# THE PRESERVATION OF MEDICAL AND PUBLIC HEALTH RECORDS

## CONFERENCE

## 25 MAY 1977

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In view of mounting concern about the level of preservation of medical records, the King's Fund Centre agreed to provide facilities for a one-day conference on this subject on Friday, 27th May 1977. The conference was attended by representatives of many different medical and non-medical organisations. It provided an unusual opportunity for the exchange of ideas between clinicians, community physicians, medical administrators, civil servants, social scientists, historians, and archivists.

The meeting was chaired by Professor Margaret Gowing, of Oxford University, who has had wide experience with modern scientific and governmental archives. Her participation emphasised the relevance of medical records in the general problem of the preservation of other categories of official papers.

The morning session was devoted to papers outlining the major aspects of the problem of preservation of medical records. These contributions, by Dr Patricia Barnes of the Public Record Office, Mr Eric Freeman of the Wellcome Institute, Mrs Brenda Parry-Jones of the Oxford Area Health Authority, and Dr H W S Francis of Manchester University, were so informative and useful that they are included with this covering note in their complete form.

In the afternoon session the members of the conference divided into four syndicate groups, discussing respectively The Legal and Administrative Framework, The Preservation and Care of Medical Records Pre-1834, Hospital Records Post-1834, and Local Authority Health Records. Representatives of each of these groups reported back briefly, before the meeting entered into a general discussion about possible lines of action.

It was felt that the meeting had demonstrated that the threat to medical records was if anything more serious than had been previously assumed. Destruction was certainly not confined to modern records: pre-1858 records, often of great historical importance, were by no means secure. There was a continuing erosion of records which in theory were protected under present legislation, and by Department of Health Guidelines. This loss of material had been increased in the wake of recent Health Service and Local Government reorganisation. If anything, the largest category of records at risk was represented by those of the former local authority health services. There was no coherent policy within the Regional Health Authorities to deal with this problem. The meeting appreciated that the danger to medical records was so great that it was not possible to rely on long-term action by central authorities to amend and enforce official guidelines. In the short term it was essential that the various interest groups acting in partnership at the local level should pool their efforts to ensure vigilance in respect of the preservation of medical records, and to introduce practical schemes for their retrieval, safe deposit, and accessibility to scholars and medical workers.

Further information about the conference, or the activities of groups concerned with the preservation of medical records can be obtained from Dr Charles Webster, Wellcome Unit for the History of Medicine, 47 Banbury Road, Oxford, OX2 6PE.

## THE STATUTORY POSITION AND ITS LIMITATIONS

DR PATRICIA BARNES, PhD, PUBLIC RECORDS OFFICE

When I asked Dr Charles Webster for the definition of medical records - at least for the duration of this Conference - he replied that it had been deliberately left vague, so that each speaker might be free to discuss the aspects of the problem before us that he - or she - knew best. The definition I propose to use is that medical records comprise both the administrative and clinical papers created by an institution, and my comments will be concerned primarily with the records of hospitals rather than those of the old Regional Hospital Boards on the one hand, or the family practitioner on the other.

In 1952 Lord Butler, then Chancellor of the Exchequer, and the late Lord Evershed, Master of the Rolls, appointed a Committee:

'To review the arrangements for the preservation of the records of government departments ... in the light of the rate at which they are accumulating and of the purposes which they are intended to serve; and to make recommendations as to the changes, if any, in law and practice which are required'.

The Committee had as its Chairman Sir James Grigg and, inevitably, is always known as the Grigg Committee; our Chairman today, Professor Gowing, was one of its members. The Grigg Committee proposals, put forward in its report which was published in 1954, cover a wide field. Very broadly, they recommended that ephemera, for example cancelled cheques, should be destroyed at the earliest possible moment. Other, less ephemeral papers, were to be subject to a system of First and Second Reviews. The First Review, to take place 5 years after papers had passed out of active use - the Put-Away date as it is commonly known - was to subject records to a single test: Have these papers any continuing administrative use? Those that had not were to be destroyed, those that were to be kept until they had been in existence for 25 years, for a Second Review. At Second Review, two questions were to be asked: again, have these papers any continuing administrative use, and the new question, have they any historical importance? Those records that survived the two reviews were to be transferred to the Public Record Office and be opened to public inspection in due course. The First, purely administrative, Review, was to be conducted by the government department alone, under the direction of its Departmental Record Officer; the Second Review was to be a joint exercise between the Department and the Public Record Office.

This then, was the system proposed and subsequently adopted throughout government. We shall need to look at it again in the particular context of hospital records, but there are two points about it that I want to draw to your attention now. Firstly, the Grigg system presupposes an orderly system of record keeping, in which it is possible to ensure that all papers, from whatever part of the organization, are dealt with, and that matters of transitory interest can, with relative ease, be distinguished from material of long term value. In theory at least, this should be the case in government departments. Secondly, the system requires rigorous supervision and cooperation within the department, as well as guidance from without.

Some 4 years after the Grigg Committee reported, the Public Records Act 1958, which provided the necessary statutory changes, received the Royal Assent. The definition of public records adopted in the Act brought certain bodies other than departments of government within its scope. We here are not concerned with the papers of Remploy Ltd., nor those of the National Institute of Houseworkers Limited, or the Trustees Savings Bank Inspection Committee. Our interest centres upon the records of the National Health Service Authorities, other than local health authorities, and of National Health Service hospitals which, since the coming into force of the 1958 Act, have been public records.

I am sure you will be glad to know that I do not propose to lead the Conference by the hand through every section, subsection, schedule and consequential amendment of the Act, let alone the legal interpretations which subsequently have been placed upon them, in the study and practice of which my colleagues at the Public Record Office have grown grey. Instead, I want to look at those of the broad principles embedded in it which concern us here today. In the first place, the Act was intended to offer a measure of protection: it requires that no paper should be discarded without some consideration of its value for administration or for future historical inquiry. Secondly, it requires that records worthy of permanent preservation should be kept in safe custody until they are ripe for transfer to the Public Record Office, or to another place of deposit appointed by the Lord Chancellor. Thirdly, it requires that the public should have access to the majority of records selected for permanent preservation 30 years - 50 years until 1968 - after their creation. Finally, it provides for certain types of record to be closed for longer periods. Clinical records, which have a high a degree of personal sensitivity, are closed to general public access for 100 years under this provision.

The Act puts the main burden of selection and care of the public records until they are 30 years old upon the shoulders of those who create them, or of their successors in function, as the Grigg Committee proposed. It does, however, require them to carry out their work under the guidance of the Keeper of Public Records, and he has on his staff the 8 Inspecting Officers and two Principal Assistant Keepers, who, under the direction of the Records Administration Officer, are charged with this formidable task.

This then is the framework which the Grigg Committee and Parliament between them have erected. It is, however, only a framework which requires cladding. The cladding, so far as the records of the National Health Service hospitals are concerned, is the Circular HM 61/73 Preservation and Destruction of Hospital Records, which the then Ministry of Health, after lengthy discussion with the Public Record Office, issued in July 1961. Save for its much younger brother HN 76/48, issued in March 1976 to remind National Health Service bodies that some of their records would soon fall due to be opened under the 30 year rule, the 1961 Circular remains the Bible for the selection and disposal of hospital records.

Those of us who have had to deal with hospital records, and here I would pay tribute to the massive contribution of our colleagues in local record offices, have Circular HM61/73 engraved upon our hearts. It defines classes of records which should on no account be destroyed, among them Annual Reports, Minute Books and any record whatsoever (supposing they had survived until 1961) earlier than 1858, the year when the Medical Act was passed. It also classifies those records that may be destroyed, both administrative and clinical, and recommends a date at which destruction can take place; these, broadly, are keyed to date of audit or to the provisions of the Statute of Limitations. Finally, if offers some rather general criteria for the selection of papers falling outside these two main categories.

With the benefit of hindsight, it is possible to criticize parts of the Circular. It is certainly in some places too precise, quoting form numbers and registers which are no longer in use. In other areas, it is not particularly helpful in laying down guidelines for dealing with those types of record which ought to pass through a process of selection rather than be subject either to total preservation or total destruction. I should add that this is a problem not unknown elsewhere. We should, however, before pressing any criticism too far, appreciate the problems which the compilers of the Circular faced, and which those who use it face still. The compilers sought to give guidance applicable to a wide range of institutions, in the sure and certain knowledge that each institution's records were - and are - different from every other. They were dealing with a widely scattered service

with a paper creating potential almost beyond imagining, and they were trying to ensure the survival of some, at least, of the clinical records in the absence of informed advice upon the value of such records for future scientific inquiry.

It is nearly 16 years since the Circular was published. In that time, the combined efforts of the Public Records Act, the Circular, the Public Record Office, the department of Health and Social Security and local archivists have, it seems to me, been moderately successful in preserving a significant volume of at least the administrative records of hospitals earlier in date than 1948. In the words of the school report 'has tried, but could do better.' There have also been many valiant, often solo, efforts without reference to the Public Records Act, by individual members of hospital staffs who have at least succeeded in placing under lock and key series of records retrieved from Board rooms, basements and in one case at least from the floors of offices, where volumes had been pressed into service as doorstops. I hope we shall hear more today of this kind of collection brought together in the face of almost overwhelming odds, as well as of more systematic activities. There is, however, abundant evidence that much has been lost in recent years, and that clinical records still present the greatest problem and are most at risk.

In my experience, and I am sure that it is shared by the archivists at least who are here, there are a variety of factors which contribute to the loss of valuable material, and the overlong retention of ephemera - cheque stubs and so on - which so often accompanies it. I have referred earlier to the paper creating capacity of the National Health Service; this undoubtedly is the major problem. To ensure the orderly preservation and destruction of the records of each hospital would require an army of records officers, inspecting officers and archivists. Secondly, that army would, in each and every case, have to surmount a variety of obstacles. To many, perhaps the majority, of hospital staff, it is an unwelcome surprise to learn that their records are subject to the provisions of the Public Records Acts and that, in the fullness of time, the public will have a statutory right of access to them, if they are worthy of permanent preservation. The inward looking, institutional character of the hospital is such that, if we are to believe what we read in the papers or indeed hear from hospital staff, powers more potent than those of the Public Records Act 1958 have not yet been able to change it. 'These records are ours, we need them, and they should stay here' is the oft repeated cry. I know, for example, of one case where a continuing need to consult administrative records nearly 200 years old was put forward in all seriousness. Such attitudes and arguments take no account of the fact that the atmospheric conditions in hospitals are scarcely appropriate to the long term storage of valuable records. Moreover, those who advance them forget that staff interested enough to gather records together eventually retire, or move on to another institution, leaving their admirable work unprotected. Every hospital is provided with that handiest means of modern records management, the incinerator, and I fear that much valuable material finds its way there when its protectors have departed. There is, too, the problem of the tensions between administrators and medical staff, which often has the result that a hospital's records are not considered as a whole, and different values are put either on administrative or clinical records. More usually it is the former which come off best, but I have known the opposite to be the case. Then there are the complexities of the doctor-patient relationship. I have myself dealt with an institution whose medical staff argued, unsuccessfully I may add, that the clinical records should be closed for more than 100 years. There is, on the part of the medical profession, an understandable reluctance to release to a place of safekeeping and into the custody of a person not bound by the doctor's professional code, highly sensitive records that will not be opened to public inspection for many years. Of course, archivists too have their professional ethics, but these are outside the experience of most doctors. More practically,

many archivists are reluctant to set aside some of their scarce accommodation to hold records that will not be open to public inspection for so many years. Finally, lest this catalogue of difficulties, incomplete though it may be, should induce in the Conference so severe a depression that it would stand in need of medical treatment - and thereby produce yet more records - there is the problem of a continuing provision for dealing in an orderly way with records as they accrue. It is one thing to be relieved of the accumulations of the past, quite another to divert scarce resources permanently to seeing that accumulations do not recur, and that valuable material is kept safe. All too frequently, the clearance of rooms full of records merely releases space for the process of filling up to begin all over again.

Thus far, I am sure, I have added little to the store of human knowledge in the field of preservation of medical records. I want now to turn to the future and to offer some ideas for our discussions later in the day. At this point, I must make it clear that the ideas are, if not wholly my own, certainly not an expression of the policy of HM Government; nevertheless, my colleagues and I are here today to consult as well as to expound in an area which has caused, and continues to cause, us concern. For the purposes of discussion then, let us assume that there is, up and down the country, a homogenous collection of records in each and every institution, some of which are worthy of permanent preservation. Then let us go back to first principles : is it appropriate that these should be public records for the purposes of the Public Records Act 1958? On balance, I think that it probably is appropriate, predominantly for the measure of protection that the Act affords. It is sometimes a modest help to the archivist when he - or she - approaches a hospital to discuss a deposit, moreover, the intervention of the Public Record Office, whether by a visit or a tactfully worded letter on official notepaper, has from time to time brought protracted negotiations for a deposit to a fruitful conclusion. I doubt, however, whether the protection would have been much help without the patient work of other interested parties within the hospital and without, or whether it is often decisive. There is much to be said for a few word in the ear of a friendly officer or board member. No doubt there will be much discussion today on how those words should be imparted and what indeed they should be; I do, however, doubt whether the opening phrase 'you are failing to discharge your statutory duty' would have the desired effect.

Experience has suggested to me that the full rigours of the Grigg system are inappropriate to hospital records and it is clear that the compilers of the Circular HM61/73 took the same view. There is a certain homogeneity between the records in each and every hospital which allows the bulk of them to be categorized and courses of action recommended, even if the recommendations should, from time to time, be brought up to date in the interest, amongst others, of covering changing fields and methods of historical inquiry. Where we may need to look again, if we are to deal with each hospital's records in a consistent way, is at those records to which, in departments of government, the First and Second reviews are appropriate. The Circular HM 61/73 makes no mention of this procedure, incidentally. Certainly most records now in safe custody have been through a review of sorts. The First Review has, however, been more a matter of survival in the face of storage problems than a systematic application of the principle of continuing administrative need - a process of natural selection if you will. Indeed, records have often been so haphazardly and inconveniently stored that I doubt whether any administrative need, if it arose, could have been met. The Second Review has in the majority of cases, been conducted by a professional archivist offered the chance of taking into safe custody those of the surviving records he considers worthy of permanent preservation. This, at least, has some of the merits of professional intervention which have been canvassed lately.

The Public Record Office, and here I can offer the official point of view of my department, has suggested that one basic improvement to the present, haphazard situation would be the appointment of at least regional records officers, as resources permit, to do the work done elsewhere by departmental record officers. There is, after all, a modest hope of improvement when the records are someone' job, though I confess, for the reasons that I have outlined above, it is a job that I should not relish. Should it be the job of the record officer to implement the Circular with the utmost rigour, or to bring some order into the area where a process of selection is appropriate? Would it be best to concentrate his efforts first on the rigorous elimination of ephemera and secondly on ensuring the survival of a high proportion of the remaining records until they are, say, 15 years old and then let the professionals take their pick?

Let us now suppose that time and resources, of the kind we have just been considering, could be devoted to bringing to light a steady flow of records for preservation. This would certainly not be the end of the problem. They are something in the order of 3000 health service establishments in England and Wales. If each produced 1 linear foot of valuable records a year - a modest amount - 3000 linear feet would have to be stored either in the Public Record Office or in recognized repositories elsewhere. Over the last ten years, taking one year with another, the Public Record Office has taken in 10,000 linear feet a year from all the departments of government: the hospital records would add nearly a third to the total. If they were, as they commonly are, transferred to local record offices, it would require a new, medium sized record office to accommodate them every four years. These are formidable figures; moreover they do not include any for the significant records of regional and area health authorities, for example, which are important in their own right. It is necessary, it seems to me, to consider whether this would be an appropriate use of resources which are, and probably always will be, at a premium. My own answer to that question, taking the wider view, would be No.

What then is the alternative? It seems to me that a more precise method of selection, a more precise definition of what is likely to be useful to a wide variety of disciplines, while still recording the history of the hospitals, is an approach worth considering and one which might make the overriding problems of control and supervision rather easier. In suggesting this line of approach, I am not proposing that records which fall outside it should instantly be consigned to the incinerator. I am, instead, putting forward some ideas upon priorities for the concentration of professional skills at national level, which would, in other areas, leave room for local initiative. I want to use the rest of my time this morning to discuss some of the possible criteria which could be used, though I confess I can see objections to each and every one; they may, however, serve to provoke discussion.

Should available resources be concentrated on safeguarding the records of, say, the teaching hospitals? This is attractive, since the hospitals clearly play a major role in the development of the medical profession. But is it sufficient? The role of the teaching hospital has changed a great deal since 1948, and many are now as much district hospitals as research centres. Moreover, both large and small hospitals play a part in the service. We should certainly try to record the changed function of the teaching hospitals, but their records will not give us the whole history of the National Health Service. Should we perhaps concentrate our efforts on the records of a single region, take as it were a regional sample? This again is attractive and has rather more merit, in my view, than the previous suggestion.

But how are we to define a typical region? Each, since 1948, has within limits been free to go its own way, and it is part of our business to try to record both this freedom and the way in which it has been used. In the interests of the historians of medical research, we might consider singling out hospitals of particular achievement - the Birmingham Accident Hospital comes to mind. It would be possible to compile a list of this kind - a shopping list in fact - but the pitfalls are innumerable; administrators move consultants change, records disappear. Moreover, this is a sectional approach which might well not meet the requirements of even 30 years hence.

It would, perhaps, be possible to look again at the types of record to be preserved and concentrate on getting most of these into safe custody, while letting the others go. For example, present day historians, particularly those in the sociological field, have more interest in, say, admission and discharge records than in Board Minutes. Such records often give prolific detail of the person concerned, details which can be manipulated in a variety of ways and in conjunction with other records. This is an attractive option, but it would have to be balanced against the possibility of taking in the very considerable statistical compilations now being made by the department of Health and Social Security, some in machine readable form. It would, moreover, make scant provision for those historians who are concerned with the history of the service as a whole or of the interplay of local interests with national policy. Finally, there is the difficulty presented to us by clinical records. We still, though I hope to be enlightened today, have little authoratative estimate of their potential value. By and large these survive beyond the periods laid down in the Circular because consultants say that they should. Should we be content with this haphazard arrangement, which may well tell us a great deal about the forceful character of the consultant as well as provide long runs of material within a speciality? This raises questions of the contribution of the specialist to his speciality, which require considerable professional knowledge to evaluate, and this knowledge is not always at our disposal. It might be better to press for statistically valid samples - if we can agree on what is statistically valid, no easy matter - right across the board. Whether or not, in the day to day pressures that bear upon them and to which they properly give priority, medical records officers could be expected to find the time or command the expertise for such an exercise is, it seems to me, very much in doubt. So too is another possibility, that of keeping considerable quantities of clinical records up to the date when all significant developments in a particular speciality are reported in the medical press. This would not be of much help to historians using statistical methods of inquiry over long periods, and it has the added disadvantage that in some branches of medicine, and psychiatric medicine is the most striking example, significant advances have not occurred until the second half of this century. The bulk to be preserved would, indeed, be formidable.

As you will have noted, I have offered no panaceas, nor have I touched upon the changing media - microform, machine-readable - in which hospital, and particularly clinical, records are now being held or created. This paper has tried to set out the background, and to provoke discussion upon the issues that have to be borne in mind in dealing with the immense problem of medical records. Whether it has been successful in its aim, I shall learn in the course of the day.

# MEDICAL ADMINISTRATORS AND THEIR RECORDS

E FREEMAN, BA ALA, LIBRARIAN, WELLCOME INSTITUTE

I have to begin this paper with a number of apologies. First, the title is more than usually obscure and unexplanatory. Secondly, although I have dared to call the operation a "survey" in the synopsis which you have before you, I must point out that I am a sociologist and I have no training in the making of surveys. The information I have was gathered through ordinary correspondence, with all the misunderstanding, vagueness and inexactitude that that implies. A properly constructed questionnaire, which I did not feel qualified to attempt, would perhaps have elicited standard and quantifiable replies. As it is, what I have to report must, at this stage, remain on the level of generalised impressions. On the other hand I have had a virtually 100 per cent response, which is considerably more than one could hope for from an impersonal questionnaire. There has also been the bonus of an amount of gratuitous information on a variety of interesting points. Finally, the project is still under way, so this is only an interim report.

The survey was begun because it was felt by a group within the Society for the Social History of Medicine, that it would be valuable to have some idea what NHS administrators were actually doing with their non-current records. Of course, we already know more or less, what they are supposed to do following the Public Record Acts, and in accordance with the various departmental directives which have been circulated. I, and those who encouraged the project, wanted to learn about the practical realities of record preservation as faced by busy administrators whose priorities are, quite properly, anything but historical. If what I have to say seems over simplified or obvious to the administrators and archivists here, I would point out that lack of experience in other professional fields is part of the problem of using records.

I directed my enquiries to the chief administrators of NHS units at four levels. Below the DHSS itself the principal units of NHS administration are the Regional Health Authorities. These have broad policy responsibilities and control considerable financial resources. I wrote to the fourteen Regional Authorities who control England, thus excluding for the time being Scotland and Wales. Below the Regions are the Area Health Authorities described by one source as "The key operational authorities in the English NHS. They have a statutory responsibility for the running of the health services at a local level". Seven Areas were approached, most of them from the Mersey Region. Health Districts (the third level) are the smallest units for which substantially the full range of general health and social services are provided, and which in consequence may be expected to generate a comprehensive range of records. I contacted fourteen Health Districts, mainly in Kent, Humberside and Devon. The hospitals I chose from the convenient group in the London area which are listed in the Medical Directory as "Special Teaching Hospitals". I felt that these were likely to be interesting on several counts. They are specialist hospitals, often with long and honourable histories, but likely to be less well-known from the historical and record point of view than the main London teaching hospitals. (As it happens, of course, one of them is the Bethlem Royal Hospital which has the distinction of being one of the very few hospitals employing a full-time professional archivist.)

The questions I addressed to all four levels of administration were broadly similar.

First, the Regional Medical Officers, Area and District Administrators, or Hospital Secretaries, as the case might be, were asked to pass my enquiry to the appropriate officer. In this way I hoped to get some idea of whom, in each particular administrative set-up, was at least considered by the person in charge to be responsible for record matters. It would, of course, be naive to assume that the signatory is necessarily and always responsible for the information in a reply, but in most cases I think I succeeded in getting through to the officer considered responsible for records by his seniors.

In the event I was mildly surprised that as many as four Regional Medical Officers replied over their own signature, although one of these had admittedly called in his statistician for advice. Replies at Regional level were generally from senior administrators with impressive polysyllabic titles such as :

Regional Statistics & Medical Records Officer
Divisional Head of Service Planning
Chief Management Scientist
Specialist in Community Medicine (Information & Research)
Headquarters Administrator
Regional Information Scientist
Medical Statistics Bureau

The Areas and Districts produced none of this rich bureaucratic nomenclature. In almost every case the reply came from the Administrator or his Deputy, although letter references sometimes revealed that some other official (unfortunately not specified) had framed the response. Letters addressed to hospital secretaries attracted replies from House Governors and their deputies, or Unit Administrators. The exception was the Royal Bethlem, which has, as I mentioned before, the rare distinction of owning a professional archivist.

It is easy to criticise and poke fun at bureaucrats with resounding titles, particularly perh when they man the higher reaches of the much-maligned NHS. In my dealings with them, so far at least, I have had generally prompt, courteous, intelligent and thoughtful replies. Contrary to my expectations I find senior NHS officials to be concerned about records beyond the necessities of formal duty and politeness. Most of them were quite frank about the gap between what they ought to be doing and what was possible in practice. They frequently betrayed simplistic ideas about what an historical record is, but there can be little doubt about the good will of most of them for the needs of the historian.

Regional Health Authorities and Area Health Authorities were asked the same two questions :-

1. Does your Region/Area have a policy for the selection, preservation and location of non-current N.H.S. and hospital records?

2. If there is no official regional/area policy, would you please supply the name and address of any individuals or units within your region/area taking a special interest in this problem.

Experience with replies to these questions tempted me to modify, and complicate, the same basic points when writing to the Health Districts, which were faced with four questions :-

1. In your District is a particular officer responsible for the selection for preservation of non-current records, administrative and medical?

2. Is your policy for the selection, preservation, and location of non-current records in any way influenced by strictly local factors?

3. What problems does your District face in preserving records of potential historical value?

4. Do you know of any individual or unit in your District taking a special interest in preserving such records?

Finally, the hospitals, the last group I approached, were let off with two questions :-

1. Does your hospital have an official policy regarding the review and selection for permanent preservation of its non-current medical and administrative records?

2. What do you find are the main obstacles, in your particular situation, to the systematic preservation of non-current records?

With the benefit of hindsight I think I would now simplify these questions and make them more uniform. Certainly that would have made the substance of the replies easier to summarise or even tabulate. As it is, I think it best if I present the results under the following headings - first, Policy; secondly, Problems and Local expedients.

## Policy

I think it not unfair to say that I detected a tendency for each administrative level to regard record preservation as the affair primarily of one or other of the subordinate units. Again and again the assumption of Regional, Area and even District officials was that the main focus of relevant records was the hospital. Indeed, so absorbing was this conviction for some of my correspondents that they confined their remarks to hospital records, in spite of what I had felt to be my explicit and plainly expressed interest in administrative and policy records at all records. I shall be returning to this point later.

Nearly everyone seemed to be aware of their statutory obligations, or - to put it more cautiously - I have no evidence as yet of serious ignorance of the legal requirements. Many correspondents referred explicitly to the Public Record Acts. Otherwise the most popular reference was the document HM(61)73 - "National Health Service: Preservation and destruction of Hospital Records", which contains among other things those two dubious appendices A and B which list respectively types of records which may not be destroyed , and those which may be destroyed after certain fairly short periods of time. There was also awareness of the more recent (March 1976) DHSS directive HN(76) 48 on "Preservation and disposal of National Health Service Records: Requirements of the Public Records Acts". There were also two references to the so-called Tunbridge Report, actually a report for the old Ministry of Health on "The standardisation of Hospital medical records", published in 1965, and which contains a section on preservation. You will note the emphasis of most of these official documents on hospital records.

Incidentally, when people actually referred to Appendix B documents (those which may be destroyed after varying intervals) it was usually to point out that they had locally adopted longer periods for retention than those required by the law.

"No set policy" ... within this region/area/district, was the commonest response after the usual, and perhaps ritual, obeisance to the requirements of the law. If a particular officer was responsible for records it was almost invariably medical records (usually defined as records relating to individual patients) which were singled out and cited as the responsibility of the senior medical record officer. Administrative and policy documents, unless old (and by "old" people seem to mean pre-NHS or even pre-second world war) came a long way down the scale of value for preservation.

Generally I found a distressing but understandable lack of awareness that there was any problem in defining a potentially valuable historical record. Some officials did have nagging doubts. As one of them put it - "there is a lot of room for dispute over what is of historical value". On occasion I was informed quite seriously that the particular unit possessed no records of value to the historian. We know what this means, of course. It means that there are no leather-bound volumes of committee minutes or doctors' case-notes in spidery handwriting, complete with long-esses and reference to Galenic simples. A few quotations will illustrate this, and I think you will understand if I leave most of them unattributed.

1. "Broadly speaking the position within this Area is that all the hospitals are of relatively recent origin... To sum up, the position is that ... we have no records of particular interest and therefore we have not felt it necessary to establish an Area policy".

2. "We would like to dispose of our non-current medical records but, although rarely required for clinical purposes, in many instances these records are in more or less constant use for research purposes, so that I see little hope of being able to dispose of the older records within the foreseeable future.

There are no obstacles to the systematic preservation of non-current records - the main obstacle is the wish of the medical staff to retain everything indefinitely."

I think it is clear that a major flaw in the current official records policy is that, so far as a large class of documents is concerned, it leaves the decision as to what is likely to be of historical value in the future to the administrators who generated the records in the first place. One cannot realistically expect busy officials with urgent work priorities in health and social security matters to be impressed by the idea that the papers they produce daily may still be of interest once they have ceased to be active documents. May I reinforce this point with a quotation, this time attributed. I am sure that Miss Allderidge, the archivist of the Royal Bethlem, will not object if I use her words as a text: "The main obstacle to establishing a proper system for the passage of material to the archives ... is the need to break down the barrier in people's minds between current records and archives ... although I am aware that my job should include the consideration of records problems at every level, the fact that I am called an archivist identifies me in other people's eyes as someone interested only in some ill-defined commodity known as 'history'. Had I been called a Records Officer, and the archives been called a Records Store at the outset I feel that certain problems would have been lessened ..."

Problems and local expedients

It may surprise you to learn that some units claimed they had no problems in preserving records and documents of potential historical value. I suspect that this may be interpreted to mean that the problems have not yet been perceived.

It is no surprise, on the other hand, to find that the major problems at all administrative levels involve the three categories of space, staff and money. Space to accommodate mounds of records which increase at a frightening rate staff to look after them & retrieve them when needed, and money to pay for both these elements.

Microfilming is a popular answer to the space problem. (No-one offered answers to the financial and staffing problems'.) Most microfilming programmes I have come across seem to be concentrated on strictly medical records. So far I know of only two units, both hospitals, which claim to film selected administrative records.

As a succinct, almost aphoristic, summary of the space problem I cannot resist quoting the remark of a District Administrator:-

"The main problem arising from the retention of records is the conflict between the fact that if kept long enough the most ephemeral of information becomes of interest and importance, against the need to keep to a minimum the expense of providing space for records which are no longer required for administrative or clinical purposes."

A few units possess what seem to be almost ideal arrangements such as active and enthusiastic Archives Committees, having close contacts with the local record office and the library authorities. Archive Committees are, however, invariably voluntary, and the danger is that their effectiveness is directly proportioned to the amount of individual enthusiasm and drive available at any particular time.

I have come across one Regional Health Authority which has exercised its right to call in a PRO advisory team to survey "the Regional Record Management systems, other than those for medical records, currently employed by the RHA and its constituent organisations". The immediate result was a short, clear report with eminently sensible recommendations. The final upshot bears quoting :-

"As a result of this report we did consider the introduction of a Regional policy and the possibility of appointing a Regional Records Officer as mentioned in the PRO report. However, we were anxious to keep down staff costs and no action has been taken..."

To offset that forlorn little tale I can report that one Regional Authority has founded a library - "which is to collect together material relevant to the planning and administration of the services...". The intention is clearly to build up a collection for historical reference, and the description I was given of the project included the interesting plea - "It would be most helpful if we could identify clearly the kind of material that is needed for long term retention." Purely departmental and statutory guidance is obviously not enough. Responsibility for this ambitious project rests with the Specialist in Community Medicine, the Regional Librarian, and the Health Care Planning Librarian.

It is the problems, inevitably, which are most impressive. I received the following very thoughtful summary of how it appears near the grassroots from a District Administrator in the Humberside Area, who confessed to being personally interested in historical matters.

"The District faces a number of problems in the task of preserving records.

(a) The upheaval of the reorganisation of the Health Service in 1974 resulted in many being lost, dispersed or disposed of. Many of the former local health authority records will be safe in the archives of the (local) District Council, while a few were salvaged by myself, and others will be in the Public Library. These will be entirely administrative documents such as the annual reports of the Medical Officer of Health. Similarly, some records relating to this District may well be located (note the hesitation!) at the Area Health Authority headquarters. The problem is that we do not have anyone charged with the duty of preserving material of historical value, and conditions since April, 1974, have been such that no person could be spared to undertake the task of identifying what should be preserved.....

(b) There are serious problems of accommodation. The preservation of patients' records ties up a large amount of accommodation at a time when this is in demand for patient and administrative services; this demand arises from lack of finance to provide new accommodation. The microfilming of records has not yet made any noticeable impact, partly because the finance is not available to undertake the work on anything other than an experimental scale, and partly because medical staff are not yet committed to such a method of preserving records.

(c) The size of the Health District, with a large number of units involved, is such that preservation tends to rely on the personal interest of individuals, particularly those who have been within a unit for many years. The 1974 upheaval resulted in the retirement or movement of many of the staff with deep-rooted interests in one place, and their replacements, even if they intend to stay for some time, have not yet acquired the "historical" interest either in documents or material things such as equipment."

One may detect a certain element of battle-fatigue in that long quotation, but I think it summarizes admirably the kinds of problem, some particular, but most of them general, which I have come across.

I have stressed that I can present only generalised, interim observations, not firm conclusions based on quantified evidence. If I have to make one firm conclusion it must be that, from my experience, what our busy NHS administrators need to look after their records properly are facilities and money and in particular skilled advice from historians. They have quite enough statutory regulation and departmental exhortation.

Unless convinced by today's proceedings that it is a waste of time I shall continue with the survey. I would appreciate advice on which questions to ask, and how to frame them. Meanwhile the file of correspondence will be kept at the Wellcome Institute in as up to date condition as possible, and I shall be ready to answer questions on any areas or units about which I have information.

# THE LOCAL AUTHORITIES AND THE HEALTH COMMUNITIES

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There are two ways of looking at the history of local authorities in relation to the health of local communities. First, until 1974 the elected local authorities of the counties and county boroughs had direct responsibility for certain medical and nursing services. Before then and since locally elected councils undertook a wide range of sanitary services, or as these are now called, environmental health. Before 1st April 1974 this work was under the oversight of medical officers of health. There is a second view point which is probably more important and which will be described briefly.

Social historians are very conscious that a very wide range of factors influence the health and well-being of individuals and communities. Much of the work of local authorities can be seen to contribute to the health of the local population. Thus education, and here is meant general and not just 'health education', may through the teaching of domestic science indirectly improve nutrition, school gymnastics and sports may influence fitness, and general enlightenment may make individuals more aware of the requirements of a health life. The local authorities' civil engineers by better road lay-out may directly reduce the number of traffic accidents. The argument could be pursued through illustrations from other activities. The social historian interested in the health of communities must take this wider view. However, the example of the services which were the responsibility of the medical officer of health will serve to illuminate the problems of the whole.

No single 'job description' would cover the work of the medical officers of health throughout their history; and no single 'job description' would cover the work of all the medical officers of health at any one time. As the office developed, particularly in this centrury, the range of duties became too wide for one person to fully understand or direct. It is, therefore, necessary to examine the work undertaken by the senior public health doctors, for child health, mental health, environmental services, etc., who worked with the medical officer of health. There were also senior professional people who were not doctors: the public health inspectors, nursing officers, and (before the unification of local authority social work services) the mental health social workers, etc. Some of these were more distinguished than the MOH himself. The influence of the medical officer of health and his staff extended to other departments of the local authority; for example on housing policy to the planning and housing departments, or on child health, to the education and children's departments.

The creation of public policy related to health was complex. A naive theory was (and still is) that the action of the local authorities flowed from statute law and the fiat of a government department. In practice, new initiatives by civil servants, while not rare, are uncommon; creativity is usually found outside Whitehall, and outside the Metropolis. There are several distinct stages: first, the early discussion and experiment, often by individuals; second, experimental application by one or two local authorities; third, investigation, sometimes by government committees or working parties; fourth, official national policy created by Act of Parliament, or

departmental circular, or the allocation of finance, or all three. At stage three local authorities were consulted by central departments through the local authority associations, such as the former County Council Association. The medical officers of health and their staff influenced this process, often by initiating experiments; by promoting discussion in professional societies such as the Society of Medical Officers of Health (now the Society of Community Medicine); or in the conferences and meetings attended by both elected members and professional officers such as those of the Royal Society of Health and the Royal Institute of Public Health & Hygiene; or were themselves members of governmental working parties and committees. The extent of the power of local authorities is limited by statute law. One method of initiating new services was by the promotion of Private Bills in Parliament by the local authorities.

The preceding paragraphs have not differentiated between the different kinds of local authorities. Before the recent re-organisation there were three kinds outside London. The county boroughs were 'all purpose' authorities, responsible for both the personal health services and sanitary (environmental) services. In counties, the services were divided, the county council was responsible for the personal health services and the county districts (municipal boroughs, the urban and rural districts) were the sanitary authorities. In some counties, the day-to-day responsibility of the county medical officer was delegated to the MOH for a group of county districts who was usually designated a 'divisional' medical officer for the county. In the 1930s and 1940s many MOHs of county districts were part-time. Thus Williams Pickles' classical study of epidemiology was published as Medical Officer of Health for Aysgarth Rural District.(1)

The pattern of delegation of powers from the council of a local authority to its committees differed widely, some conducting all major work in full council, others delegating much more to the committees.

The range of sources related to local authority work in relation to health services may be illustrated by this outline list:

1) Parliamentary Records(2)

   Particularly parliamentary questions and adjournment debates. Also private bills promoted by local authorities.

2) Governmental Publications and Public Records

3) National Bodies

   eg. Society of Medical Officers of Health

4) Journals

   eg. British Medical Journal, Lancet, The Medical Officer and Public Health

5) Newspapers both national and local

6) Local Government

i) Minutes and reports of local councils and committees
ii) Annual Reports, particularly Treasurers and Medical Officers of Health
iii) Departmental records:
Principally Health Department, but also Clerk's Department, Treasurer, Architect, Surveyor or Engineer, Housing, Children's Welfare, and Education.

7) Personal files of senior officers which may contain:

(a) Own published papers
(b) Offprints and cuttings which influenced them
(c) Papers relating to participation in Governmental working parties, national bodies and significant personal correspondence with colleagues.

While important documents of almost all kinds may be lost, certain of these records are particularly vulnerable: these are (6)iii and (7) above. The printed records of the major authorities are almost invariably available, such as the minutes of the council and its committees. These usually convey what was done, but do not often say why such action was taken at that time and place. The departmental and personal files are needed to arrive at an account of how policy was formulated and implemented.

In relatively recent times there have been three periods during which the loss of records has been heavy:

A. The second world war:
Some by 'enemy action' but most by the clearing of basements to create air-raid shelters and in response to the drives for saving 'waste paper'.

B. The implementation of the National Health Act, 1946, in July, 1948.

C. The re-organisation of the Health and Local Government Services in 1974.

The records of the local authorities relating to health are particularly vulnerable at the present time. The disappearance of many small authorities and the complex pattern of the way in which they were divided in the creation of large units has meant that the records of many county districts have been destroyed without thought. The public health service was unfashionable for a very long period before 1974, and some officers of the new health authorities assume that the old records are worthless, or of much less interest than those relating to hospitals.

It is my view that the work of the local health authorities, of the medical officers of health and their staffs between 1948 and 1974 compares well with any other period of their history. If one examines the control of infectious disease, or the development of functional cooperation between the three arms of

the NHS under the 1946 Act, or the intellectual contribution to social medicine, the public health medical officers of that period compare well both with their predecessors and with their contemporaries in the hospital service and the universities. Some of this distinction is shown in what is wrongly regarded as the prerogative of the 19th Century environmentalists, as for example, the progress made in counties under the Rural Water Supplies and Sewerage Acts, 1944-1963. It is the undervalued records of this period which are at present most vulnerable and which require urgent action for their preservation.

References

1) William M Pickles (1939)
Epidemiology in a Country Practice
Re-issue 1949. Bristol: John Wright

2) See: Maurice F Bond (1971)
Guide to the Records of Parliament
London: HMSO

## THE RECORDS OF THE INDEPENDENT CONTRACTORS

Huw W S Francis

Little attention has been given to the records of the 'independent contractors'. These are the general medical practitioners, the general dental practitioners, the pharmacists and the ophthalmic practitioners. All of these contract to give services to the patients of the National Health Service; they are not salaried employees of the NHS and their remuneration depends on the number of patients on their lists (for the family doctors), or the number of NHS prescriptions they dispense (the chemists and the opticians). The records are of four kinds:

Clinical records of patients
Business records of practices or shops
Administrative records of the NHS bodies concerned with this aspect of patient care
Association records of the national associations set up to co-ordinate activities and to represent the local committees nationally

The 'contractors' are, since the re-organisation of 1974 the responsibility of the Family Practitioner Committees, of which (outside London) there is one for each Area Health Authority. The FPCs are the descendants of the Insurance Committees created by the National Health Insurance Act, 1911. The local insurance committees met first in the middle of 1912. For example, the West Riding of Yorkshire Insurance Committee first met on 11th July 1911 in the County Hall, Wakefield. The National (Health) Insurance Commission had asked the local authorities to give the local insurance committees help in the initial stages of establishing themselves. The Deputy Clerk to the County Council acted as the secretary of the West Riding Committee in the early stages.

There is, therefore, a very interesting field for the social historian in these archives. There are accounts of the problems faced by each profession locally, there are the formal and informal relations with local government, the hospitals, and with the preventive services under the Medical Officers of Health. The existence of these records is not known to many, and similar problems of preservation arise as have been described for the other parts of the health services.

Acknowledgement: Mr D Cammidge, Administrator, Wakefield Family Practitioner Committee, and formerly Clerk, West Riding Local Executive Committee, for access to the early West Riding records

# LOCATING & PRESERVING OXFORDSHIRE HOSPITAL RECORDS

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## Origin and background to the project

A rather loosely-defined local interest in the history and surviving records of individual Oxfordshire hospitals had ante-dated the present project. I myself was first approached in 1969, to locate and list the records of the Radcliffe Infirmary, both at large within the hospital and deposited at the Bodleian Library, as part of the Radcliffe's Bicentenary celebrations. In the course of this operation, I became aware of the untapped potential of these records and the need for someone to take over the responsibility for their care and conservation, for already there were alarming gaps and losses in the series.

The personal interest of my husband and myself in psychiatric records brought about an extension of my part-time, sessional activities to take in first the Warneford Hospital archives and then those of Littlemore, the former Oxfordshire County Asylum. At that time, the records of the Warneford were scattered throughout the hospital, in cellars, safes, in the Medical Records Office and in various cupboards. Until 1976, I had no office accommodation at the Warneford and then, in the pressure to produce an Archives Exhibition and a short history of the hospital, as part of its Sesquicentenary celebrations in July 1976, a small room was provided for my use. The Exhibition was successful in providing the necessary publicity to back my personal concern about the medical archives at large in other hospitals, which were especially vulnerable during the administrative changes of the re-organisation of the Health Service. A case of need for a "rescue" project was presented to the Area Health Authority (T) backed by Professor Gelder, Professor of Psychiatry at the Warneford, and the scope and costing of this present project was worked out and accepted.

The existence of collections of archival material in various Oxfordshire hospitals was already known to me, but I was anxious to discover the precise amount and their state of preservation. To facilitate the work, an office, adjoining the Medical Library at the Warneford, which was adequate for handling and sorting collections of archives, was made available to me last December. This has now been fitted out with steel shelving and serves the dual purpose of housing the whole of the Warneford archives, reunited from their various places of custody.

## The scope and funding of the project

The aim of the project was to trace, list and take the necessary basic steps to preserve any archival material of pre-1948 origin in hospitals and units throughout the Oxfordshire Area Health Authority (T). In all, some 30 hospitals were comprised in the survey, serving both rural and urban communities and covering a maximum radius of 30 miles from Oxford itself. The actual work was carried out on the basis of a series of four-hour sessions, for which the archivist is paid £8 per session. Travelling expenses and subsistence costs when visiting hospitals some distance from Oxford are paid as to all N.H.S. staff. A total of 120 sessions was granted, to be completed within the academic year 1976-77. The cost was to be met entirely from interest from Trust Funds and made no claim upon routine Exchequer grants. Following reorganisation, Oxfordshire A.H.A. is administered in 6 sectors. The distribution of the archivist's session was outlined as 40 Psychiatric sector, 40 Radcliffe sector and the remaining 40 sessions were to be split between the other 4 sectors, which were likely to produce a far smaller volume of archives.

The whole project is co-ordinated from my office at the Warneford Hospital, where secretarial help has been available for Psychiatric sector material and for correspondence and general administration. It was agreed that other typing, e.g. of catalogues, should be undertaken by secretarial staff in the hospitals or sectors which produced the archives, wherever this was possible.

The hospitals surveyed displayed wide variety in age and type, ranging from the oldest, the Radcliffe Infirmary (established in 1770), to geriatric units opened in the 1940's. The whole group provided a range of medical, surgical, orthopaedic, psychiatric, mental handicap, geriatric, rehabilitative and cottage hospital services. They occupied buildings ranging from purpose-built hospitals, e.g. Radcliffe Infirmary, the Warneford and Littlemore; former workhouses, e.g. Cotshill Chipping Norton, St. Mary's Wallingford, Neithrop Hospital Banbury and Cowley Road Oxford; cottage hospitals raised and supported initially by public subscription, e.g. Burford, Didcot and Chipping Norton War Memorial Hospital and finally, private houses converted in the present century for hospital purposes, e.g. Longworth, Warren Hospital Abingdon and the Park Hospital for Children, at Oxford. Not suprisingly, therefore in view of their previous functions and long history some of these hospitals had retained on the premises archival material relating to defunct bodies, e.g. Local Highway Boards, Rural Sanitary Authorities and Poor Law Unions, in addition to their specifically medical material.

Method of implementing the survey

The project has been essentially a personal contact exercise. inquiries produced few speedy or useful replies; a telephone conversation explaining the purpose of the search was more useful, but not to be compared with an actual visit, which could also take in any interesting architectural features of the hospital building, as well as its remaining records.

The starting point was a discussion of the general situation with the Area General Administrator of O.A.H.A.(T)., whose interest and support has been greatly appreciated throughout the project. Contact was then made with each of the individual Sector Managers, who, in turn briefed me about whom to contact initially at each of the hospitals under their control.

Once at the hospital, inquiries usually began in the most obvious places, e.g.the Hospital Secretary's office, the Medical Records Office and the library (if any) and then proceeded to less likely explorations, some of which proved fruitful. If no space was available for sorting and listing the records, or if a longer period of work was required, the archives was transferred to my office at the Warneford and returned to the hospital on completion of listing and cleaning. Destruction of some ephemeral modern material was undertaken because of fire-risk in two cases.

The deeds of all the A.H.A. hospitals are held centrally at the Manor House, Headington, on the site of the new John Radcliffe Hospital, and considerable supplementary information has been extracted from this source for almost all the hospitals surveyed.

The method employed in recording the material discovered took two forms. A catalogue with a brief historical introduction is compiled for hospitals with a significant quantity of records extent, whilst an alphabetical card-index serves for the smaller, less-productive hospitals, showing the surviving material (if any) and also giving any available historical information about the institution.

## The extent and condition of the records

The whole range of archival material, legal, clinical and administrative, was interpreted as coming within the scope of this project, i.e. deeds, plans, documents, papers, bound volumes, printed reports, newspapers, photographs, modern Hospital Management Committee Minutes, etc. Objects of interest found within the hospitals were also examined, ranging from old items of equipment, e.g. restraint apparatus, old surgical appliances, paintings, statues and printer's blocks. By letting it be known that a safe home would be provided for all "finds", a number of interesting objects have been brought in, ranging from inscriptions, keys, Grecian statuettes to a Victorian bed-pan.

Fires, floods, damp storage conditions, ignorance and lack of appreciation of the value of the records to posterity were the main agencies to which loss or damage to archives could be attributed. Some members of staff regretted the lack of publicity which the archives work had had and were genuinely unaware, in some of the peripheral hospitals, that they could have called upon the archivist's services when faced with a storage problem. There were only a couple of instances of deliberate destruction of records, in one case apparently related to the stigma of the previous functioning of the hospital as a workhouse, but in almost all hospitals the insidious process of loss and disappearance of individual items could be observed to have taken place over the past few years. On the credit side, it was heartening to come across groups of documents which had survived miraculously intact in the most unlikely places as, for example, the complete series of 13 volumes of Minute Books 1828-1948, two early Visitors' Books, and a bundle of original letters 1828-32 which were retrieved in perfect condition from a cavity under the floor of the present Hospital Secretary's Office at the Warneford. These valuable items could just as easily have gone up in flames in the event of a fire in the vicinity, for the rest of the cavity was filled to capacity with modern papers, files and prescription forms. On the debit side, many of the records were recovered in a fragile or damaged condition, affected by tears, damp, moulds, rodent and pigeon droppings and insects.

In cases where no records whatever had survived for a particular hospital, an attempt was made to collect together some background information on the spot, including the recollections of staff and patients and with particular reference to building extensions and changes of function of that hospital over its lifespan.

## Remedial work

Initially, the archives were dusted, cleaned and, in the case of leather-bound volumes, treated with a leather dressing containing a fungicide. Individual items were protected in manilla envelopes and boxed, when appropriate, in purpose made record cases. Fumigation and drying out of some of the worst items is to be made possible by kindness of the Oxfordshire County Archivist. Staff of the repairs department at the Bodleian have expressed willingness to repair some of the most endangered documents if money can be found for this purpose. A policy is being followed of photocopying some of the rarer and more fragile items discovered, with a view to depositing some of these copies at the Oxfordshire County Record Office. Some photography of the older hospitals (some currently threatened with closure and demolition) and of any unique features, e.g. a seclusion cell at one of the former workhouses, is to be carried out as economically as possible by a member of the Littlemore Hospital staff.

The initial object of this whole exercise has, in the present economic climate, to be basic and unambitious, namely, assuming responsibility for the safe custody of the located archives, listing and cleaning them and overlooking their arrangement in a locked, damp-free room or cupboard, usually in their hospital of origin.

Other classes of record encountered

Items other than straight hospital records were discovered in the course of the survey, including Highway Board Ledgers, Rural Sanitary Authority and early Rural District Council Account Books and a range of Poor Law records relating to the Chipping Norton, Banbury and Wallingford Unions and going back as far as 1835.

The policy which I followed was to transfer these groups of records to the Oxfordshire County Record Office as being the appropriate authority to administer them. In many cases, the records transferred actually fitted into collections already in Record Office custody. It is pleasing to be able to report that use has already been made of some of the transferred Poor Law items by interested researchers.

Items of hospital origin relating to hospitals which have ceased to be administered by Oxfordshire following reorganisation are to be transferred to the appropriate County Record Office, where they will be of local interest. For example, the original lease of Bourton-on-the-Water Cottage Hospital, the third such hospital to be established in England, in 1861, and a series of its annual reports 1861-1947, were found in the North Oxfordshire Sector Headquarters at Banbury, and will be transferred to Gloucestershire County Record Office.

In some hospitals, collections of modern records were sorted and some ephemera, e.g., duplicate stores order books, invoices and bank-book stubs, were weeded out for destruction in accordance with the N.H.S. Circular H.M. (61) 73, and the remaining more manageable, quantity left aside for re-consideration at a later date. A batch of 45 case files and some x-ray plates which had been retained incorrectly in one hospital which had acted as an Emergency Medical Services Hospital during World War 11, was forwarded to the D.H.S.S. Archives Registry at Nelson, Lancashire, as they might be relevant to claims for disability pensions. In the case of one hospital in Northamptonshire, administered extra-territorially by Oxfordshire A.H.A., copies of the listed archives and a xerox of the original Hospital Byelaws were provided for the Northamptonshire Record Office.

General conclusion

1. That the project has been a worthwhile exercise goes without saying. Considerable local interest in the surviving records and in the past history of individual hospitals seems to have been aroused by the visits and a great deal of goodwill was encountered, almost without exception. It was certainly true, in a couple of cases, that acting as an internal member of the A.H.A. staff gave me access to material where previous attempts by external archive-holding authorities had been unsuccessful.

2. The project certainly could not be completed within the stipulated time but for the extensive work already carried out on the three largest and most time-consuming archival collections, the Radcliffe Infirmary, Littlemore and Warneford Hospitals. To some extent, therefore, the costing of the project is misleading, since it does not take into account the cost of these pre-1976 sessions.

3. The richest archival collections were found, as might be expected, in the oldest hospitals; the most complete series being the documents and deeds of the Warneford 1567-1974; followed by those of the Radcliffe Infirmary, 1764-1972; the Horton General Hospital, Banbury, 1869-1974 and of Littlemore Hospital, 1845-1964. Three of the Cottage Hospitals produced significant collections of Minute Books, Patients' Registers, Annual Reports, deeds and miscellaneous papers, from the end of the nineteenth century onwards. The quantity of documents per hospital ranged from nil to several thousand.

4. So far, about 330 volumes, from 1835 on, of non-hospital material relating to defunct bodies and retained in various Oxfordshire hospitals were discovered and transferred to the County Record Office.

5. The main difficulties have been financial - the need to manage on the most modest outlay possible - and the necessity of operating efficiently and speedily within the sessions available. The whole question of financing essential repairs is a matter of grave concern to me, since I know of many items whose condition is so precarious that they will not survive if not treated appropriately forthwith.

6. Providing short-term storage is not usually an unsurmountable problem once a hospital realises the value and interest of the records which it holds. The long term policy with regard to hospital archives is more problematic. Many hospitals rightly feel possessive about their archives and would prefer to keep them on the premises and this raises the question of what is the minimum acceptable standard of care to be provided inexpensively. Some hospitals feel that by depositing their archives at outside repositories they are depriving members of their staff from easy access for interest and for study. Perhaps one solution would be to have a central repository for the total hospital archives of each A.H.A., but here again the problem of financing and staffing the venture would have to be faced. At the moment, the policy pursued in Oxfordshire is essentially a flexible one involving liaison with both the County Record Office and the Bodleian Library. Records, at the moment, are retained in their hospital of origin if they are wanted there and efforts are made to provide adequate and careful accommodation. Non-hospital records are to be transferred to their most suitable place of preservation, usually the appropriate County Record Offices. Opportunities to deposit bulky collections of clinical material, rarely referred to but requiring preservation, at the County Record Offices' depository has been a welcome development, e.g., The Medical Records Officer at the Radcliffe Infirmary recently solved an acute storage problem at the Eye Hospital by transferring 1500 volumes of case notes, 1884-1946, to the Oxfordshire County Record Office's depository at Witney, by courtesy of the County Archivist.

7. A secondary aim of the project has been to make the archives more easily available to students and researchers, and with this in view, the Warneford and Littlemore archives have been fully indexed. It is hoped to extend this to include the other larger archival collections if sessions will allow. By the end of the project, copies of all the listed archives will be available for reference purposes in the hospitals of origin, in the appropriate sector manager's department, in the Bodleian, the Oxfordshire Record Office and the Oxford Central Library and also at the National Register of Archives in London.

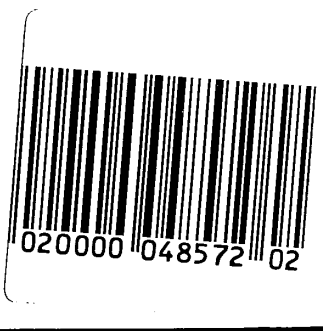
8. It will not be possible to produce any positive figures about the survival and destruction of hospital archives in the Oxfordshire area until the completion of this final term's field work, as a number of hospitals have still to be investigated.

9. It would undoubtedly be beneficial to extend this project to include hospitals further afield e.g. administered by the Oxford Regional Health Authority, if this could be financed. Even when the increased travelling time involved is taken into account, it would still be a viable proposition.

10. I would welcome the news that similar "rescue" projects could be put into operation by other A.H.A.'s, as I am convinced that there is still material at risk all over the country, which needs urgently to be listed and placed under specific care and custody. Sadly, intervention has already come too late in the case of some of the Oxfordshire hospitals, e.g. Cowley Road, the former Oxford City Workhouse, produced no archival material whatever and it seems likely that the whole of the post-1770 Poor Law material for the City was consigned to the flames there in 1948.

Conclusion

Record preservation is always something of a fringe, "Cinderella" service and this balance is justifiable in the case of a patient-orientated Health Authority at the present time, but, I hope , despite all the economic pressures that the care of irreplaceable hospital records can be safeguarded. Perhaps the combined interest, resources and experience of all of us present today can apply the necessary pressure to promote care at a national level of such material as remains at large and, therefore, at risk.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