chronic sick – fresh air and happiness – to which in 1910 was added a system of ‘After Care’ clinics to provide continuing care for those discharged. Surgeons from all over the world, many from America, came to learn their methods.¹⁷

In 1919 Robert Jones used Baschurch as a template for a proposed national scheme for the care and cure of crippled children, to be co-ordinated by the Ministry of Health. Long-stay open-air country orthopaedic hospitals, supported by a system of scattered out-patient/after care clinics, would link with local authorities to meet the educational needs of children and with GPs to ensure the early referral of cases.¹⁸ Although the scheme received ministerial support it was not formally adopted because of financial constraints and early schemes were funded from charitable sources.¹⁹

Poliomyelitis is an acute viral infection affecting the muscle controlling nerves of the brain and spinal cord. Numerically its incidence was dwarfed by tuberculosis (Table 1) and most cases were of a limited nature, but its ability to cause temporary or permanent paralysis, deformity, or death within hours made it one of the most dreaded infections in the world. Historically the disease mainly affected children under five years old thus acquiring the epithet infantile paralysis.²⁰

The disease attracted growing attention and alarm from late-nineteenth to mid-twentieth century as worldwide its incidence increased, (e.g. In New York in 1916 27,000 people were paralysed, 9,000 died).²¹ Repeated epidemics in the USA led to major research to develop a poliomyelitis vaccine.²²

Both the cause and method of spread of poliomyelitis have been much disputed (it was thought to be a summer disease) and its sporadic incidence and variability of symptoms created problems of initial diagnosis. There is no proven specific treatment for poliomyelitis, and although treatment aimed at preventing deformity and reducing residual disability the recovery or otherwise of muscle power depended more upon the degree of neurological damage than of medical intervention.²³ Of those with paralysis, only 30 per cent recovered fully.²⁴

There had been sporadic outbreaks of poliomyelitis in England and Wales during the nineteenth century but an epidemic in Bristol in 1909 with further localised epidemics in subsequent years led to poliomyelitis being made a compulsorily notifiable disease in England & Wales from 1st September 1912 and to a series of epidemiological and clinical investigations by the Local Government Board of England and Wales between 1912 and 1918.²⁵

Localised outbreaks continued during the inter-war years then a sudden upsurge in the early post-war period. The first nationwide epidemic occurred in 1947 with 7,716 notifications and 707 deaths with significant outbreaks continuing throughout the 1950s.²⁶ However, by 1959 incidence had declined markedly. The introduction of polio vaccination in the mid 1950s 'curtailed a post-war polio epidemic that was threatening to reach new and frightening levels'.²⁷

TABLE 1. Poliomyelitis and Tuberculosis Death Rates in England and Wales

	Death Rate per Million living (E&W)			Average Deaths per Annum (E&W)		
	Polio	Tuberculosis		Polio	Tuberculosis	
		Respiratory	Other		Respiratory	Other
1911-20	4	1007	368	176*	38775	12621
1921-30	4	767	225	115	31640	7739
1931-39	4	601	121	101	25259	4972
1940-44	3	563	113	90	21945	4489
1945-49	9	459	76	317	19236	3216
1950-54	8	229	31	342	10086	1347
1960	1	68	7	46	3105	330
1961	2	65	7	79	3002	332

Source:

- (i) Cmd 7734 Report of the Chief Medical Officer for 1947, p.167
- (ii) Cmd 8582 Report of the Chief Medical officer for 1950, p. 173
- (iii) Cmnd 1856 Report of the Chief Medical Officer for c1961, p.224.

* Excludes 1911.

Outbreaks of poliomyelitis between 1910 and 1913 affected Cumberland, Westmorland and Barrow in Furness, with 24 deaths and 137 paralysed.²⁸ The 1913 outbreak was investigated by Dr. Macewen of the LGB although he was not able to identify how the disease was transmitted and that the epidemiology of the disease was unclear.²⁹ Drs. K. Fraser and E. Henderson, Cumberland and Westmorland Medical Officers of Health acknowledged that poliomyelitis was the chief cause of crippling in both counties.³⁰

There were further notable outbreaks between 1922 and 1956, in 1947 Cumberland and Westmorland being cited as having among the highest incidence in England.³¹



FIG. 1. A view of Ethel Hedley Hospital showing children on the open-air veranda.
(Courtesy of Cobi Harteveld)

The Ethel Hedley Hospital

Mr Oswald Hedley had bought the Calgarth estate shortly before World War 1 (Fig. 1). In 1914 he offered Calgarth Park as a convalescent hospital for wounded Belgian soldiers and it continued until 1919 as an Orthopaedic War Hospital, operating as an auxiliary unit of the military base hospital in Manchester.³² His friend Charles Hough, formerly senior surgeon in Derby, now residing at White Craggs, Ambleside, acted as Medical Superintendent, with Harry Platt as Chief Visiting Surgeon. On the cessation of war it was agreed that Calgarth Park should re-open as a special hospital school for the combined education and the treatment of both the mass of hitherto neglected poliomyelitis victims and children with other crippling conditions.³³ The hospital was dedicated to the memory of Mrs. Ethel Hedley, who played an integral part in the organisation and running of the wartime hospital but who had died in 1916.

Oswald Hedley had borne the costs of wartime reconstruction and maintenance, over £100,000, and similarly funded the capital conversion costs of the new hospital.³⁴ He also financed the initial running costs although charges, initially 25s per child per week, had been introduced by 1923. The hospital was run through a Board of Management and Executive Committee and until 1948 functioned as a 'voluntary hospital' its revenue being derived from financial arrangements with local authorities, payments from private patients and possibly from gifts and collections.

The initial 20 beds, for children up to the age of 16 years, were increased to 50 by 1924, – a girl's and a boy's ward – plus operating theatre, gymnasium, plaster and treatment rooms. The hospital served Westmorland, Cumberland and North Lancashire, with some 400,000 of a population, with Cumberland the main catchment area. As previously Charles Hough superintended day-to-day work (Dr Jean Bucknell from 1933) with Harry Platt as Consulting Surgeon (attending and operating monthly) which he shared with his work at Ancoats and Biddulph Grange Orthopaedic Hospital, Shropshire.³⁵

Robert Jones and Agnes Hunt advised on the running of the hospital and were early visitors. The hospital's *modus operandi* was as outlined in the proposed national scheme – prevailing approaches to treatment and multi-professional teamwork. Disease prevention was outside the scope of the hospital's work.

The hospital school opened on 7th September 1920, catering for children aged 3-14, and continued throughout the life of the hospital. The daily programme/timetable was designed to match, as far as possible, that of other schools. By 1949 when the Ministry of Education took over the school there were 6 teaching staff.³⁶

An after care service, based upon the Shropshire model was established in 1921, Agnes Hunt sending a nurse (Miss Cornes) specially trained in after-care work to help establish arrangements.³⁷ There were clinics in Kendal, Windermere, Lancaster, Ulverston, Whitehaven, Maryport, Carlisle and Penrith, each visited monthly by the Medical Director, After-Care Sister and Physiotherapist.³⁸

Early work focussed upon major operative treatment of deformed children from the pre-war poliomyelitis epidemics, aimed at gradual unfolding of deformities. The value of the hospital was demonstrated in 1922 when 'the early treatment of 15 new poliomyelitis cases from Westmorland not only prevented contractual deformities but allowed muscle power to be largely restored'. Harry Platt recounting this experience to Manchester Medical Society noted that 'the co-ordinated approach at Windermere made it relatively easy to respond to sporadic outbreaks whereas unfortunately this was not the case in many locations elsewhere'.³⁹ Dr. K. Fraser similarly remarked in 1937/38. The prompt admission and treatment of 14 cases from the Penrith area contrasted with the 1911 epidemic which left a trail of tragedy in its wake.⁴⁰

928 in-patients were treated during the ten years to 1930, 37 per cent and 20 per cent from Cumberland and Westmorland respectively (Table 2).⁴¹ Poliomyelitis constituted 25 per cent of patients and congenital deformities including club feet and congenital dislocation of the hip accounting for 24 per cent.

Results were classified into seven categories including 36 per cent classified as freed from disability, 10 per cent having some residual disability, and 4 per cent having died.

Charles Hough concluded that the local Scheme had enabled the early detection of crippling conditions as demonstrated by the reduction both in waiting lists and in the number of major operations. Cases of contractual deformity were becoming less

frequent.' Instead of stumbling over cripples at every turn we are beginning to go out and look for them'.⁴²

TABLE 2: The Ethel Hedley Hospital: In-Patients by Category 1920-29

Category	Total Nos.
Poliomyelitis	237 (25%)
Congenital Deformities	229 (24%)
Tuberculosis (Surgical)	117 (13%)
Injuries	62
Spastic Paralysis	52
Rickets	48
Osteomyelitis	42
Infective Arthritis	36
Birth Palsy	26
Pseudo Coxalgia	23
Postural & Static Deformities	22
Miscellaneous Bone Diseases	19
Miscellaneous	15
	928

Source: CRO (K) WT/HOS/2 The Ethel Hedley Hospital Report on the first 10 years work 1920-1930.

Recollections of former patients and staff

During preparation of this paper letters were placed in local newspapers seeking information from people who had connections with the hospital. 26 former patients and 15 former staff members responded, collectively covering the period 1935-1970.

Former patients described mixed emotions, e.g. apprehension, loneliness, camaraderie, character building, but were largely favourable. Although treatment was protracted, with in some cases residual disabilities, they have been able to lead normal lives. There were some allusions to a strict/institutional regime although the majority recall a generally happy atmosphere, fostered by the staff, and describing education, social outings, sports days, pantomimes and participation in the Scout and Guide movement.

It is not possible here to reproduce every comment and I will focus upon treatment methods, plus visiting arrangements and observations regarding Sir Harry Platt which were recurrent themes.

Treatment methods

Treatment invariably involved immobilisation for periods of one to two years followed by gradual mobilisation. Children could be encased in moulded plaster of Paris or treated via fixation, traction and frames. During treatment for congenital disorders

limbs could be held widely spread in ‘frog’ position utilising a bar placed between them.

JG (1956) recalls that ‘what immediately caught your eye were the ugly metal beds and the weird contraptions which were on some of them; these were orthopaedic frames used to hold patients fairly immobile. These frames sat on the bed and had space underneath so the nurses could lift them complete with patient so that they could change the beds etc. They were constructed of metal and the upper part was padded and leather covered with the leg positions adjustable for various types of treatment. Once the patient was fixed to the frame a metal cage was placed over the legs to support the weight of the bedclothes which went over the whole thing. As we couldn’t wear pyjamas we were given what was called a modesty cover. This was a square of old institutional blanket, cut to size. Unfortunately this was no help when it came to the dreaded bed bath’.

Comments regarding **poliomyelitis** included initial diagnosis, survival, fortitude and residual disability, plus feelings expressed for those less fortunate.

MC (1950) ‘A lot of the children were suffering with poliomyelitis, they were lying head down at an acute angle in traction their discomfort can only be imagined’.

IR (1953-55) ‘We had a lot of polio cases. TK had polio in both legs and they were no good at all to him’.

DB, from Orton, contracted polio in July 1947, aged seven years, although not diagnosed until December. ‘Polio was never mentioned when I took ill’ and required a second opinion to identify the condition. ‘My legs and head hurt, I screamed a lot whenever anyone moved me. I was in Ethel Hedley for nine months, learning to walk again.’ ‘The polio left me with my toes not working on my left foot, a badly dropped foot and my hip not 100 per cent’.

HM (1946-47) suggests her parents were concerned because little was known about poliomyelitis. ‘The polio affected my arms down to both legs. It has left a weakness down my right side’

JM (1940-51) ‘I became aware of polio around 1947 – a side baby ward and iron lung was made ready for a new patient with polio (from Blackpool); we visited her but staff wore white gowns and masks. It was thought that polio came from ice cream’.

JS (1953-63) from Grange over Sands recalls that she’d been poorly for a few days. When the GP suggested to her mother that they see how she progressed over the weekend she said ‘no, she’s got polio’ and that she needed to be in hospital. Her whole body had been paralysed and was left with lower limb paresis (diminished function) and some weakness of the left arm. ‘It must have been horrific for my parents not knowing if I’d survive (a young boy at my school had caught polio and died). One day my mum was told by the Sister ‘it’s gone to her brain, you can see her eyes turning; if she survives she’ll only be a cabbage’.

She had a series of tendon releases and application of plaster requiring periods in hospital each year between 1953 and 1964, although she questions the necessity of this. ‘I’ve often thought it was frankly criminal to keep me in hospital all those months for no good reason that I could see but it was the norm. In those days we accepted it. What the Doctor said was gospel. I am now 59 and continue to wear callipers and boots, and use a power-chair’.

J, A and TD, aged two years, six years and 18 months were admitted with polio in 1944. A. was in plaster from head to toe and totally paralysed except for some use in her right hand. Tony recalls that she was in an iron lung for some time. However, she was later able to edit a magazine for the disabled. Tony (in hospital for 12 months) was left with one leg shorter than the other and has had difficulty walking all his life. J says that she was ‘the lucky’ one. ‘I had to learn to walk again but am able to lead a normal life’.

HB from Kendal was at the hospital from 1940 for about 4 years having contracted polio when aged 16 years. ‘She was paralysed from the neck down, very limited use of left arm. She learned to knit having one needle stuck in the bed clothes; she also painted and weaved. Sadly she died in an iron lung aged 35 years’.



FIG. 2. Honor Blamire meeting County Guide Commissioner July 1945.
(Picture courtesy of Sally Jones)

Most comments regarding **congenital disorders** focus upon the manner in which young children were immobilised.

JR (1940-51) 'Babes in plaster up to their chests with legs in a sort of yoga position, sat on wooden boxes, like thrones.'

PM (1962) similarly notes 'It was a cruel treatment for congenital hips and was a long slow process. As babies, they set off being fitted with leg splints, which had to be widened. Then on to a plaster cast from their waist to their ankles, which were called frog plasters. During the day, they were sat up on a box, and tied on to it, and to the cot bars. So cruel, poor things. If this was not enough, then the next stage was the dreaded "frame", set up on a bed, strapped, and weights attached to their legs, which over time were outstretched, to different widths.' They lay like this for months. IR (1953) added. 'When the plasters were removed we had to start potty training.'

GG (1945-47) had congenital dislocation of the right hip, was a patient for 18 months. 'Sir Harry Platt tried traction and plaster cast for over 12 months then asked her parents' permission to pin the hip – 'the first time anyone had performed this procedure. He continued to monitor me until I was 15 years old. Further surgery was required later and my leg was shorter and rotated outward but had it not been for Sir Harry Platt I would not have been able to had such a full and active life'.

With regard to changed approaches to treatment CH (1969-70) notes:

'It horrifies me now to think that very young boys some only three years old were put on traction and to keep them completely immobile, fastened them onto a frame, leaving them to lie flat on their backs for 12 months or so. When I did my health visitor training in 1985 I was given an eight year old girl to follow up and she had Perthes' disease (congenital hip disorder). She was on crutches, at home and the good leg (shoe) was built up by about four or five inches so letting gravity do its work with the bad hip.'

Bone and joint tuberculosis treatment was a similarly lengthy process. It also included outdoor rest about which there were numerous comments.

JG (1956-57) 'Bigger boys like me underwent a more unpleasant form of torture. Lying flat on the bed your feet were pointed to opposite corners then a strong cord was attached to the problem leg with two inch wide Elastoplast from ankle to mid thigh. In my case a seven pound weight was attached to the cord and looped over a pulley which was fixed to the corner of the bed.... this was to gently open up the joint, take pressure off and allow the drugs to work. For 18 months, apart from Elastoplast changes [not a pleasant experience], I felt like a trussed and oven-ready chicken.

The only thing apart from immobility and fresh air was a daily injection of Streptomycin. I rather think this drug was in its early stages as it was very thick and syrupy. The one thing that all patients got each day was a spoonful of malt extract and one of cod liver oil. I would spit it out when the nurse turned her back. My Mother wondered how I had so many fishy smelling handkerchiefs'

DM (1946-48) 'The principal aim of the frame was to keep my frame straight and rested. My legs were securely bandaged down and I was strapped at the waist and shoulders. They told me I would be like this for two years. This combined with my loss of freedom of movement led to intense depression and loss of appetite. However, I came home cured in 1948. When I came off the frame I had to learn to sit up and over weeks to bend my knees little by little. When the important doctor from Manchester visited to my horror he grasped above and below my right knee and bent my knee fully. I felt sure it would snap. Sir Harry Platt, for that was he, expressed satisfaction with my progress and totally oblivious to my open mouthed shock proceeded to the next bed'.

JW (1955) recalls, 'the children who were being treated for tuberculosis, sleeping outside on the balcony and, first thing in the morning, having to brush frost off the top of their blankets'.

Some children revelled in the fresh air approach, which extended beyond those with tuberculosis. JS - 'There was great camaraderie among the girls on the ward, particularly in the summer months when we'd have our beds pushed out onto the balcony. You were regarded as a bit of a 'wuss' if you didn't go outside. Once there you stayed till September, whatever the weather. I remember them coming round at night and dragging a huge tarpaulin sheet over us to keep off the rain/hail/sleet etc'.

RA was not so enthusiastic: 'The most distressing part of my stay there was when I was placed on the balcony during the winter of 1947 (not a good one) the pot hot water bottles froze in our bed. Four of us were placed there when we were suspected of contracting tuberculosis I was never more pleased when that interlude was over'.

As an example of the protracted nature of corrective treatment, JM with double congenital talipes - 'both feet curled under and pointing clockwise and anti-clockwise' - spent numerous periods in the hospital from aged six weeks in 1940 until 1951. Each visit involved surgical manipulation then feet encased in plaster but by the time that she was 12 her feet were straight and she has been able to live a normal life.

There were several recollections of death -

HM (1956-7) 'About four or five died-with TB'.

EG (Pre-training Nurse 1947-49) 'I recall two young children, boy and girl, died from TB meningitis. It was my first experience of seeing and laying out a deceased person'.

JM (1950-1) 'The one very sad time was when one of the girls also from Carlisle died. She also had polio and was actually looking better with rosy cheeks but shortly afterwards we were informed she had died, the virus infection going to the brain'.

Visiting

Daily visiting was introduced in 1959.⁴⁵ Hitherto it had been monthly only (Sunday 2-4pm), an arrangement which the Hospital Rules underlined 'Visiting by parents or friend cannot be encouraged.' Children were not allowed to visit. The reasons for such restricted visiting were not made clear other than to suggest that the arrangements were made in the best interest of the children.

Ethel Hedley Hospital was not unique. Since the beginning of the twentieth century it had become the norm for children in hospital to be separated from parents for long periods, an audit in 1953 revealing that only 300 of 1,300 hospitals allowing daily visiting.⁴⁶

Increasing concerns regarding the emotional needs of children in hospital led to the establishment in 1956 of a committee, chaired by Sir Harry Platt, to study arrangements for the welfare of children in hospital.⁴⁷ It recommended that there should be unrestricted visiting of young children. The Report was adopted by the Ministry of Health as official policy, albeit permissive only.

Dr. Fraser had observed that 'The worst aspect of institutional treatment of cripples, to get to the nearest of them (Windermere) is a 3 hour journey from Carlisle; the treatment is frequently very prolonged and parents are undoubtedly averse to losing sight of their children for so long a period'.⁴⁸

Those who had been patients in earlier years, whilst acknowledging the transport difficulties faced by parents, particularly from Cumberland, felt that visiting times were too restrictive. Some suggested that it was more stressful for parents than the children, whose tears were short lived.

JS (1953-63) 'Visiting was needlessly cruel – I think they worked on the basis that children got upset when parents left, so restricted visiting to monthly'.

JM (1950-51) 'The hardest part to bear was visiting times which were once a month and two adults only. I did not see my brother or sister during the long time I was in hospital'.

DB (1947-48) 'A patient's sister could only view from the grounds using binoculars'.

DM (1946-48) 'Daddy had the idea that they (brother and sister) could get round the back and wave to me on the balcony. Neither of them could see anything except my hand waving and it all ended in tears – mine as well'.

Sir Harry Platt

Harry Platt remained connected with the hospital throughout its life. 'On one occasion he was asked to return to operate in the mid-60s on a difficult adolescent hip; Harry must have been about 80'. (He died in 1986, aged 100 years).

His national and international 'standing' added much to the hospital's prestige. He was particularly interested in teaching and in fostering international interchange of students. He visited the United States on numerous occasions and invited American orthopaedic surgeons to Ethel Hedley Hospital (Fig. 3). British Orthopaedic

Associations meetings and conferences were held locally also providing occasions to promote the hospital. His operating sessions were attended by medical personnel from across the north of England.



FIG. 3. Harry Platt with visiting American surgeons in July 1945

Harry Platt operated at the hospital on Saturday, once a month.

IR (1953-55) 'It was always a buzz when he was coming. It meant a lot of hard work; the floors had to be polished until you could see your face in them'.

JG (1956-57) 'His name was spoken in hushed and reverential tones. We youngsters thought he must be God'.

He was known for his irascibility and impatience in the operating theatre, (prone to kick out at the nearest bucket- a habit terminated when an infuriated Sister filled the bucket with plaster of Paris).⁴⁹

IW (1960-70) 'He was not a vicious man but could be very exacting in the operating theatre'.

There was also a softer side:

JM (1950-51) 'Sir Harry was a very solemn looking man, the young children were frightened and cried and we had one young girl the only private patient who broke into hysterics. I was the first in the ward as he entered and as he left I smiled at him and he turned back and came and shook hands with me and said how pleased he was to see someone smile'.

Clinical activity and disease incidence after 1930

In apparent contradiction to Charles Hough's optimism the demand for services remained, with full-bed occupancy continuing beyond 1948. Average occupancy for the period to 31/3/1950 was 52, with 47 children on the waiting list. However the incidence of tuberculosis had been decreasing throughout the twentieth century,

which was accelerated by the introduction in England and Wales of a tuberculosis vaccination scheme (BCG) in 1954.

The introduction of a mass poliomyelitis vaccination programme in America in 1955 was followed in England and Wales in January 1956. In 1960 Dr Henderson suggested that the scheme had gone well locally.⁵⁰ By 1962 83 per cent of persons under 20 in England had been vaccinated and notifications and deaths had declined markedly.⁵¹ After 1961 A second, oral, vaccine (Albert Sabin) became the vaccine of choice, and by the late 1960s notifications of polio in England and Wales were minimal.⁵²

Hitherto poliomyelitis had remained endemic with periodic outbreaks in Cumberland and Westmorland causing upturns in admissions at those times – 28 and 19 from those counties in 1947. However, by 1960 Dr. Bucknell reported upon low bed occupancy and by 1964 the local House Committee determined that the usefulness of the hospital had diminished and sought to ascertain how long it should be retained.⁵³ By then the declining incidence of poliomyelitis and tuberculosis and changing the pattern of hospital provision – prognosticated even at the time the hospital opened – were beginning to have an impact.

Hospital provision

The 1920 ‘Dawson Report’ recommended that medical care should be organised within regional hierarchies based upon technical complexity within which patients could be referred between hospitals.⁵⁴ This, the first formalising of a comprehensive health care system, led to protracted debates throughout the 1920s and 1930s and it was not until necessary integrated hospital planning during the Second World War that decisive moves were made towards a national health service.⁵⁵

These debates were very relevant to orthopaedics. Harry Platt played a leading role in the inter-war years toward establishing regional fracture schemes and unified accident services.⁵⁶ PEP and the Ministry of Health endorsed this regional approach, arguing for the incorporation of schemes for helping cripples within comprehensive orthopaedic departments of regional or sub-regional units.⁵⁷

Ministry of Health surveyors for the North West (1945) acknowledged the work done at Ethel Hedley Hospital and that it was regularly visited by Manchester orthopaedic surgeons, but felt that its size and remoteness made it difficult both to be fully resourced and obtain other specialist skill.⁵⁸ There was a danger of giving insufficient attention to conditions other than the deformity and, whilst not pressing for immediate closure, they did not perceive the hospital (or other similar) to have a permanent place in a well-organised scheme.⁵⁹

The advent of the NHS in 1948 changed both the management organisation relating to Ethel Hedley Hospital and the pattern of hospital consultant services. A regional management structure was created with the hospital incorporated within Manchester Regional Hospital Board but having the majority of its cases referred from Cumberland, now within Newcastle RHB. The hospital was visited by consultants based at Lancaster

Royal Infirmary (Messrs I. Kitchin and D. Purser) and Cumberland Infirmary, Carlisle (Mr. W. McKechnie).

Rationalisation of health care provision was articulated in the 1962 Hospital Plan which had at its core the concept of large-scale (district) general hospitals and with them the closure of some existing small hospitals, unless retained for other purposes.⁶⁰ The Plan anticipated the closure of Ethel Hedley Hospital by 1975 as other major developments – at Whitehaven, Carlisle and Lancaster – were fulfilled.⁶¹

Closure

Table 3 demonstrates both the decline in the numbers of polio and tuberculosis cases treated at Ethel Hedley Hospital between 1920-26 and 1964-69 and the overall decline in case numbers by the 1964-69 period. Indeed the 1960s presents a picture of gradual decline, and by 1967 Messrs Kitchin and Purser commented that they had insufficient cases in their care to keep the beds utilised.⁶²

TABLE 3: Ethel Hedley Hospital: Count of admissions 1920 – 1969

Category	All Admissions of Nine Diseases		
	1920-26	1944-48	1964-69
Poliomyelitis	155 (42%)	85 (30%)	7 (5%)
Tuberculosis	65 (18%)	57 (20%)	6 (4%)
C.T. EV. & Club Foot	51	24	39
Congenital Deformity of the Hip	26	32	18
Osteomyelitis	13	38	15
Pseudo Coxalgia	14	13	33
Spina Bifida	6	9	9
Rickets	28	2	4
Torticollis	10	26	7
	368	286	138

Source: Manchester Medical Collection, Platt Papers, John Rylands University Library, Manchester

Harry Platt, in a letter to the Secretary of the League of Friends referred to the spectacular decline in the incidence of poliomyelitis, tuberculous disease of bones and joints, and other crippling disorders and it was logical that (as a minor user) Manchester RHB should be reluctant to continue the hospital as an active orthopaedic-surgical centre.⁶³ The Consultants who had succeeded him had been treating orthopaedic cases at their general hospitals. The Regional Hospital Board consulted with local interests throughout the 1960s and although there were those such as the League of Friends, who wished to retain the hospital for the care of children, others were more concerned to use the hospital for alternative uses e.g. a convalescent hospital or hospital for the elderly.

Ultimately these proposals were rejected by Manchester RHB because of perceived difficulties in running and staffing an isolated unit and the cost of bringing the hospital to modern standards and the Board decided that a recommendation for the closure of Ethel Hedley Hospital be submitted to the Secretary of State.⁶⁴ Newcastle RHB was asked to deal with the problem so far as children from that area were concerned and a 12 bed extension to the Orthopaedic ward at Royal Lancaster Infirmary was provided for those children within the Manchester RHB catchment area.

Official notification of the intended closure of Ethel Hedley Hospital was received on 31st December 1969 and, following the transfer of the 16 remaining children, the Ethel Hedley Hospital closed on 4th July 1970.⁶⁵ There was no closing event. Sister Woodhouse, the last person to leave, merely locked the doors.

Overall assessment

Ethel Hedley Hospital was of its time, the care of ‘crippled children’ through prolonged rest under the ideal conditions of a country orthopaedic hospital. It was the physical manifestation of Hugh Thomas’s and Agnes Hunt’s earlier pioneering work, Robert Jones’s vision and Harry Platt’s skill and leadership (with dedicated support) directed toward a perceived clinical need. Local philanthropy enabled an integrated hospital and after-care service to be provided when hospital provision was not universal and which offered leading-edge treatment for children that may not otherwise have been available.

Not all treatment methods were wholly successful. Prolonged immobilisation for Perthes’ Disease has been abandoned because the often disappointing results outweighed the disruption to family life; similarly the ‘frog position’ for congenital dislocations has been superseded.⁶⁶ Harry Platt acknowledged that poliomyelitis treatment was more the management of deformity than the disease itself.⁶⁷ Residual disability was not uncommon as evidenced by respondents. Finally antibiotics, which are very effective in controlling disease, were not available for much of the life of Ethel Hedley Hospital.

Today more operative treatment is offered and some conditions do not necessitate prolonged immobilisation and hospital stay. This, however, varies from disease to disease and prolonged casting remains for some conditions. Thus the fundamental principles of orthopaedics expounded by Hugh Thomas remain largely valid today.

Ultimately the judges of the hospital’s worthiness are those who were recipients of the care that it provided, the separation from families, and whether the outcome justified the lengthy treatment process. Some respondents express gratification for being able to live a normal life ‘It was a wonderful place’; others more philosophical ‘Who can be sure whether it was all worthwhile. What might have happened if I hadn’t had all the operations? Now with Post Polio Syndrome you have to start the battle all over again’. Similarly ‘It was a good hospital but no-one now cares about polio and so no-one bothers about the residual problems of older people’.

Perhaps as a final testament; ‘When I was at Calgarth (1944) I had the joy of seeing children go home as walking cases, saved from a life of immobility – the need produced the man – just as the need of all those children produced you (Sir Harry Platt) and motivated your work’.⁶⁸

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