

# Building up our Health:

*the architecture of Scotland's  
historic hospitals*



FRONT COVER

**Elevation of Oldmill Poorhouse, Aberdeen, Brown & Watt, 1907.**

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### **Acknowledgments**

The text for this book was prepared by Harriet Richardson, with contribution from Ranald MacInnes.

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# Foreword

**For many of us, a visit to a local hospital will happen at one stage or another, whether it be a maternity ward, a cottage hospital or a city infirmary. This perhaps explains in part the popularity of medical dramas on television, but also the regular discussion of our health service provision in the media. Our hospitals are prominently sited and designed with pride to cater for changing needs, many are an important part of the character of our towns and villages, even where the buildings have found new uses as part of wider changes to our health infrastructure.**



In 1989 Historic Buildings and Monuments (now Historic Scotland), aware of new pressure on the hospital estate resulting from the creation of hospital trusts, worked with the Scottish Civic Trust to provide a nationwide overview of hospital buildings. In this we were aided by funding from the Scottish Research Council. This provided an instructive report on the history, diversity and extent of the building type, which in turn has been a key resource for those working on the future management of these hospitals

which may have been listed for their special architectural or historic interest. We believe this resource is worthy of broader publication and celebration.

*Building up our Health* celebrates this rich legacy, explaining the evolution of the different types of hospitals and giving examples of the best. Evolving to suit medical advances and new philosophies of healthcare, hospital architecture is developing all the time and many former hospitals now continue to benefit their communities in other

ways, from offices (such as Historic Scotland's own HQ at Longmore House in Edinburgh) to residential (as the Marcus Humphrey House, at Quarrier's Village, Bridge of Weir).

We hope you enjoy this book – a fascinating story of the development and evolution of one of Scotland's key building types.

**Malcolm Cooper**

Chief Inspector

Historic Scotland's Inspectorate

*Design for District Asylum Inverness.*

*B.*



*South Elevation of Main Building*

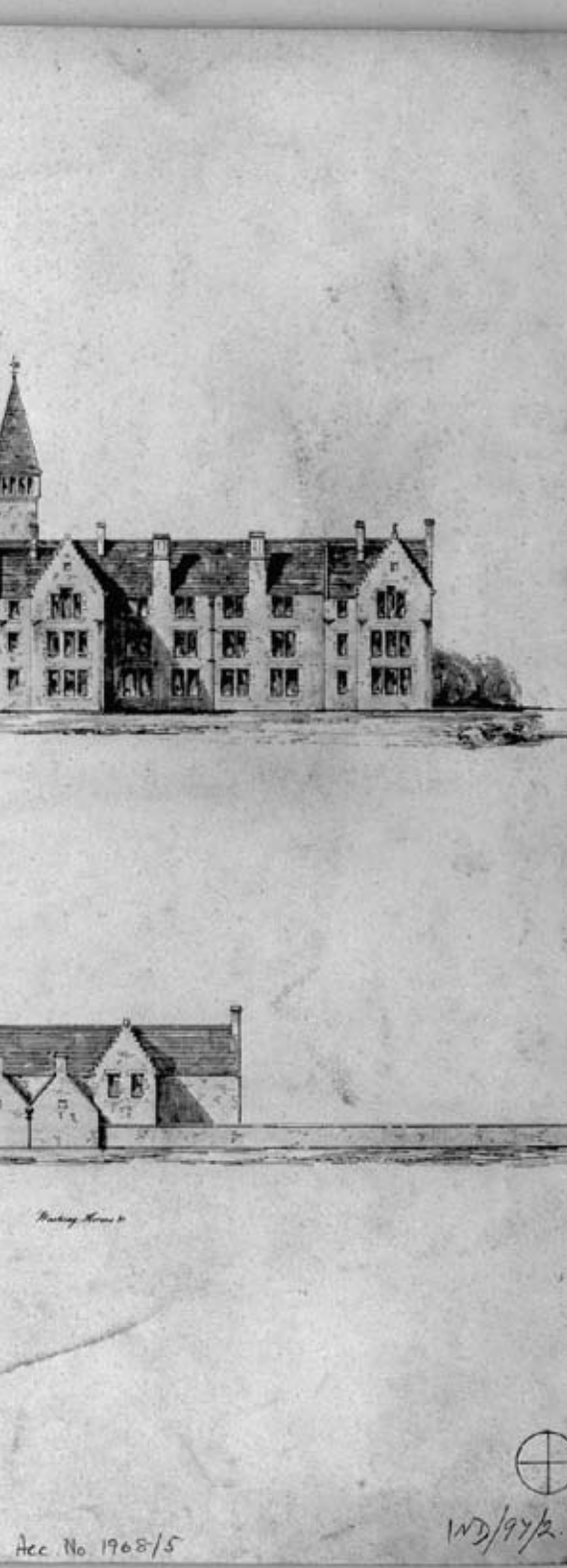


*Kitchen*



*Lecture Building*



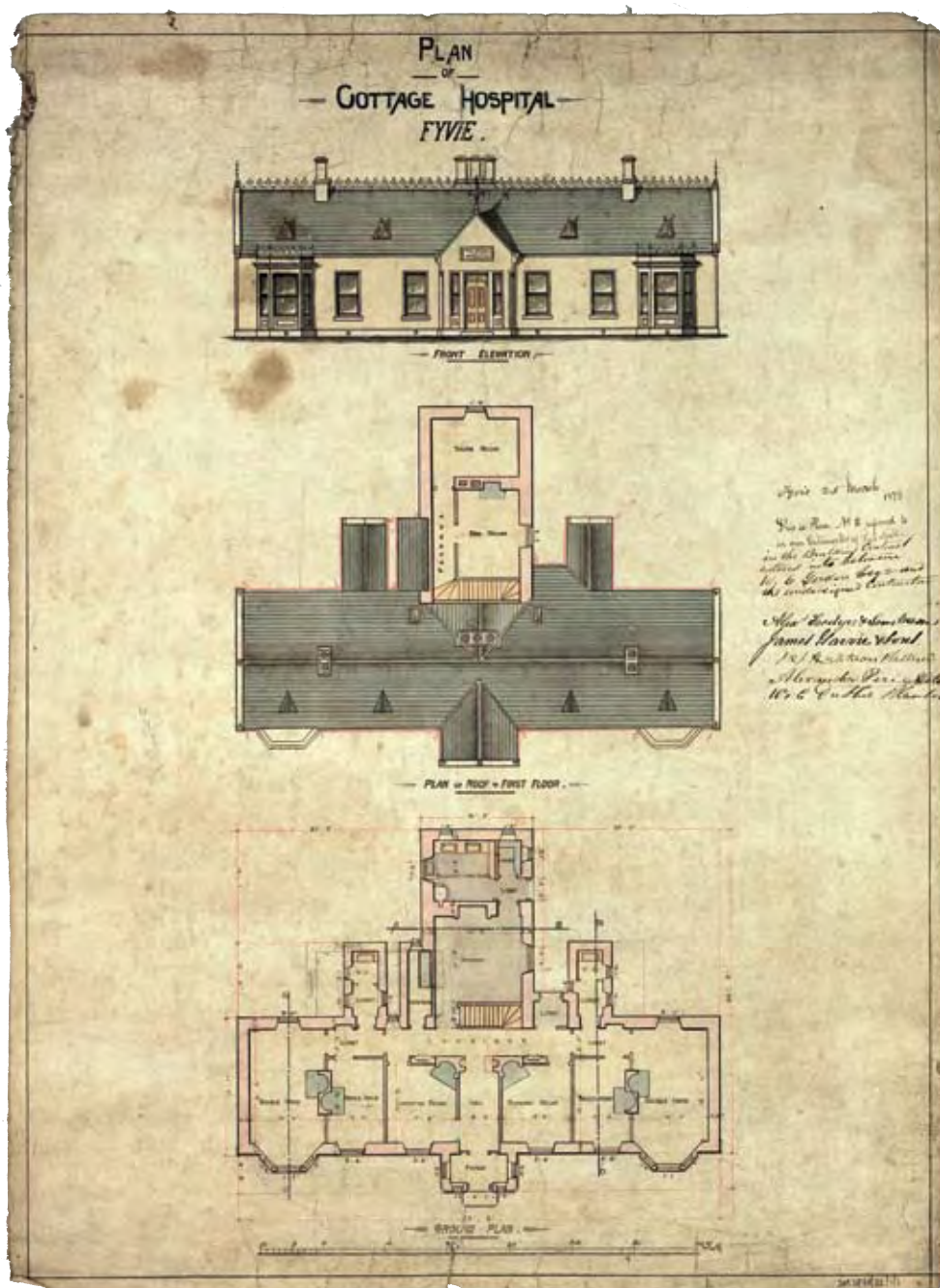


# Introduction

This book aims to give a taste of the rich architectural heritage of Scotland's hospitals. The hospital is a distinctive building type, and one with which we are all intimately familiar. When we think of a hospital, most of us would probably imagine one of the great Victorian general hospitals, such as the former Edinburgh Royal Infirmary, with its old-fashioned Nightingale wards. These long wards, where the patients' beds were placed opposite each other, have lost their appeal to modern planners and designers, though are often remembered fondly by both patients and nurses. From the latter's point of view they were easy to supervise, and from the former's, one never felt forgotten or out of sight.

Elevation drawing of Craig Dunain Hospital,  
Inverness, James Matthews, 1864.

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Plan of Fyvie Cottage Hospital, Duncan and Munro, 1879.

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**Corstorphine Convalescent Hospital,  
Edinburgh, 1867, photo 1912.**

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Hospitals come in many different guises and sizes. Since the first ‘modern’ medical institutions appeared in the 18th century there have been hospitals with as few as three beds, to vast complexes housing many hundreds. Apart from general hospitals there were cottage hospitals, asylums for the mentally ill, poorhouses (most of which cared for the sick as well as the poor), isolation hospitals for people suffering from infectious diseases, and a raft of specialist hospitals which catered for different illnesses, groups within the community or parts of the body. Each of these produced a slightly different architectural response,

and they are considered in separate chapters.

These pages are to present only a brief overview of a broad spectrum of these buildings, an outline of their evolution, providing a good sense of their architectural merit.

Scotland has a particularly rich medical heritage with a long and distinguished history of academic excellence. The Royal College of Surgeons in Edinburgh has, indeed, some claim to being the oldest medical incorporation in the world, dating back to 1505, while in the 18th century Scottish universities established themselves as important centres for the study and practice of

medicine. Alongside famous Scottish medics such as Archibald Pitcairne, James Syme, Sir James Young Simpson and Sir Alexander Fleming, students came from far and wide to study here. These included Joseph Lister, who came to Edinburgh in the 1850s, later to become Professor of Surgery there.

But sometimes progress had a darker side, and undoubtedly the most infamous pair associated with Edinburgh’s medical past was Burke and Hare. For a brief period they sold fresh corpses to Professor Robert Knox for dissection. Unlike the ‘resurrectionists’ who traded in bodies stolen from burial grounds, before they were caught Burke and Hare



**Glasgow Royal Infirmary in Cathedral Square, Glasgow, photo circa 1910.**

*© Reproduced courtesy of Glasgow City Archives and Special Collections*

murdered their hapless victims, whom they lured to their lodging house in Tanner's Close.

Less well known perhaps, and long overdue for celebration, is the architectural heritage of Scottish medicine, and in particular, the many hundreds of hospitals that have been

built in which to treat the sick. The first truly medical institutions appeared almost three hundred years ago, in the early 18th century. Before that time medical care was mostly conducted within the home, and 'hospitals' were more commonly understood to be places of refuge for the poor, or

schools such as Donaldson's Hospital. Before the Reformation, monasteries often included a small infirmary, though this would usually have been reserved for members of the order. Treatment of the sick outside the monastic community is hard to document, but certainly did occur and is associated with particular monastic orders – notably the Augustinians.

More common were leper hospitals which began to appear from about the 12th century, a mark of how readily identifiable the disease was. They were usually separate communities, on the edge of a larger settlement. In Scotland 178 medieval hospitals have been identified, but the majority of these had no medical function, serving as poorhouses, almshouses or hospices for pilgrims and travellers.

Few of these survived into the late 16th century. In England, Henry VIII's dissolution of the monasteries during the 1530s and 1540s wiped out nearly all the hospitals; only a very few survived or were re-

founded subsequently. In London these included St Thomas's and St Bartholomew's, general teaching hospitals, and St Mary of Bethlehem for the mentally ill – or Bedlam as it was known. Epidemics of infectious diseases or plague, from the Black Death in 1348 to the Great Plague in 1665–6, led to pest houses being provided. These were temporary places where the infectious could be isolated from the healthy, and would be abandoned once an epidemic subsided.

By the early 18th century the study of medical science was gaining momentum, but outside London there were no hospitals in Britain where patients could be observed in great numbers. This was also the dawning of the Enlightenment, when humanism engendered a desire to improve the human lot. The time, therefore, was ripe for establishing hospitals for the sick poor, especially in towns or cities where medicine was being studied. It is significant that the first general hospital to be founded outside

London was in Edinburgh, where the Royal Infirmary began humbly enough in a rented house in 1729. It was not until 1736 that a general hospital opened in the provinces in England, at Winchester, also in a converted house.

These marked the beginnings of the voluntary hospital movement, meaning charitable institutions that were funded by voluntary subscription. Subscribers were granted privileges dependent upon the amount of their donation. The most generous would be entitled to a place on the governing board, but all would be able to recommend candidates for admission. Most patients were very poor – anyone with enough money would have procured medical attendance within their own home. Even operations were conducted on kitchen tables.

Hospitals were founded by physicians but also by a variety of philanthropic individuals, wealthy merchants and through the efforts of guilds, institutions and public

bodies. Truly municipal hospitals came later, in the wake of legislation concerning public health, poverty and mental illness. Public health acts were instrumental in establishing a network of isolation hospitals, while the new Poor Law set up ‘workhouses’ in England, Wales and Ireland and ‘poorhouses’ in Scotland, where the destitute sick were given medical care. A series of Lunacy Acts established county asylums for paupers suffering from a range of conditions which were then certifiable as ‘lunacy’.

In the second half of the 19th century hospital design began to change, responding to new understanding about the way in which infections spread and a belief in the beneficial effects of sunshine, fresh air and cleanliness. The architectural press promoted the new pavilion-plan hospital with its cross-ventilated wards, and separation of different patients, whether surgical from medical in a general hospital or measles from diphtheria in an isolation hospital. By the end of the century an ever greater complexity of ancillary buildings was

needed – a boiler house to provide heating and hot water, kitchen, laundry, operating theatres, X-ray room, outpatient departments, offices, committee room, chapel, mortuary, and a nurses’ home. Asylums were designed as self-sufficient communities with their own farm for produce and occupation for the patients, recreation halls, garden grounds and staff houses – the medical superintendent’s house was often a substantial detached villa.

In the 20th century hospitals became less the sole preserve of the very poor, encouraged by developments that made operations safer and more successful, such as antisepsis and anaesthetics. The state began to intervene more formally, providing sanatoria for people suffering from tuberculosis and introducing maternity and child welfare schemes. There were also widespread calls for reform of the Poor Law. Some areas developed initiatives in municipal health care which foreshadowed the National Health Service. In Aberdeen in the 1920s a joint hospitals scheme was

devised to bring together the Royal Infirmary, maternity and children’s hospitals and the University medical school on one site.

During the Depression years of the 1920s and 1930s many voluntary hospitals were financially stretched, with fund-raising a constant effort. Yet the concept of a National Health Service (NHS) was not welcomed by all. Primarily resisted by the medical profession, it was also viewed with alarm by many who had devoted themselves to keeping their local hospital going. Nevertheless, in 1948 the NHS was inaugurated and the opportunity was there to modernise buildings and rationalise services. The enormous advances in medical science in the 20th century have changed hospital requirements in so many respects. Transport too has played a part, with public transport and then car ownership making the logistics of hospital locations very different from pre-war days.

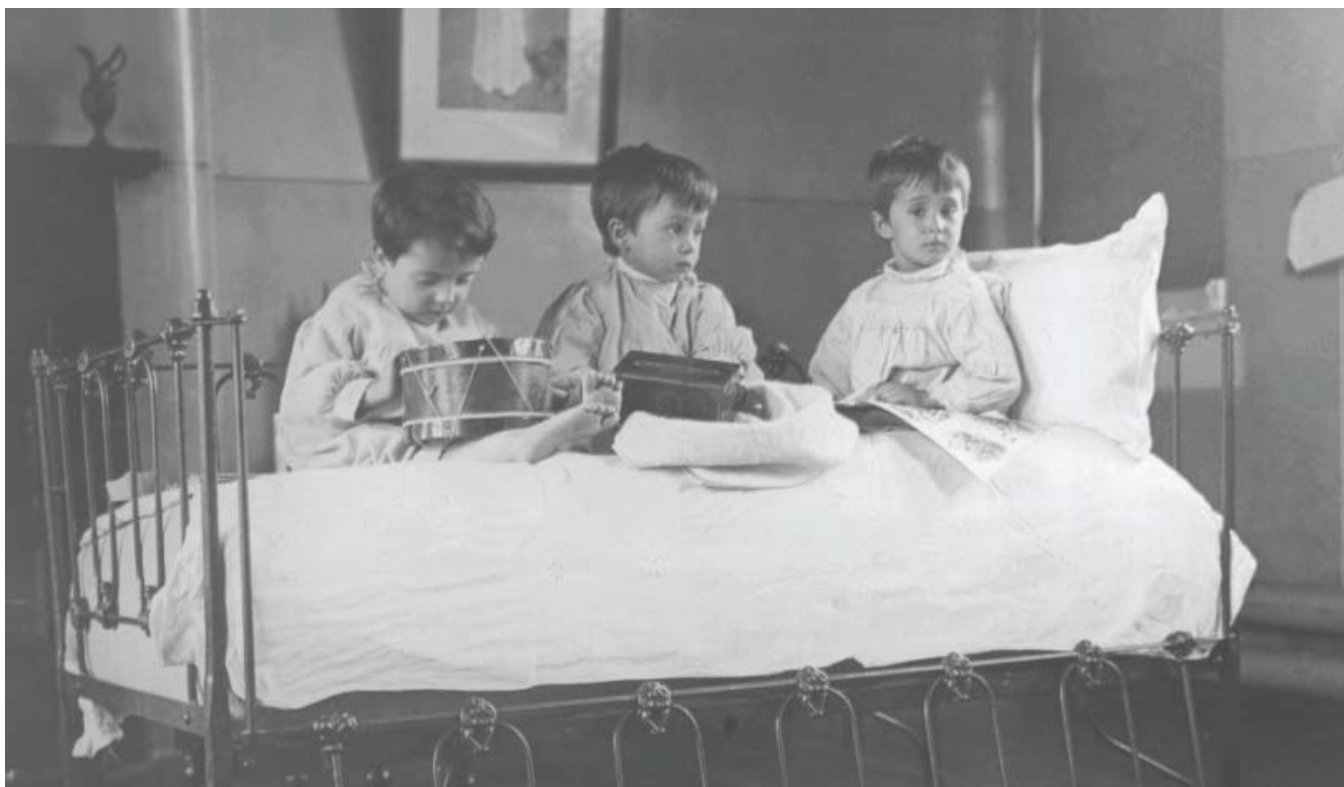
Although post-war architecture and design is only now gaining greater popularity amongst the population at



large, it will not be too long before hospital buildings of the later 1960s, 1970s and into the 1980s will be more widely appreciated, though many have been so greatly added to and altered that the integrity of the original design has been compromised. Part and parcel of this new wave

of hospital construction was the redundancy of older buildings. The final chapter of this book considers their fate, and looks at some which have been successfully converted to new uses. Until 1990 health-care buildings were given ‘Crown immunity’ from planning regulations,

and a listed building could be altered without regard to its historic value. Many hospitals with special architectural and historic importance now have full protection through listed building status, and many have been saved that might otherwise have been demolished.



**Children at Ruchill Hospital, Glasgow, circa 1922.**

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**Interior of Ward 16, Royal Infirmary of Edinburgh.**

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# General Hospitals

Mr Malcolm Macnicol, a Consultant Orthopaedic Surgeon, has some personal thoughts about the change in hospital architecture.

‘The changes in hospital architecture from 1962 include the move from sandstone Gothic or red brick to the geometric and box-like, although the earliest modern buildings evoked interest in us, as medical students – not least the Nuffield Transplant Unit at Edinburgh’s Western General Hospital and the Group Practice Surgery at Kelso. With the new hospital buildings came segmentation of the old “Nightingale” wards into four- and one-bedded units (better for privacy and infection control

but less cheerily communal and harder for the nursing staff to supervise).

‘For doctors the serried ranks of patients in one large ward were daunting but the open geography did encourage larger, more communicative ward rounds, and sociable meals at one or two tables, with informal concerts to the whole ward at Christmas when the turkey was carved by the senior surgeon. Now these full ward rounds are impossible and the small, often windowless, offices mean that staff even eat lunch and dinner in isolation. Gone also are the wood-panelled board rooms where coffee and conversation were enjoyed.

‘Theatre suites too have changed

and are barrack-like, with no outside views. At the old Bangour General Hospital a cow would occasionally chew the cud with its head inside a theatre window, while the original Royal Hospital for Sick Children theatre opened directly on to the southern front hall and door, and also offered great views to the north and east.’



## Chapter 1: General Hospitals

The modern general hospital has its origins in a handful of institutions founded in the early 18th century. In Scotland, the first amongst these was Edinburgh's Royal Infirmary, which began in a small rented house in 1729, having been proposed a few years earlier by the Royal College of Physicians. Its success soon led to the construction of a handsome new building. This was a new type of public building, paid for by the wealthy to serve the poor, and so in its appearance a balance had to be struck between the dignity and philanthropy of the benefactors and the modest status of those whom it was to benefit.

*Fig 1.1 Royal Infirmary of Edinburgh, William Adam (begun 1738), photograph circa 1870.*

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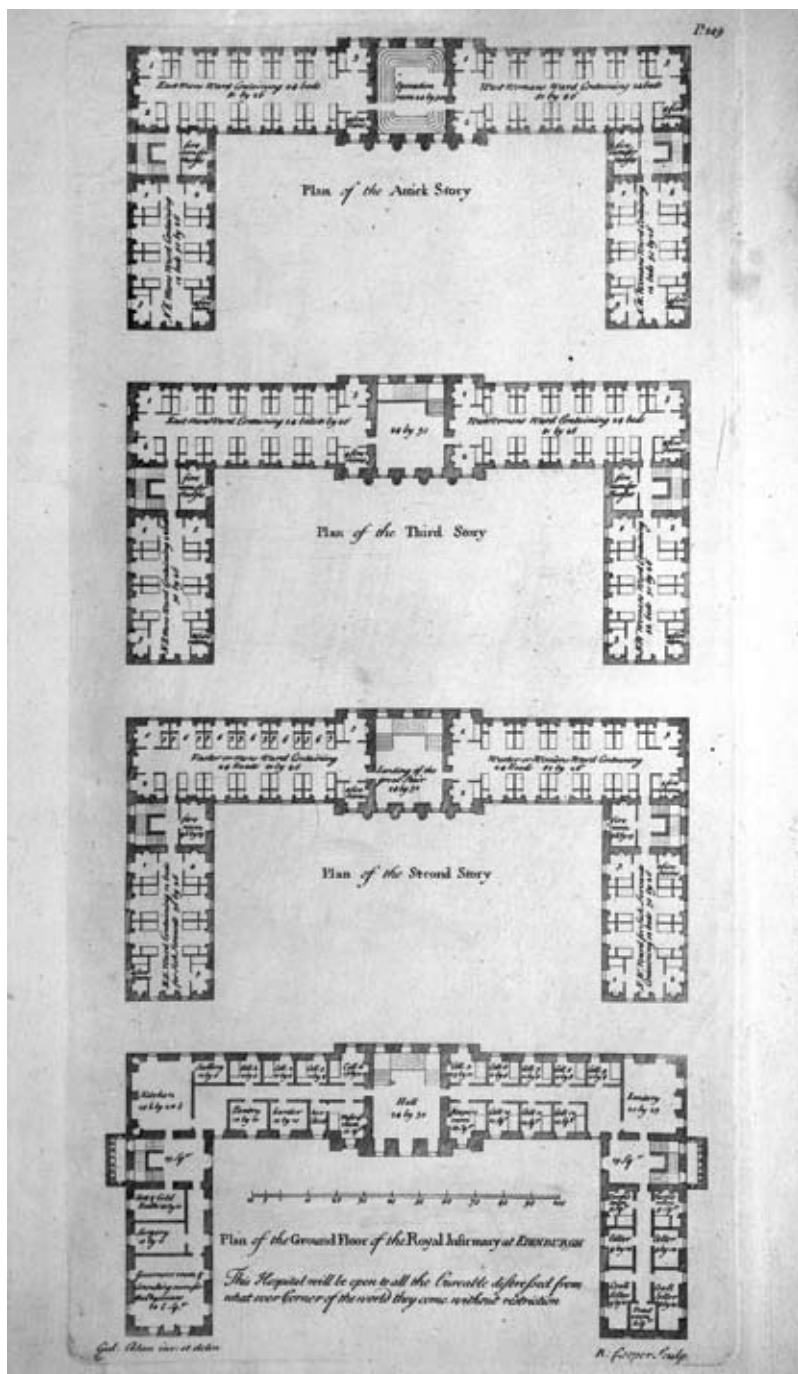


Fig 1.2 Royal Infirmary of Edinburgh, plan by William Adam, taken from Adam's *Vitruvius Scoticus*, 1812. © Courtesy of RCAHMS. Licensor [www.rcahms.gov.uk](http://www.rcahms.gov.uk)

The architect commissioned to design Edinburgh Royal Infirmary was William Adam (c.1689–1748). The foremost architect in Scotland at that time, Adam was instructed to design a solid and durable building, with little or no expense on functionless ornament. He achieved the balance perfectly by using simple elegant classical proportions, with rich embellishment reserved for the very centre of the building. The Infirmary was built in stages, beginning in 1738, and only completed ten years later [1.1 and 1.2].

In all, it was intended that it should conveniently accommodate 200 patients, and it was even stipulated that each patient should be allowed a bed. This is an uncomfortable reminder of conditions that the poor might





**Fig 1.3 Royal Northern Infirmary, Inverness, circa 1830-1860, John Smith of Banff.**  
© NHS Highland Archive

have expected at that date, if single occupancy of a bed had to be spelled out or advertised as a peculiar benefit of the institution. Wards contained either twelve or 24 beds, the smaller ones in the wings, the larger in the central section. In terms of size, external appearance and internal layout, the infirmary was every bit as well designed as its London counterparts: St Thomas's, Guy's and St Bartholomew's hospitals.

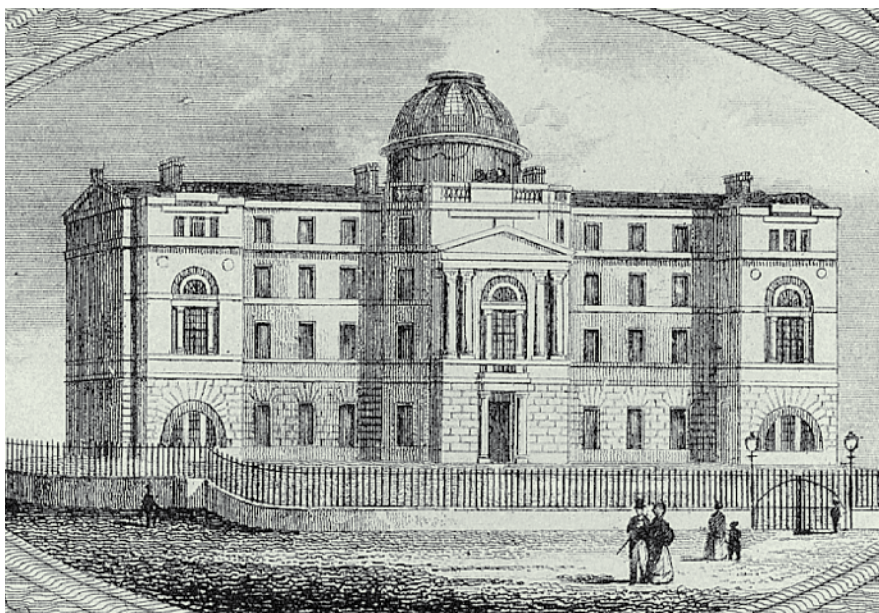
The Royal Infirmary of Edinburgh was not merely of Scottish significance; it was the first teaching hospital to be established in Britain outside London. By 1700 Scotland had already gained a reputation as an important centre for studying medicine. The first Chair of Medicine in Britain was established at Aberdeen

in the late 15th century, but to gain clinical experience medical practitioners completed their training abroad. Once the Royal Infirmary was established, this was no longer a necessity. Surgery and anatomy could now be demonstrated to two hundred students at a time in the large operating theatre in the attic, top lit by the cupola that ornamented the roof.

A few further general hospitals were founded over the course of the 18th century, but not on quite such ambitious lines. In Glasgow the Town's Hospital of 1732 was also purpose built and on a large scale, but was principally a workhouse or poorhouse with some medical attendance. Nevertheless, this and the Royal Infirmary in Edinburgh served as the models for Aberdeen's first general

hospital, which was founded in 1739 and for which William Christall produced the design, the foundation stone being laid in January 1740.

In Dumfries, the Royal Infirmary began in a modest Georgian building erected in 1778, while in Inverness the Royal Northern Infirmary was founded at the very end of the 18th century, opening after some delay in 1804. Designed by John Smith of Banff, the core of this building survives, much added to at different periods, but retaining a strong sense of its original appearance. It was not dissimilar to contemporary country houses, with the central block graced by a pediment supported by Corinthian pilasters resting on the rusticated ground storey. Originally this far smaller central block was



*Fig 1.4 Glasgow Royal Infirmary, Robert Adam, perspective engraving, 1847 from Sketch of the History of Glasgow, by James Pagan.*

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linked by single-storey ranges to two-storey pavilions at either end [1.3]. The need for more accommodation eventually led to the single-storey ranges being built over, and later still an operating theatre was built out onto the front above a new covered entrance.

Its near contemporary, the Glasgow Royal Infirmary, was both more sophisticated and more complex in plan and elevation. Here, at last, was Glasgow's answer to Edinburgh's Royal Infirmary. In comparison with the other town infirmaries which were in existence by the end of the 18th century, such as Aberdeen and Dumfries, Robert Adam's

(1728–1792) design for the Glasgow building was far more ambitious, and its impressive principal elevation was a dignified expression of civic pride. Adam was not the first choice and was only brought in, almost by chance, following the death of the appointed architect and the refusal of his assistant to take over the commission. Adam himself died in March 1792 shortly after completing his designs. His brother James (1732–1794) took over the job until he too died in 1794, the year that the infirmary opened.

Demolished to make way for James Miller's (1860–1947) new Royal Infirmary in the early 1900s, the Adam infirmary was a palatial

building, elegantly neoclassical in style, with accommodation for 200 patients. It was remarkably tall, with four full storeys and attic over a basement, the central bays ornamented with a raised portico and surmounted by a dome. This could not be confused with any private gentleman's residence, but was far more obviously a public building more akin to a university. It was indeed paid for by public and institutional subscriptions, and, like its rival in Edinburgh, was a teaching hospital [1.4].

A surviving Georgian hospital which shares something of the verve of Adam's Glasgow Royal is Gray's Hospital in Elgin. Its founder, Alexander Gray, was a surgeon in the Navy and to the Bengal Establishment of the East India Company. When he died on 26th July 1807 he left £20,000 to establish a hospital for the local sick and poor. His will contained

many oddities and was contested by his relatives. In particular his wife rejected his accusation that she was ‘the most abandoned and deliberately infamous wife that ever distinguished the annals of turpitude’. Between 1807 and 1814 the case was in the Court of Chancery, but the family were unsuccessful.

James Gillespie Graham (1776–1855) was appointed as architect on the recommendation of the Earl of Moray, with whom he had worked in laying out his estate in Edinburgh’s New Town. The architect’s skill in town planning is evident in the positioning of the Elgin hospital, its main front aligned with the town church, later rebuilt on the same site by Archibald Simpson (1790–1847). In 1815, on 11th June, the foundation stone was laid. Reputedly the ceremony was interrupted by news of Wellington’s victory over Napoleon at Waterloo. The hospital opened

on 1st January 1819, providing just 30 beds which were available to any parishioner in the county of Moray on presentation of a note of recommendation from their local minister [1.5].

In the next decades further general hospitals were built, usually founded by the local gentry and funded by voluntary public subscription, and thus termed ‘voluntary hospitals’. The elegant classical proportions of their

elevations fronted unadventurous plans that had moved on little since the earlier 18th century. Typically they comprised wards, an operating theatre ideally top lit or with even north light, a board room and other rooms for hospital officials, a kitchen and laundry, a dispensary, and often a chapel and mortuary. There might be accommodation for the matron or for senior medical officers, but not yet for nurses. Heating was by open fires until well into the 19th century.



*Fig 1.5 Dr Gray's Hospital, Elgin, James Gillespie Graham, completed 1819.*

© Elgin Museum





Generally these components were arranged off a central corridor, hence the term ‘corridor plan’ for this type of hospital.

Fine examples of provincial infirmaries from the 1830s can be found in Perth and Montrose. In Perth a dispensary was established in the early 1830s. Dispensaries were often the precursors of a hospital, operating in a similar way to the modern outpatients’ clinic. A generous gift of £1,000 in 1836 allowed a purpose-built infirmary to be erected. It was designed by William Macdonald Mackenzie (1797–1856), the City Architect, in a fashionable Greek

Revival style, and opened in 1838. Montrose Infirmary was built to designs by a Glasgow architect, James Collie (c.1810–1881), and opened in 1839. Also adopting a Greek Revival style, it featured a portico supported by fluted Doric columns. Its foundation was linked with that of the Montrose Lunatic Asylum, established in 1781 as an asylum, infirmary and dispensary. When the separate infirmary was erected, it accepted all but the mentally ill, including those suffering from infectious diseases. Later separate fever wards were built to stop the spread of infection [1.6].

*Fig 1.6 Montrose Infirmary, James Collie, 1839.*







*Fig 1.7 Chalmers Hospital, Banff, William Lambie Moffat, 1864.*

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By the middle of the 19th century, advances in medical knowledge, coupled with technological innovations, paved the way for new types of hospital design in which the very layout and methods of construction would have a positive effect on the patients' treatment and chances of recovery. Chief among these was a type of plan which separated out the different functions of the hospital, with the wards placed in blocks or pavilions in varying degrees of detachment. Familiar today as Nightingale wards, this shift in the basic design of the ward seen in pavilion-plan hospitals also saw the introduction of interior finishes that could be cleaned easily, radically reducing the risks of infection setting in or disease spreading throughout the hospital. The catalyst for this change was the Crimean War, and the appalling casualties in the hospitals from disease rather than battle wounds.

The widespread adoption of the pavilion plan from the 1860s quickly caused hospitals built only a decade

**Fig 1.8 Edinburgh Royal Infirmary, David Bryce, elevation from *The Builder*, V28, Dec 17, 1870.**

*Reproduced by permission of the Trustees of the National Library of Scotland*

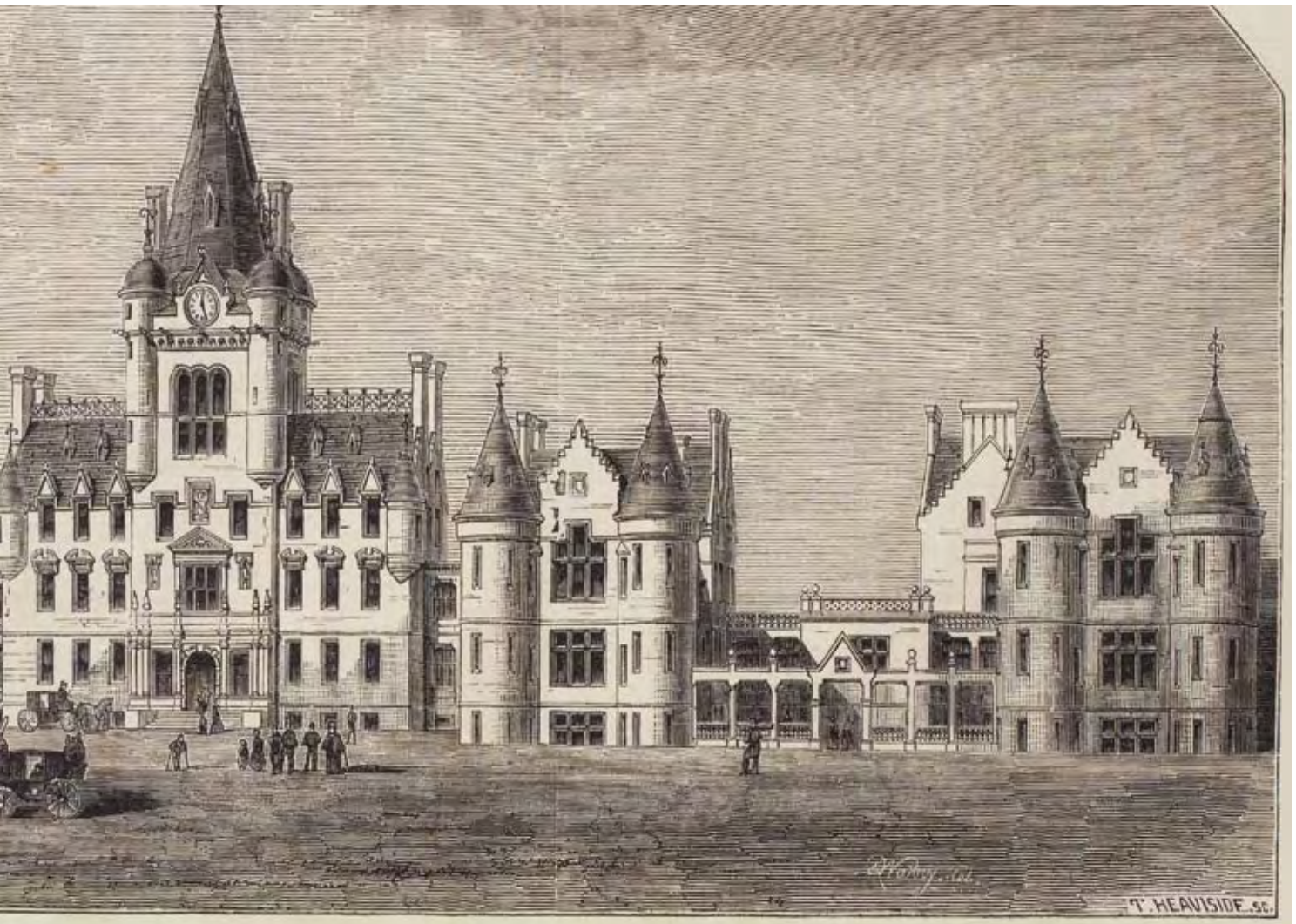
or so earlier to be outdated. Yet the few general hospitals built in this period are richly varied. The grace of Archibald Simpson's Aberdeen Royal Infirmary at Woolmanhill, built in 1840 of cool and glittering grey granite, contrasts strongly with the mullioned windows and shaped gables created just fifteen years later for the new Dundee Royal Infirmary by the English architectural practice Coe & Goodwin. Chalmers Hospital in Banff of 1864 is another fine example [1.7]. Designed by Edinburgh-based architect William Lambie Moffatt (1807–1882) in his characteristic Jacobean style, the tall, two-storey original block has a busy skyline with a proliferation of gables crowned at the centre by an ogee-capped cupola. Funds to build the hospital were



left by Alexander Chalmers, who died in 1835. His wife died in 1848, after which nearly ten years of legal wrangling delayed any progress on the building. Moffatt drew up the plans in 1860, but deliberately turned his back on the new pavilion principles,

instead arranging the wards on one side of a corridor running around the inside of an open court. This and the rather grandiose style of the building were deliberate attempts to distance the hospital from the new poorhouse and workhouse infirmaries which





invariably adopted the new type of plan.

During the 1870s two large general hospitals were the first of their kind in Scotland to adopt the pavilion plan: the Western Infirmary in Glasgow by John Burnet senior

(1814–1901), designed 1867, built 1871–4 and the rebuilt Royal Infirmary of Edinburgh by David Bryce (1803–1876), built 1870–9.

The Western was hampered by a lack of funds which delayed building work and reduced the scale of the hospital

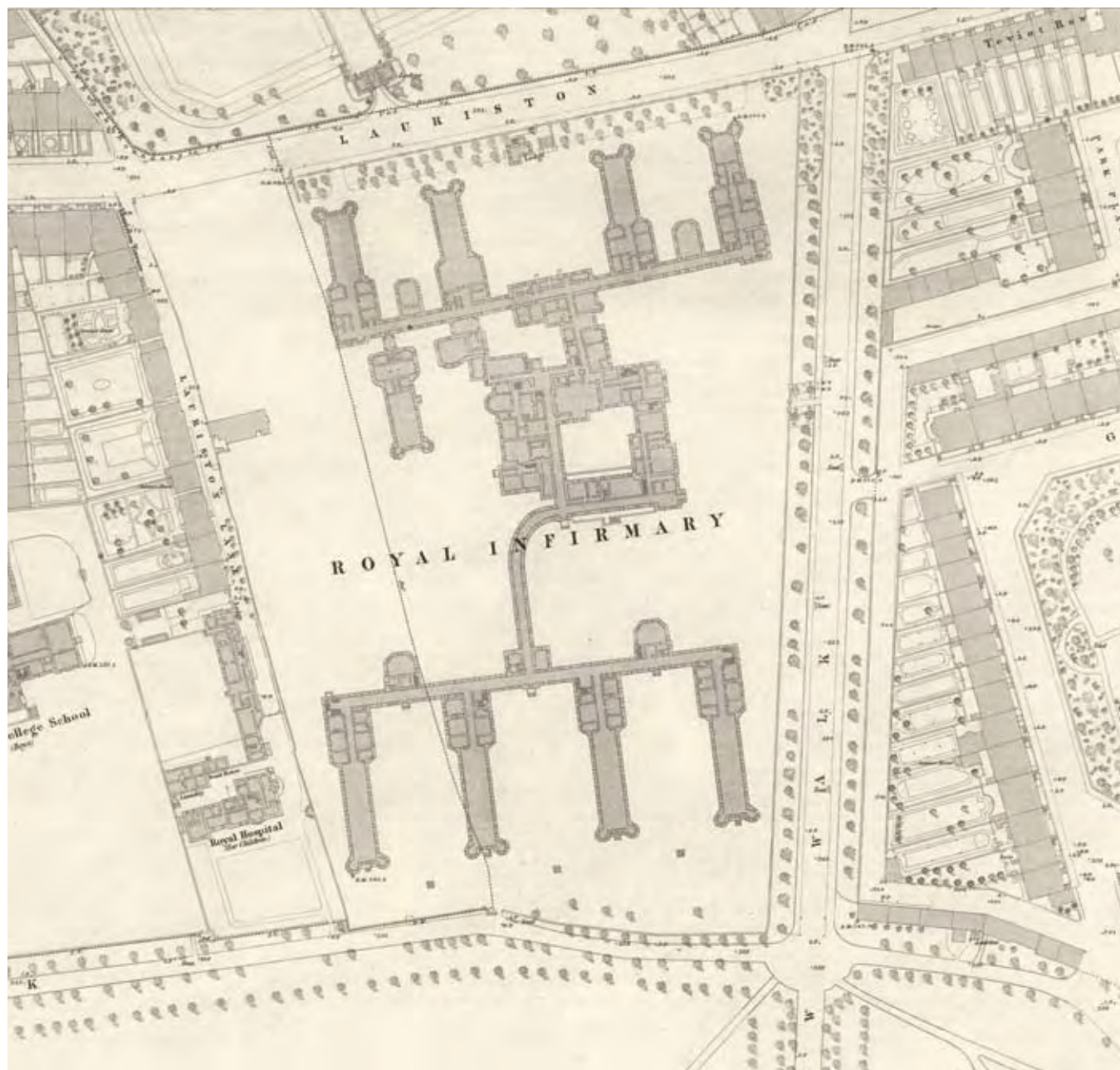


Fig 1.9 Detail of 1876-7 map showing plan of Royal Infirmary of Edinburgh.  
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in the first instance to 150 beds. It was a teaching hospital, established as part of the move to relocate Glasgow University to Gilmorehill. The new Royal Infirmary of Edinburgh, on the other hand, provided an unprecedented 600 beds, arranged in eight three-storey pavilions with one large ward on each floor. Though now itself replaced by the newest Royal Infirmary, Bryce's beefy Baronial masterpiece remains an important architectural landmark in the city. At its heart is the entrance range with a picturesque clock tower rising high above the site. Behind this range was part of William Adam's George Watson's Hospital of 1738–41 which was incorporated into the new building. The large roughly square site, sloping southwards, created a logical split into the surgical hospital section facing Lauriston Place to the north, and the medical section facing the Meadows to the south [1.8 and 1.9].

At the time of its opening, the *Illustrated London News* described the new infirmary as the largest in the

United Kingdom and probably the best planned. Despite its vastness it was not long before additions and alterations were necessary – a nurses' home in 1890, laundry buildings in 1896, the Diamond Jubilee Pavilion of 1897 and two new pavilions for ear, nose and throat cases in 1900 were all designed by Sydney Mitchell & Wilson. These were followed in 1935 by the Simpson Memorial Maternity Pavilion, designed by Thomas W Turnbull.

The increasing size and scope of the infirmary marked the rising success of hospital care. Medical knowledge was expanding, treatments were improving and hospital buildings were becoming better suited to their function. Towards the end of the 19th century an unusual ward type evolved in response to tight and awkward sites; this was the circular ward.

Circular ward towers could be placed in a north corner of a site and still provide ample sunshine, light and air. The first to be built in Britain were in London in the late 1880s. Only two





*Fig 1.10* Balconies at the Royal Alexandra Infirmary, Paisley, Thomas Abercrombie, 1897-9.

hospitals in Scotland went in for such novelty. The first was the Kirkcaldy Cottage Hospital, now demolished, where plans for a circular ward were drawn up in 1895. The second was at Paisley at the Royal Alexandra Infirmary, rebuilt on a site off Neilston Road by the local architect Thomas Graham Abercrombie (1862–1926) in 1897–1900, but since superseded by the new hospital at Corsebar Road. Abercrombie’s elegant complex placed the circular ward tower at the north-east corner of the site and rectangular ward pavilions to the south, but their balconied ends were curved, echoing the circular tower and harmonising the design [1.10].

General hospitals continued to evolve in the early decades of the 20th century. Many of the older ones, such as the Royal Alexandra and Edinburgh’s Royal Infirmary, were rebuilt – often on a different site to allow for expansion as towns grew in size and the population swelled. More people now were willing to be admitted to a hospital, not just the



poorest in society for whom treatment at home was impossible. Glasgow Royal Infirmary, however, was rebuilt on its existing site and Robert Adam's fine building demolished to make way for the present building designed by James Miller in 1900. Miller was also the architect of the new Perth Royal Infirmary built in 1911–14, and for Stirling Royal Infirmary, rebuilt in 1926–8.

A growing trend was the provision of more specialist departments – such as the ear, nose and throat department added to the Royal Infirmary of Edinburgh. Separate specialist hospitals had become a phenomenon of the later 19th century, but the teaching hospitals in particular were keen to draw specialist cases back into the general hospital. The idea of centralising services, key to the National Health Service, had an important forerunner at Aberdeen where a joint hospitals scheme was devised by Professor Matthew Hay, the city Medical Officer of Health. His bold aim to bring together the



**Fig 1.11 Aberdeen Royal Infirmary, James Brown Nicol, 1936.**

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different voluntary hospitals services in Aberdeen on one large site bore fruit at Foresterhill. Here the new Royal Infirmary was built alongside a maternity hospital and children's hospital, together with a nurses' home and the medical school buildings of Aberdeen University. They shared services including steam for heating, kitchens, and sterilising and laundry facilities. The University undertook pathological, bacteriological and biochemical work for the hospitals.

The new Aberdeen Royal Infirmary building was designed by

James Brown Nicol (1867–1953) in 1927 and occupied a central position in this ambitious scheme. Impressively severe and uncompromising in grey granite, the infirmary consisted of three five-storey ward blocks for medical, surgical and special cases. The ward blocks extended south from the gently curved east–west corridor, fanning out from the central administration area. This arrangement was a welcome variation to the usual long, straight barrack-like corridors, and allowed a freer access of air and sunshine into the wards. When

the infirmary opened in 1936 the *Aberdeen Press and Journal* was warm in its praise, and along the way noted that it had 1,995 ‘ultra-modern’ doors and 2,652 windows [1.11].

### The Emergency Medical Scheme

As war with Germany became more certain, plans to cope with the possible casualties were put in motion. The result in Scotland was seven large new hospitals, of the most basic and simple design, that were swiftly erected after the outbreak of war in 1939. The blueprint for the hospitals was drawn up by the Office of Works but local architectural firms were engaged to carry them out. Law Hospital in Lanarkshire was the first, completed before the end of 1939. It comprised 16 wooden ward huts each containing two forty-bed wards, grouped in fours around a central administrative and service section. There were also separate staff blocks and an isolation unit. Heating was by coal stoves (the nurses’ home at Ballochmyle in Ayrshire was equipped with only three such stoves in the

corridor, earning the building the nickname of ‘Siberia’ among the staff). Little different from an army camp, the Luftwaffe mistook Law Hospital for a military barracks and it was lucky to evade bombing [1.12].

These most basic types of ward huts were first devised during the Crimean War by Isambard Kingdom Brunel (1806–1859), as quick kit-hospitals that could be shipped out and assembled close to the scene of battle. Similar huts had been built during subsequent conflicts, and a small industry grew up making temporary buildings from timber and corrugated iron that could be bought cheaply and put up quickly. Many of these were acquired by local authorities to serve as municipal infectious diseases hospitals.

Six more emergency hospitals were built or acquired across Scotland: Raigmore (Inverness); Stracathro (near Brechin); Bridge of Earn (Perthshire); Killearn (Stirlingshire); Ballochmyle (Ayrshire) and the Peel (Selkirkshire). Existing hospitals were also drawn into the scheme with hatted annexes

*Fig 1.12 Law Hospital, Carlisle, Luftwaffe vertical photograph, taken 1940. © RCAHMS (Luftwaffe Collection). Licensor www.rcahms.gov.uk*

added, notably at Bangour (West Lothian). They had been built to take expected casualties from England, and so they were placed close to main railway lines, though well away from towns and cities that could themselves be targets for bombing raids. As it turned out the numbers of casualties from the south were not as high as at first feared, and the hospitals took in patients from nearby military camps, evacuees from city hospitals and sometimes prisoners of war.

Although they were created as temporary hospitals, and not expected to last more than twenty years, Killearn was the first to be closed in 1972. The Peel closed next in 1989, and at about the same time Raigmore’s brick huts were pulled down but the site retained for a new general hospital. The others were upgraded and retained during the 1980s. Bridge of Earn closed in 1992, and Ballochmyle in 2000, the hospital buildings demolished to make way for a housing development. Stracathro Hospital is still in use with a few of the wartime buildings surviving.









# Cottage Hospitals

Gillian Hutton is the senior Charge Nurse at Aberfeldy Community Hospital where she has worked for 10 years.

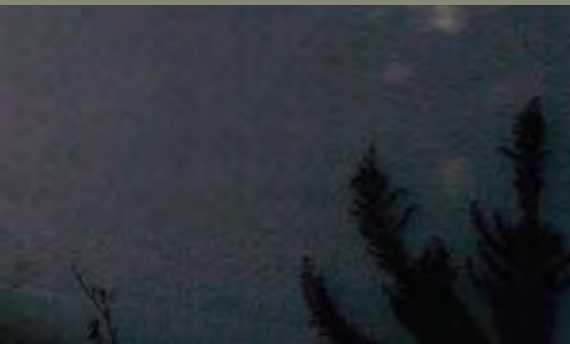
‘The hospital is a great community resource,’ says Gillian, who is in charge of its day-to-day management. The hospital provides a variety of services for the people of Aberfeldy and the surrounding district and has 12 inpatient beds which cater for a variety of needs, a physiotherapy service, an occupational health service and a minor injuries clinic.

Gillian worked previously in a large city-centre hospital, and

while she sometimes misses the hustle and bustle of a busy high-tech ward, she finds this is more than compensated for by being recognised and thanked in the street in Aberfeldy by past patients or their relatives. ‘There is a real sense of belonging to the community here and a great deal of community spirit amongst the patients and staff of the hospital.’

Gillian notes the value of a local hospital to communities, however small, in that people like to be treated where they know the staff and other patients and sometimes they meet friends they have not seen

for a long time. The location of this hospital means that people do not have to make the journey to Perth Royal Infirmary. The vernacular details in the architecture of the building underline its recognition and status at the heart of the community.



## Chapter 2: Cottage Hospitals

**General hospitals were only really viable in towns and cities, but in the mid-19th century the journey from villages and small rural communities to even the nearest town might be fraught with difficulty. Accidents needed swift treatment, and not a long uncomfortable ride in a cart over rough roads; and most patients would be deprived of visits from friends and family if they were removed too far from home. The answer was the cottage hospital – a small rural hospital run by the local medical practitioners, offering its services to a broader spectrum of the local community and usually charging a small fee to those who were in a position to pay for their treatment.**

**F**lorence Nightingale was a great champion of this new type of hospital, the first of its kind opening in a converted house in Surrey in 1859. It was not long before Scotland had its own cottage hospitals, two opening in 1865 – one at Crimond in Aberdeenshire and the other in St Andrews. Little is known of the former, though unusually it seems to have been purpose built from the outset. In St Andrews the more usual route was taken, with the hospital first opening in a rented house with just six beds. A larger house was acquired

in 1880 but it was not until 1903 that a purpose-built hospital was erected, designed by a local architect, Charles F Anderson.

By the turn of the century, Scotland was peppered with cottage hospitals, many with great architectural charm. They proved popular not only with medical practitioners and patients but also with the wealthier local citizens, who sometimes gave generous sums towards their foundation and endowment. Due partly to their small scale, but also to their ethos, these were usually given a domestic



*Fig 2.1 Gables at Ross Memorial Hospital, Dingwall, William Cumming Joass, 1873.*

appearance. Plans were more varied, though often took on board the key principles of pavilion planning. One early example is the Ross Memorial Hospital at Dingwall, which opened in 1873 as a memorial to Dr William Ross who had died in 1869. It was designed by local architect William Cumming Joass (d.1919), whose son John James Joass (1868–1955) went

on to have a highly successful career as an architect in London, known for his stylish commercial buildings. The father's charming little Gothic hospital is a far cry from these. Originally with just eight beds disposed in two-bedded wards, it was unusual in accepting fever and infectious cases as well as surgical and accident cases. These two sections were carefully

separated. Henry Burdett (1847–1920), the philanthropist and hospital reformer, commended the design and reproduced the plan in his book on cottage hospitals, first published in 1877. A low, single-storey building, it has an array of gables to its main front that enliven what might otherwise have been rather a dull façade [2.1].



*Fig 2.2* Leancoil Hospital, Forres, John Rhind with Henry Saxon Snell, 1892.





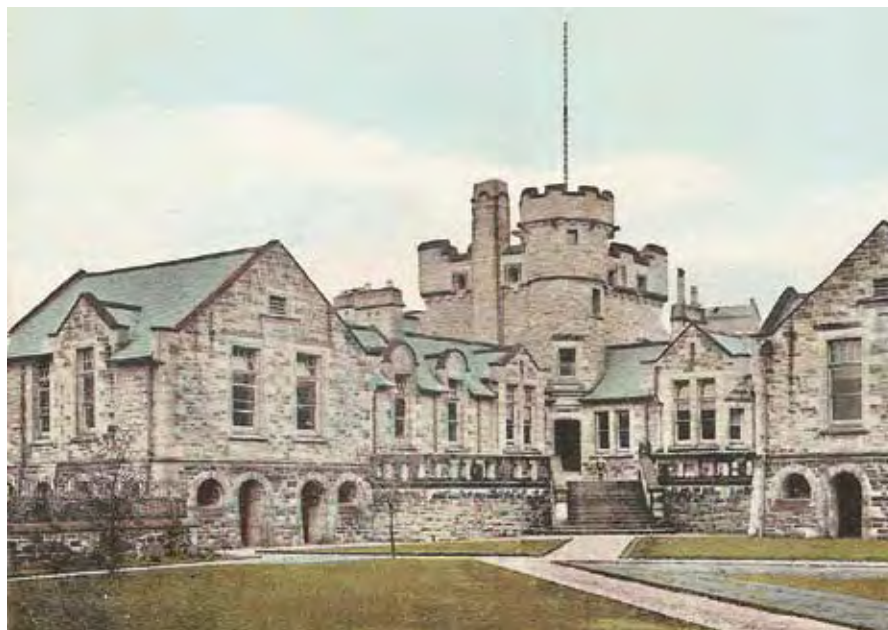
Leancoil Hospital at Forres, by contrast, makes a much grander architectural statement with its two-storey gabled entrance block fronting a sturdy tower. A public meeting held in 1888 first mooted the possibility of building a cottage hospital here, and in the following year John Rhind (1836–1889) was asked to provide plans. These were sent to Henry Saxon Snell & Son, the pre-eminent London-based hospital architects in England at that date, for their comments. However, before they could reply, Rhind had died and Saxon Snell (1830–1904) took over as architect to the project. The resulting hospital, which opened in 1892, blends Baronial and Jacobean details which, along with the overall design, are probably the work of Rhind, with Snell refining the plan, perhaps in details such as the sanitary annexes separated from the wards by cross-ventilated lobbies. Extensions have been added at both ends, while a 1930s maternity wing blends its modern style sympathetically with the old by using the same tone of

materials and keeping to a single storey [2.2].

Perhaps the grandest cottage hospital was that built in Langholm in 1896–8: the Thomas Hope Hospital [2.3]. Over £100,000 were left by its eponymous founder for a building of good architectural character. Hope, a native of Langholm, had made his fortune in America. After his death a group of trustees was appointed to

administer his bequest. A competition for the design was assessed by Ewan Christian (1814–1895), the ageing and then ailing architect to the Church Commissioners in England. In 1894, Christian awarded the job to John Henry Townsend Woodd of London, a former pupil. Woodd and his partner Wilfred Ainslie drew up the plans, and work began in 1896. The hospital opened in May 1898. Built of the

*Fig 2.3 Thomas Hope Hospital, Langholm, John Henry Townsend Woodd, 1896–8, postcard circa 1905. © Unknown*



*Fig 2.4 Former Cromarty Hospital, Cromarty, opened 1894. © Cromarty Courthouse Museum. Licensor [www.scran.ac.uk](http://www.scran.ac.uk)*



local white freestone, mostly bull- or rock-faced, it was principally of one storey over a raised basement that was partly arcaded. It was described at the time as being in the ‘Border style’, presumably because of its bold central tower with its hints of a peel tower. One of the building’s distinguishing features is its octagonal mortuary. There are also elaborate ironwork gates supplied by Peard & Co of London.

The Thomas Hope Hospital is exceptional; most of the cottage

hospitals that proliferated in the late 19th century were plain and simple buildings, and many of these fell foul of the National Health Service (NHS) policy of centralisation.

Cromarty’s cottage hospital, for example, opened in 1894 but was closed in 1953. Its domestic scale readily lent itself to conversion to a private house [2.4]. Plain and simple, in the hands of a gifted architect, could also possess considerable architectural flair. This is evident at Aberfeldy’s cottage hospital, dated

1909, and opened the following year. It was erected under the auspices of Sir Donald Currie of Garth on a site granted free by the Marquis of Breadalbane. The architects were Dunn & Watson, who produced a design that blends with the local architecture, being single-storey and white-harled with crowstepped gables and green slate roof. This sensitivity to Scottish vernacular architecture is reminiscent of Sir Robert Lorimer’s (1864–1929) romantic Scots-style buildings.

Cottage hospitals continued to prove popular in the interwar period, often being founded either as a memorial to an individual or as a war memorial. At Girvan, the Davidson Cottage Hospital was built in 1921 to designs by Watson, Salmond & Gray. It was founded and endowed by Thomas Davidson as a memorial to his mother. The usual central administration block was flanked by wards, but it has much charm with details such as the

broken segmental pediment above the entrance, and the simple Lorimeresque dormerheads [2.5]. The quality of the masonry and slate work is excellent. Tilberthwaite slates were used, which are a silvery grey in colour. In this modest building the architects produced an intimate character, very different from two other general hospital projects designed by the firm: Philipshill Hospital at East Kilbride (1925–31), and the Paying Patients’

Wing at the Victoria Infirmary in Glasgow (1930–31).

Another memorial hospital of the 1920s is St Margaret’s Hospital at Auchterarder, built in 1926 from funds gifted by A T Reid of Auchterarder House in memory of his family. Designed by Stewart & Paterson, it opened in 1929, a simple but excellently conceived design with very little ornament but distinguished by scale and composition [2.6].

*Fig 2.5 Davidson Cottage Hospital, Girvan, Watson, Salmond & Gray, 1921. © Crown Copyright: RCAHMS. Licensor [www.rcahms.gov.uk](http://www.rcahms.gov.uk)*



*Fig 2.6 St Margaret’s Hospital, Auchterarder, Stewart & Paterson, 1926. © St Andrews University Library. Licensor [www.scran.ac.uk](http://www.scran.ac.uk)*











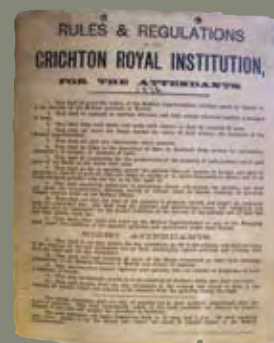
# Mental Health

Morag Williams was the archivist for Dumfries & Galloway Health Board for over 20 years. She was based in a variety of buildings at the Crichton Royal Hospital in Dumfries. The Crichton consists of buildings from different periods of local sandstone which make up an important architectural site. These include the earliest, Crichton Hall, designed by William Burn, which opened in 1839; a fine Gothic Revival church of 1897 by the Edinburgh architect, Sydney Mitchell; and a handsome farm quadrangle of the 1890s. All are listed as category A.

It is testament to the importance of the Crichton and its many dedicated

superintendents over the years that it has an excellent archive with a detailed record of every patient in the hospital since 1839. These notes bring life to those who lived at the hospital. Their ailments are often described in poetic language and in one instance the brain is referred to as 'the palace of the soul'.

In her role as archivist, Mrs Williams has been involved with a wide range of people, from rose experts in India to those interested in Scottish pipe music. She admits that being the archivist for such a prestigious hospital has tended to take over her life, although she is grateful to have had the opportunity to make friends from all over the world.



## Chapter 3: Mental Health

**Our understanding and treatment of those suffering from mental illness is every bit as complex in its history and evolution as that of general medicine. As with general medicine, specific types of buildings were devised in which to take care of such patients when families or friends were unable or unwilling to do so. For these patients, asylums were built. Encouraged by a number of significant pieces of legislation, ‘lunatic’ asylums gradually proliferated in the course of the 19th and early 20th centuries.**

**B**y the mid-19th century seven chartered asylums had been founded: the royal asylums at Montrose (opened 1782); Aberdeen (1800); Edinburgh (1813); Glasgow (1814); Dundee (1820); Perth (1827) and Dumfries (1839). There was also just one unincorporated public asylum – Bilbohall, in Elgin (1835). A dozen poorhouses had separate wards for the mentally ill, and there was a ‘lunatic department’ at the general prison in Perth. A further 14 poorhouses took in ‘paupers’ suffering from various mental illnesses, usually of a harmless nature, housing them with the rest of the inmates rather

than in separate wards. In addition there were some 23 licensed houses or private establishments, and two schools for ‘idiot’ children – that is children with some form of mental handicap. The very terms used until relatively recently for the mentally ill are indicative of changing public perceptions. Expressions such as ‘lunatics’, ‘the mad’, ‘idiots’, ‘imbeciles’, ‘the mentally defective’ or ‘deficient’ often had quite specific definitions, and were not necessarily meant to be pejorative.

It was during the 18th century that a more humanitarian attitude to the conditions of the insane emerged.

The very first lunatic asylum in Scotland was founded in Montrose. Here in 1779 Susan Carnegie of Benholm Castle enlisted the help of the Provost, Alexander Christie, to raise subscriptions to establish an asylum. At that time 'lunatics' were kept imprisoned in the Tolbooth in the middle of the High Street. She hoped that by providing a quiet and convenient asylum where such persons might receive good treatment and medical aid, some of them might be able to return to society. Her aim was to raise £500 with which to build a lunatic hospital. Eventually almost £700 was raised and the asylum was completed in the summer of 1781. Montrose's Royal Lunatic Asylum, Infirmary and Dispensary began as a combined general and mental hospital, though these two functions later separated. In Aberdeen the Royal Asylum first opened in 1800 and was founded by the managers of the Royal

Infirmary there, which had provided limited accommodation for lunatics.

In Edinburgh efforts to raise funds to build an asylum were met with apathy. A public appeal launched in January 1792 had raised little more than £200 after 14 years. Even the last of the Royal Asylums, the Crichton Royal at Dumfries which opened in 1839, was dubbed by the local press the 'Crichton Foolery' and bitterly attacked as a misguided and undesirable avenue for philanthropy.

Early attempts to improve conditions for lunatics through legislation were unsuccessful. In 1817 a Lunacy Bill was rejected by parliament, but the reports prepared at the time reveal much about the standards of accommodation offered to lunatics. Edinburgh was particularly bad, with overcrowding and neglect the principal causes for concern.

Of the first purpose-built asylums in Scotland, few survive

today. Montrose Asylum moved to a new site in 1866 and the original buildings have since been demolished. In Aberdeen, the original modest single-storey asylum built in 1800 was replaced by a more commodious building in 1819 designed by Archibald Simpson, which in turn was added to, subsumed and recently pulled down. At the Royal Edinburgh Asylum the original buildings designed by Robert Reid (1774–1856) in 1809 have also gone.

Perhaps the most regrettable loss, from an architectural viewpoint, is the Glasgow Royal Asylum designed by William Stark (1770–1813) in 1810, probably the most influential purpose-built asylum of the early 19th century. It was the first hospital built with a radial plan derived from Jeremy Bentham's panopticon. Bentham (1748–1832), the great philosopher and reformer, published his writings on this unusual circular

**Fig 3.1 Detail from 1st Edition Ordnance Survey Map, showing Glasgow Royal Asylum (City Poorhouse), 1857-8. Reproduced by permission of the Trustees of the National Library of Scotland**



building design in 1791. Originally devised by his brother Samuel for a workshop where the skilled craftsmen could occupy a central observation post from which they could supervise the work of unskilled men, Jeremy saw the potential of the design for prisons, hospitals or even schools, where a small staff would be able

to keep watch over all the inmates. Stark commended this aspect of the plan, noting that not only could the ‘keepers’ constantly watch over the patients but the superintendent could keep his eye on both patients and staff. Stark’s variation on the panopticon – which comprised four wings radiating from an octagonal tower with a spiral



stair at the centre – also allowed strict segregation of different types of patient, as well as the separation of the sexes, with separate passages and stairs between day rooms, galleries and grounds. The need for supervision of not only patients but also staff reflects the difficulty of attracting good staff to work in asylums, at a time when the pay was poor and there was no training [3.1].

As Stark had observed, the design also had potential for expansion, and it was not long before additions were being made at the outer ends of the wings. Eventually, however, it was realised that a new building on a new site was necessary, and a new asylum was built at Gartnavel to which the patients were transferred in 1843. The original building continued in use as a poorhouse and was finally demolished in 1908.

Stark went on to design Dundee Royal Asylum, begun in 1812 though not opened until 1820 and also now demolished. Here Stark produced a somewhat less obviously institutional design on an H-shaped plan where a

central two-storey-and-attic range was flanked by long single-storey wings. This allowed for a greater variety of accommodation to suit the different classes of patients. In the centre block, as well as areas for staff and a committee room, there were good-sized rooms, often with fireplaces, for ‘higher-class’ patients. The wings were similar to those at Glasgow, with a row of single cells on one side and a long corridor or gallery on the other.

Contemporary with the Dundee Royal Asylum was Robert Reid’s Royal Edinburgh Asylum at Morningside, built in 1809–13. Although originally founded with a view to serving the very poor, financial constraints meant that Reid’s building was designed for paying patients. Reid devised a collegiate, quadrangular plan comprising four three-storey pavilions linked to square two-storey pavilions at the angles. In the grounds there were to be detached houses for ‘higher-class’ patients where they might keep servants, carriages and ‘other small comforts’, as Reid himself explained. Only two ranges of

the main asylum were built, offering large rooms with fireplaces for the patients.

Stark’s radial plan was developed by Watson and Pritchett for the West Riding Pauper Lunatic asylum built at Wakefield, Yorkshire in 1816–18. Their plans were published in 1819 and clearly influenced William Burn (1789–1870), who designed additions and alterations to the Dundee asylum in the 1820s, the Murray Royal Asylum at Perth in 1821, the Crichton Royal at Dumfries in 1834 and Edinburgh asylum’s West House for paupers in 1840. In particular Burn adopted the central octagonal tower from which wings for the patients extended. As in Stark’s radial plan, at the centre of the tower there was a spiral stair, and from the rooms around this central core the patients could be observed.

Burn’s plans for the Crichton Royal were on the most ambitious scale, comprising a double Greek cross with wings radiating from two octagonal stair towers, though only one half was built [3.2].



**Fig 3.2 William Burn's drawing of Crichton Royal Hospital, Dumfries, 1834.**

© Dumfries and Galloway Libraries, Information and Archives

The importance of the Crichton is not merely in its architectural history. As the building was approaching completion, its first superintendent was appointed. On the recommendation of Elizabeth Crichton, the asylum's foundress, the position went to Dr W A F Browne (1805–1885), who had been Medical Superintendent of Montrose Royal Asylum since 1834. Browne

had studied medicine at Edinburgh University, after which he had continued his studies on the continent, notably in France, where he visited the asylums of Paris and studied under the leading psychiatric doctors of the age, Philippe Pinel and Jean-Étienne Dominique Esquirol. In 1837 he had published an influential series of lectures on 'What Asylums Were, Are and Ought to Be'. Under Browne's



management, the asylum acquired the high reputation sustained by subsequent medical superintendents. The buildings were also added to, and included many structures of great significance in asylum design.

In the same year that the Crichton Royal first opened, a new site was acquired for the Glasgow Royal Asylum at Gartnavel, outside the city, with an elevated, airy

position. Charles Wilson (1810–1863) drew up the plans for this asylum of two halves, comprising separate ranges for paupers and paying patients with a chapel at the heart of the site linking the two. Though the chapel was not built until 1904, the asylum itself was built in 1842–3, initially for 420 patients. Up to now asylums had been architecturally plain, generally sparingly classical in style. By contrast

Wilson's palatial building was Tudor Gothic, its appearance reminding one spectator of Windsor Castle. Each range was U-shaped with the central section containing the main entrance, reception rooms and staff accommodation while the patients occupied the flanking wings. Almost all the private patients occupied single rooms, but the paupers mostly slept in dormitories of varying sizes with

up to 22 beds. As well as the inmates from Stark's old asylum, the new building took in large numbers of pauper patients from Glasgow's Town's Hospital and other poorhouses, soon leading to overcrowding and a need for extension [3.3].

By the mid-19th century the royal asylums were stretched to their limits, and there seemed to be ever-increasing pressure to provide more accommodation in particular for pauper lunatics. In 1855 a Royal Commission was appointed to examine the problem, which resulted in the first major piece of legislation to provide for the mentally ill: the Lunacy (Scotland) Act of 1857. This established a central 'Board of Lunacy' to oversee the provision of district asylums and inspect any establishment where the mentally ill were lodged. An amendment to the Act of 1862 allowed parochial boards, which had formerly only had responsibility for the sane poor, to care for pauper lunatics if they could offer suitable accommodation. This usually took the

form of lunatic wards attached to the poorhouse, but sometimes entirely separate parochial asylums were built.

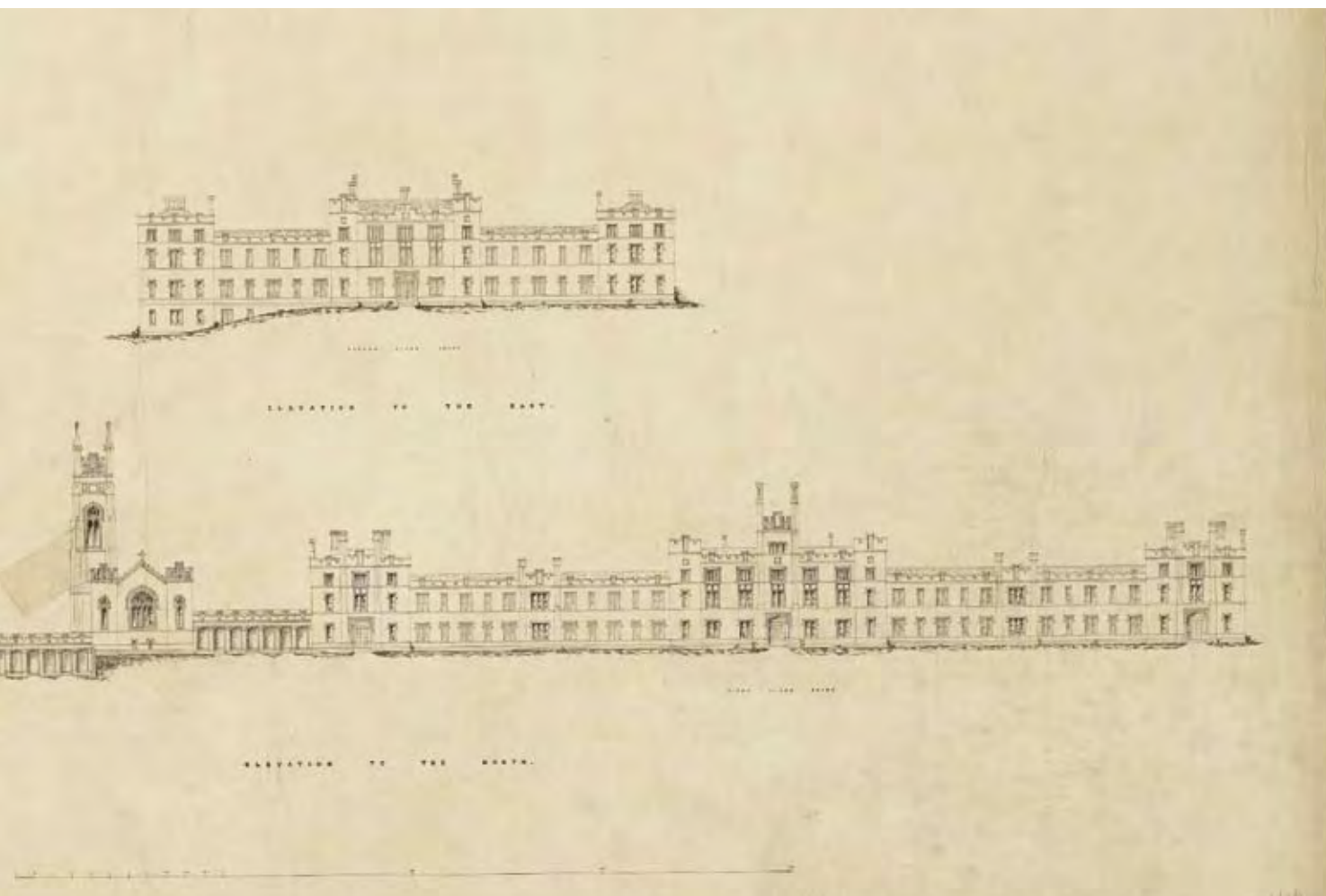
The first district pauper asylum to be built was for Argyll. Designed by the Edinburgh City Architect, David Cousin (1809–1878), it opened in 1863 at Lochgilphead. Cousin's plan was for an asylum for 200 patients, comprising single rooms and ground-floor day rooms with dormitories and further single rooms above. Its first medical superintendent was Dr (later Sir) John Sibbald (1833–1905), subsequently appointed as a Commissioner in Lunacy.

Two further district asylums were completed the following year in Perth (later Murthly Hospital, opened April 1864), and Inverness (Craig Dunain Hospital, May 1864). Later district asylums opened in Banff (Ladysbridge, 1865), Fife (Stratheden, 1866), Haddington (Herdmanflat, 1866), Ayrshire (Ailsa Hospital, 1869), and Stirlingshire (Bellsdyke, 1869). The Commissioners in Lunacy had the power to pass or reject plans for



proposed new buildings or alterations to old ones. Funded from the rates, district asylums were typically fairly plain, but their architects often produced impressive buildings, with as much variety as gables and bays could provide. The Northern Counties District Asylum in Inverness is a good





example. In 1859 the District Lunacy Board purchased the site, 180 acres (73 hectares) on the hillside above Inverness, and a restricted competition was held for the architect. Designs were invited from James Matthews (1819–1898) of Aberdeen, who secured the commission, Peddie &

Kinnear of Edinburgh (who went on to design the Fife District Asylum), and a York architect, George Fowler Jones (1817/18–1905). Matthews was an unsurprising choice given his experience in poorhouse planning and design. His asylum bears more than a passing resemblance to the model

*Fig 3.3 North and East elevations of Glasgow Royal Asylum at Gartnavel, Charles Wilson, 1842–3.*

© Courtesy of RCAHMS.

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**Fig 3.4 South front of Craig Dunain Hospital, Inverness, James Matthews, 1864.**

© Royal Commission on the Ancient and Historical Monuments of Scotland; E/2968/cu  
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poorhouse plan he designed in 1847 with his partner Thomas Mackenzie (1814–1854).

Occupying a magnificent raised site, the long, three-storey building followed the accepted plan, with a high proportion of single cells. Modest innovations included the patients' dining hall, brought to an unusually prominent position at the heart of the patients' accommodation, and the staff and service area placed

to the rear. It was one of the first to remove its airing courts in 1874. This progressive act was somewhat belittled by the constant complaints of the Commissioners in Lunacy, when they inspected the hospital, of the lack of warmth in the buildings and the poor diet of the patients [3.4 and introduction].

During the 1870s two more district asylums were built, at Melrose (later Dingleton Hospital, opened

in 1872), and for Midlothian and Peebles (later Rosslynlee Hospital, 1874). In addition new parochial asylums were built, often as part of a large new complex that included a new poorhouse. There were already six such asylums by the mid-1860s, mostly in the populous areas in and around Glasgow. One of the few to be built on a separate site was the large and imposing Barony asylum (Woodilee Hospital) in Lanarkshire, of 1871–5.

A need for more diverse classification of the patients and better management of different types of mental illness led to experiments in planning. For the City of Glasgow District Asylum at Gartloch inspiration came from abroad, in particular taking into account developments in Germany and America. A competition held for the design in 1889 was won by Thomson & Sandilands, with building work under way in 1892. Completed in 1896, this complex institution for 570 inmates was divided into





**Fig 3.5 Drawing of the administrative block at City of Glasgow District Asylum at Gartloch, Thomas & Sandilands, 1896.**

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two halves, with separate sections for medical and non-medical cases. A larger asylum section cared for chronic cases requiring little or no nursing, while a smaller hospital section cared for acute patients requiring special nursing. Situated on rising ground, this impressive group of red sandstone buildings was designed in a French Renaissance manner with richly carved details. The decorated, spiky dormerheads add particular verve, culminating in the massive twin pinnacled towers of the asylum section's administration block. In this section the patients were classified and allocated to three-storey pavilions or villas, linked to the administration block by single-storey corridors. It was symmetrically laid out with the usual division of males to one side and females to the other. Gabled, single-storey ranges contained workshops on the male side and the laundry and wash house on the female side, reflecting the division of labour given to the patients [3.5 and 7.4].

**Fig 3.6 Interior of great hall, Craig House, Edinburgh, A G Sydney Mitchell, 1889-94.**

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To the south was the hospital section, comprising a two-storey, U-plan administration block, and a single-storey, H-plan ward block with central kitchen and dining facilities. South-facing verandas allowed open-air treatment. Here there were observation wards, with sections for the sick and for those suffering from infectious diseases. The Medical Superintendent was provided with a large detached house on the site, and a nurses' home was added to the south-west in 1900, closely resembling the asylum villas in style but with slightly less decorative detail. Further additions included a fifty-bed sanatorium in 1902 (now demolished), and in 1904 a farm workers' block was completed (also now demolished), with a fine farm steading.



These developments towards separating the patients into smaller groups depending on their illness, particularly as seen in the linked villas in the asylum section at Gartloch, were taken a stage further in the early years of the 20th century with the colony or village-plan asylum. The benefits of accommodating patients in smaller groups in a more home-like environment had been evident for some time, but

were usually only available for the wealthiest paying patients. Before the widespread provision of asylums, pauper lunatics had been boarded out, with a concentration of boarders in Kennoway in Fife. There had also been suggestions of establishing a colony in the Orkneys at one time. Many existing asylums began to build villas on their estates. The Crichton Royal Asylum, for example, already owned a number of domestic houses



in which it accommodated the wealthier patients together with their servants. This was taken further at the Royal Edinburgh with the creation of the Craig House complex in 1889–94 comprising two hospital buildings, three detached villas and New Craig House for central amenities such as recreation halls and dining rooms [3.6]. It was the brainchild of Dr Thomas Clouston (1840–1915), the Physician Superintendent at Edinburgh, and his architect A G Sydney Mitchell (1856–1930). They worked closely together to produce buildings which embodied Clouston's approach to treating mental illness. Variety was the keynote; and so the buildings are eclectic in style with a plethora of different details, broken rooflines and differently coloured materials. Although first enjoyed by private patients, separate villas were slowly introduced for pauper and rate-aided patients as well. Murthly Hospital, Perth's District Asylum, was one of the first to do so, with two villas being erected in 1894 [3.7].

On the continent the colony system had developed from the Belgian colony at Gheel which, legend has it, was founded in medieval times after the Irish Princess Dymphne was converted to Christianity and fled to Gheel. Her father pursued her there and beheaded her, leading to her being canonised as a martyr. Her shrine gained the reputation of curing the insane, whereupon Gheel became a place of pilgrimage for the mentally ill. Pilgrims were boarded in the village which gradually developed

into a mental colony until, during the 19th century, it was placed under the control of a Commissioner and a Board of Governors.

The success of the Gheel system led to village asylums being introduced elsewhere. They were particularly favoured in Germany, and one of the earliest to be widely publicised in Britain was Alt-Scherbitz near Leipzig, founded in the 1870s. The influential Commissioner in Lunacy for Scotland, Dr John Sibbald, was impressed by the system, publishing a paper in 1897 on 'The



**Fig 3.7 Pinel Lodge, Murthly Hospital, Perth, built in grounds of hospital, 1894.**

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**Fig 3.8 Church at Bangour Hospital, West Lothian, H O Tarbolton, 1924–30.**

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Plans of Modern Asylums for the Insane Poor' in which he gave a full description and plan of Alt-Scherbitz and recommended it as a model for future asylums in Scotland.

Three new district asylums were built around the turn of the century on this plan: for Aberdeen (Kingseat Hospital), designed by Alexander Marshall Mackenzie (1848–1933) and built in 1901–4; Edinburgh (Bangour), by Hippolyte J Blanc (1844–1917), 1898–1906; and Renfrew (Dykebar), by Thomas Graham Abercrombie, opened in 1909. The colony plan lent itself particularly well to a gently undulating site such as at Dykebar, where the villas nestled in the landscape. Bangour was perhaps the

finest of the three. A competition held in 1898 for the asylum specified the colony plan, and Blanc devised a self-contained village with its own water supply and reservoir, drainage system and firefighting equipment, that could be self-sufficient by the industry of able patients.

As at Gartloch, the site was divided into two sections for the medical and non-medical patients, with power station, workshops, bakery, stores, kitchen and laundry in the middle. The patients' villas housed from 25 to 40 patients each and varied from two to three storeys. On the ground floor were day rooms, dining rooms and a kitchen, with separate dining rooms for the nurses.

The dormitories were located on the upper floors. Another important aspect of the colony system was the replacement of the large common dining halls with smaller dining rooms within the villas. This was also a feature of Kingseat and Dykebar. Bangour's large recreation hall contained an area measuring 28 metres by 16 metres, with a stage at the north end. By incorporating a lattice steel girder support for the roof, the entire space could be opened up without the need of supporting pillars. There was even an orchestra pit in front of the footlights which was specially constructed to allow it to be covered at floor level when the hall was used for dances.

A church was added to the site in 1924–30, designed by Harold Ogle Tarbolton (1869–1947). Set in a central position on the site and in a severe Romanesque style, it is one of the most impressive hospital churches in Scotland. The dark brown stone of the church contrasts strongly with the cream-painted villas near to it [3.8]. In

**Fig 3.9 One of the buildings added to the Baldovan Institute around 1900.**

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1931 the nurses' home, with its two ogee-roofed octagonal central turrets, was extended by Ebenezer J MacRae (1881–1951) with a large new wing, blending sympathetically with the original block.

Provision for those suffering from chronic or incurable forms of mental illness or disability took longer to develop. Amongst paupers, those viewed as quiet and harmless were often housed within the workhouse alongside all the other inmates. Efforts to improve the lot of children came first from individuals. At Baldovan Institution, to the north of Dundee, the first serious attempt was made to provide education and homes for 'imbecile children' and orphans in 1852. Founded by Sir John and Lady Jane Ogilvie, in 1853 they provided a new building, designed by the English architects Coe & Goodwin who had recently won the competition to design Dundee Royal Infirmary. The asylum was a great success. The 1850s building was replaced by a handsome new hospital range erected in 1900 to



designs by J T Maclaren (1863–1948) [3.9].

More ambitious in scale was the Royal Scottish National Institution built in 1861–2 at Larbert. This evolved from a small training school for 'idiot children' run by a Dr Brodie from a house in Gayfield Square, Edinburgh, in 1855. From this the Society for the Education of Imbecile Youth in Scotland was formed in 1859 with a view to providing more suitable accommodation. Dr Brodie became the first Medical Superintendent of the new Institution, initially with just nine children transferred from Edinburgh. Now largely demolished, the new Institution was designed by Frederick Thomas Pilkington (1832–1898) in his characteristic rogue Gothic style. It comprised five distinct sections for different classes of inmates with one

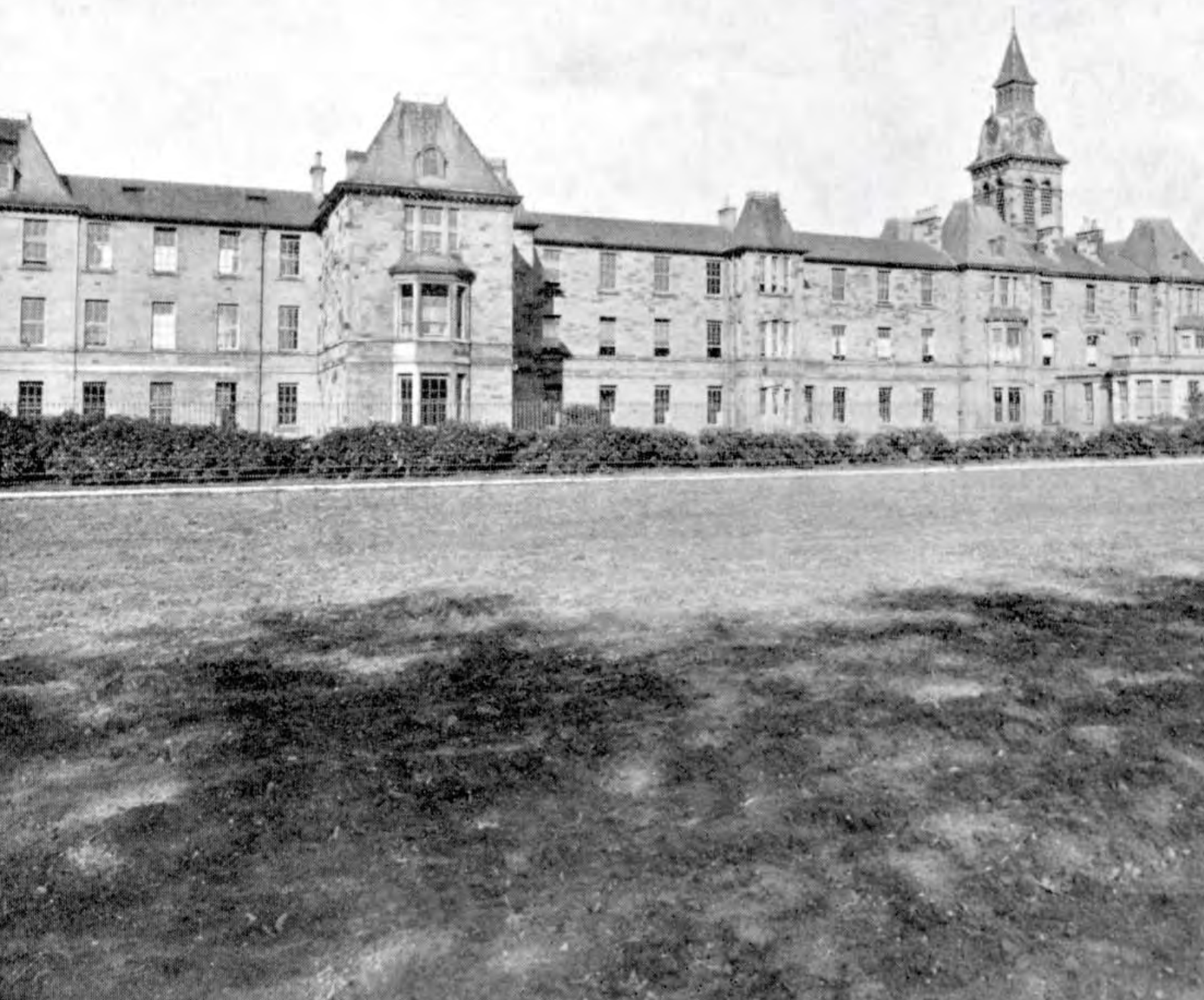
central service and administrative section.

It was not until 1913 that the Mental Deficiency and Lunacy (Scotland) Act introduced public funding for the care of mentally disabled adults. After the First World War several institutions or colonies were founded, notably at Birkwood, Lanarkshire in 1923 and Lennox Castle, Stirlingshire in 1936. Both were centred on mansion houses with extensive grounds where purpose-built accommodation was provided. Gogarburn, near Edinburgh, which opened in 1931, and Hartwoodhill, by Shotts, a development of the later 1930s, were built on the colony system, but the vast institution of Lennox Castle returned to a degree of centralisation with its two vast dining halls capable of seating 600 patients each.



**Southern General Hospital, originally built as Govan Combination Poorhouse, 1872.**

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# Poorhouses

Richard Frazer (right) and Josiah Lockhart (left) are both involved with the Grassmarket Community Project in Edinburgh. This project provides a way of helping the poor in the 21st century, and offers food and friendship, together with work and training in weaving, gardening and woodwork. As Richard notes, 'The poorhouses may have gone but the poor are still with us.'

Poorhouses were usually the responsibility of parishes, and this project echoes this pattern in that it is associated with the parish church, Greyfriars Kirk.

The problems that Richard and Josiah are dealing with

are in many ways the same as those for which the grandiose poorhouses of the 19th century were designed, although the philosophy is very different. Unlike the poorhouses, which were intended to keep the poor isolated from public view, here people are free to come and go as they wish.

The project is currently using a rented building which they have adapted as best they can for their needs, but they are planning for a new, architect-designed, purpose-built building in the near future which they hope will challenge the current poverty of expectation which associates helping the poor with mean buildings.



## Chapter 4: Poorhouses

**In the 19th century around seventy poorhouses were built in Scotland. Many of these not only housed the very poorest in society, but also offered varying degrees of medical attendance for the sick and provided some level of care for ‘paupers’ suffering from mental illness. The largest, set up in populous towns and cities, developed separate infirmaries and asylums that operated in tandem with other state provision. In their planning and design they evolved into a distinct building type, which, despite the often restricted funding, resulted in some handsome architectural responses.**

**T**he 1845 Poor Law (Scotland) Act marked the starting point of this new breed of poorhouse. Before that the poor were given assistance via the Kirk Session, but with the establishment of the Free Church after the Disruption of 1843 the old system was in tatters. Locally raised rates or assessments on the parish had been sporadically introduced in the 18th century and these became the principal way in which money was raised to relieve

the poor. In rural areas money was given directly to them. Only the large burghs and towns provided ‘in-door’ relief, in either a workhouse, a poorhouse or a hospital (the designation of ‘hospital’ was rarely connected with medical institutions, which were more usually called infirmaries). The Town’s Hospital in Glasgow was one such, partly a municipal venture, but with the involvement of both the Kirk and the city merchants. In January 1732





a committee was appointed to look for a site and to commission plans for a suitable building. In May, plans presented by John Craig (d.c.1745) and Allan Dreghorn (1706–1764) were selected – deemed to be ‘the fittest and the cheapest’. The building was plain and simple, of three storeys and attic with projecting wings at each end. It contained a large hall in which the inmates assembled for worship, a committee room and offices, as well as the inmates’ accommodation [4.1].

By the beginning of the 19th century it also housed sick and ‘fatuous’ (chronically mentally disabled) persons. Limited medical care was provided by the Glasgow College of Surgeons and Physicians, who alternated in attending the hospital. In 1840 it moved into the old Glasgow Royal Asylum building, where it remained until the early years of the 20th century.

In Aberdeen a poorhouse was established in 1739, the same year

*Fig 4.1 Glasgow Town Hospital, 1733. 19th century watercolour.*

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Fig 4.2 King James VI Hospital, Perth, 1748.

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as the Royal Infirmary. Edinburgh's charity workhouse had been established by 1742, and a poorhouse was built at Ayr in 1756.

In Perth a charitable hospital had been founded in 1569 by Royal Charter, managed by the Minister and Kirk Session of St John's Kirk. The King James VI Hospital was to provide, 'by all honest ways and means an Hospital for the poor, maimed, distressed, persons, orphans and fatherless bairns within our burgh of Perth'. The first building was

destroyed by Oliver Cromwell around 1652, and the charity seems to have lapsed until the mid-18th century. A new building was begun in 1748, the foundation stone laid by James Cree who may have provided the design. Of four storeys, and on an H-shaped plan, it has minimal classical ornament imposed on a Scottish vernacular idiom. Contrasting with this well-ordered simplicity is the oversized belfry, capped by an ogee cupola and weathervane that crowns the building. This may have been a later addition,

as there is evidence to suggest that the cupola and bell were gifted by the Duke of Atholl in 1764, having been removed from the Mansion of Nairn, to the north of Perth, which was being demolished at that time. The King James VI Hospital remained in its original use until 1812 when Perth adopted a system of 'out-door' relief only for its poor, and the hospital's medical function was taken over by the new Perth Infirmary which opened in 1838. Subsequently the building was used for various charitable purposes, including a school. It survives today, having been converted into flats in the 1970s [4.2].

During the first decades of the 19th century a series of parliamentary select committees and an enquiry by the General Assembly of the Church of Scotland considered the management of the poor. The workhouse system was ushered in to England and Wales following the Poor Law Act of 1834 and Scotland had a good ten years in which to consider its effectiveness before introducing





**Fig 4.3 Contrasted Residences for the Poor, published in A W Pugin, *Contrasts*, 1841.**

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its own legislation to reform poor relief here. Both north and south of the border, model plans were issued which, from an architectural viewpoint, graphically demonstrate the differences in hopes and aims of the two Acts. Even though the model Scottish plan was for a poorhouse considerably larger than most actually built in Scotland, it was significantly prettier than the model plans by Sampson Kempthorne (1809–1873) widely copied in England. Indeed, Kempthorne’s ‘hexagon plan’ was particularly grim, and was pilloried by A W N Pugin (1812–1852) in the 1841 edition of his book *Contrasts*. Here, pairs of illustrations contrasted Pugin’s idealised vision of medieval Britain with contemporary views. Thus the contemporary residence for the poor is in effect a prison in which the inmates endure a harsh regime, whereas the ancient poorhouse resembles a monastery, centred on a chapel, where the lives of the inmates are dominated by the Church [4.3].

Stylistically, Pugin's prison-like poorhouse was an austere near-featureless building, with a mean classical-style entrance, while the 'antient poor house' was Gothic, with lancet windows, gables, turrets and crenellations. Pugin's *Contrasts* reflects a shift in the moral consciousness of the 1840s. The second generation of workhouses erected in England eschewed classicism in favour of Gothic detailing, if only in a gabled elevation. In 1846 plans for Canterbury Union Workhouse were published in the *Illustrated London News*, and although never built, it was highly commended at the time, and appears to have formed the basis of Mackenzie & Matthews' model plan of 1847.

As in England the bulk of the poorhouses were built in a relatively short space of time, not long after the introduction of the new Act and the majority took the model plans as their starting point. In 1848 there were 14 poorhouses in Scotland, some of which had been in existence

long before 1845. Between 1849 and 1859, 19 poorhouses were built, and between 1860 and 1870 a further 30 were constructed. Only half-a-dozen or so more were built after 1870.

A typical example and one of the earlier generation of poorhouses is the Kirkcaldy Combination Poorhouse, situated between Kirkcaldy and Kinghorn. Its long, low two-storey main range punctuated by projecting gabled bays overlooks the Firth of Forth. Plans for the building were provided in 1849 by William Lambie Moffatt, a specialist in the field of hospital, asylum and poorhouse architecture. He had been a pupil of William Burn and worked in England with William Hurst (1787–1844) until Hurst's death when he returned to Edinburgh. The poorhouse follows closely the model plan, with the principal block providing the paupers' accommodation, a dining hall and kitchen centrally placed to the rear, and a single-storey range for stores. A separate infirmary was added later. By the turn of the century the Kirkcaldy

Poorhouse contained sanctioned accommodation for 130 paupers [4.4].

Most of the similarly sized rural poorhouses constructed the length and breadth of the country in the 1850s and 1860s differ little in outward appearance from that built for Kirkcaldy. Examples can be found in the Highlands, where William Lawrie (d.1887) of Inverness was the architect of the Inverness Poorhouse, built in 1859–61 (later Hilton Hospital); the Nairn Combination Poorhouse, 1860–62 (largely demolished); and the Black Isle Combination Poorhouse at Fortrose, 1856–9. Lawrie was the Inverness half of the Aberdeen firm run by James Matthews, and became a partner in 1864. Sutherland Combination Poorhouse in Bonar Bridge, built in 1863–5 (later Migdale Hospital) [4.5], is almost identical to the Inverness Poorhouse but the architect here was Andrew Maitland (1802–1894) who had earlier produced plans for Easter Ross Poorhouse, Tain (1849).

The former Upper Strathearn

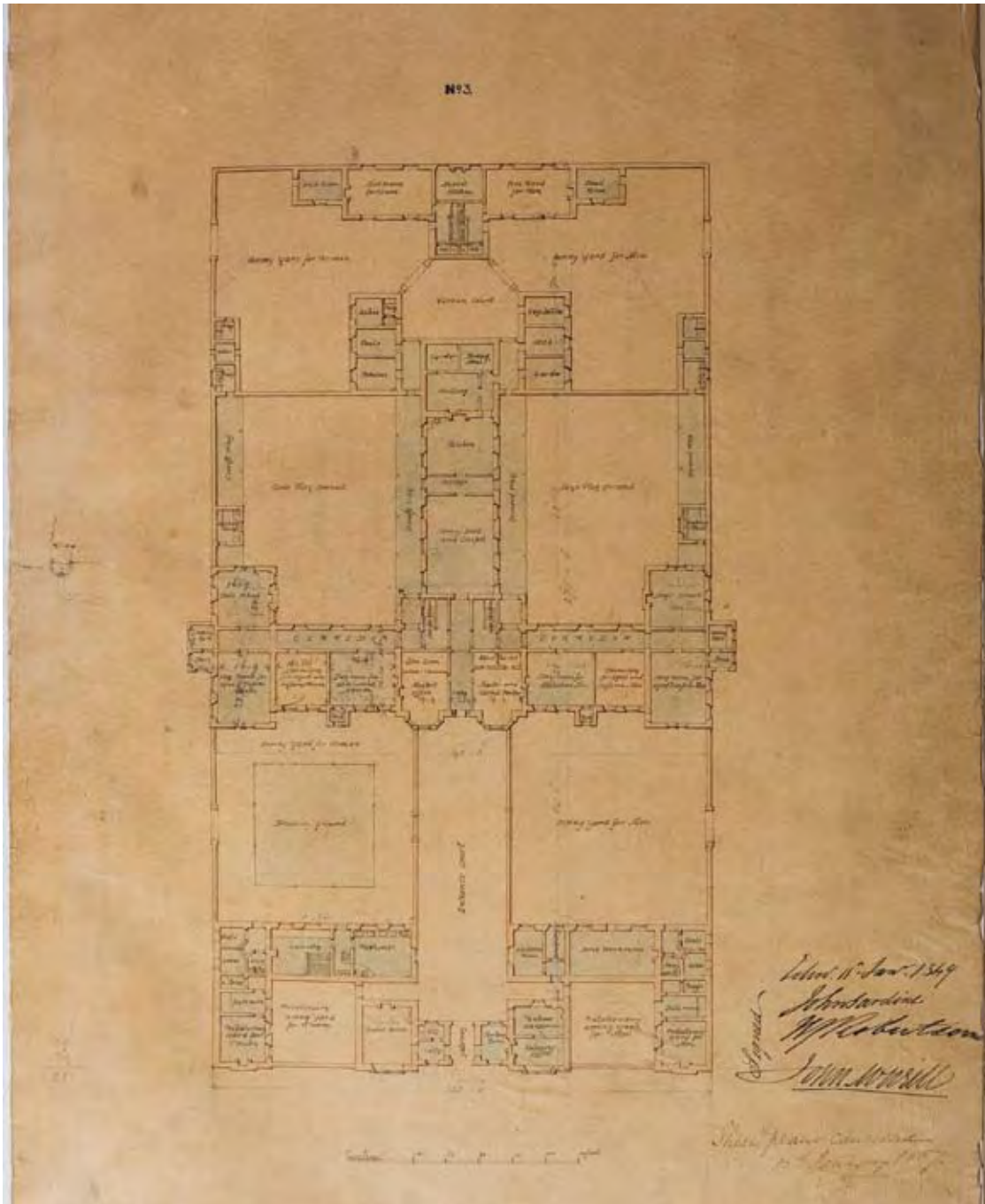


Fig 4.4 Plan of Kirkcaldy Parochial Union Poorhouse, William Lambie Moffat, 1849. SCOTLANDSIMAGES.COM/The National Archives of Scotland RHP 30864/2





*Fig 4.5 Sutherland Combination Poorhouse (Migdale Hospital).*  
© NHS Highland Archive



*Fig 4.6 Upper Strathearn Poorhouse, Auchterarder,*  
**James Campbell Walker, 1862-3.**

Poorhouse at Auchterarder in Perthshire is another good example, with a number of its ancillary buildings surviving. Built in 1862–3, though somewhat smaller than some of the Highland group, it is recognisably from the same stable [4.6]. The architect here was James Campbell Walker (1821–1888) of Edinburgh, who also furnished plans for poorhouses for Galashiels (1859), Dysart (1860), Athole (latterly Atholl) and Breadalbane (1861), Dumbarton (1862), and Islay (1865). Like William Lambie Moffatt, Walker served his apprenticeship with William Burn, who was equally proficient designing complex institutional buildings as the great country houses for which he is chiefly remembered today.

While these rural poorhouses might typically accommodate around a hundred paupers, and sometimes considerably fewer, in the densely populated urban centres the numbers in need of relief were far greater. In Edinburgh two new poorhouses were erected in the 1860s to serve the densely inhabited districts of the City and St Cuthbert's. These were large institutions, designed on a modified pavilion plan, where the different classifications of inmates were separated – not merely male and female, elderly, infirm and children, but the 'deserving' poor, or those of good character were housed separately from the dissolute, 'doubtful', improvident and vicious.

St Cuthbert's evolved from

the charity workhouse which was condemned in 1863 by the City's Medical Officer of Health. Peddie & Kinnear produced the plans for the new, much-enlarged poorhouse in 1866; surprisingly for a poorhouse it was Italianate in style, with a fine campanile gracing the entrance block. It opened in 1868 as the Craigleith Hospital and Poorhouse. In 1930 it was taken over by Edinburgh Town Council and became a municipal general hospital – the Western General.

By contrast, on the other side of Edinburgh, the City Poorhouse at Craiglockhart adopted a distinct Scottish vocabulary in the Baronial details, string courses, and crowstepped gables. Accommodating a thousand



paupers, it was built in 1867–9 and was designed by the firm of George Beattie & Sons of Edinburgh. Their principal architect at that date was William Hamilton Beattie (1842–1898), who went on to design Jenners department store in 1895. A competition had been held for the poorhouse commission, and Beattie's

design had won, his plans bearing the telling motto 'Comfort for the Poor and Care for the Ratepayer'. In the main, architectural embellishment was kept to a minimum, but Beattie produced a decorative flourish on the central entrance bay which rises to an octagonal tower with faceted, steep-pitched roof [4.7]. Like St Cuthbert's,

it replaced an earlier institution, the Edinburgh Charity Poorhouse built in 1739–43. By the mid-19th century it occupied a number of buildings on an overcrowded site at Forest Hill. The new complex was designed to have three main sections: the poorhouse itself at the centre, and on either side an infirmary for sick paupers and an

*Fig 4.7 City Poorhouse, Edinburgh, George Beattie & Sons of Edinburgh, 1867-9.*



asylum for the mentally infirm, only the first two being completed in 1869. The poorhouse section comprised five blocks linked by corridors. Centrally placed to the rear were the dining hall, kitchen and ancillary service buildings. There were separate blocks for the different classes of inmates, including departments for children that incorporated school rooms.

Comparable large-scale poorhouses were built in the west of Scotland. Glasgow's Southern General Hospital at Govan began as the new Govan Poorhouse, designed in 1867 by James Thomson (1835–1905) to replace the old premises in disused cavalry barracks in Eglinton Street. The barracks had been converted into poorhouse accommodation in 1852 by Black & Salmon, and comprised a series of day rooms on the ground floor with a double row of wards above. Ill-ventilated, with just one window, the wards mostly held 12 beds. Like Craiglockhart, the new building was designed with a central poorhouse block flanked by asylum

and hospital sections. The three-storey poorhouse was dominated by a distinctive French Renaissance-style clock tower, and has a varied roofline with pavilion roofs capped with decorative ironwork. To the south, the asylum section was of two storeys with twin square towers capped by pavilion roofs. To the north, the two-storey hospital block was designed on the pavilion plan. It was renamed the Southern General Hospital in 1923, by which time most of the beds were occupied by chronic or infirm cases. The last of the poorhouse beds disappeared in June 1936 and the hospital was handed over to the Public Health Department.

A new poorhouse and parochial asylum for Greenock was built in 1876–9 (later Ravenscraig Hospital) [4.8]. It replaced a succession of buildings which the parish had employed since 1821. Plans were drawn up by John Starforth (1822–1898) for an institution to house 750 paupers. At £122,904 it cost far more than the original

estimate, and considerably more than the poorhouses of a decade earlier, provoking a public outcry. Built of Wemyss Bay red sandstone and with Cumberland slate roofs, it comprised the usual three sections – poorhouse, hospital and asylum. Starforth, an Edinburgh-based architect, had trained with Burn & Bryce, and there is more than a hint of Bryce in the Baronial detailing of the Greenock poorhouse. Bartizans and crowstepped gables lend movement and interest to the building, particularly on the long principal elevation that faced north and stretched on for 102 metres.

In 1894 central control of the Poor Law and its buildings was taken over by the Local Government Board (LGB), which was also responsible for the control of infectious diseases. Unsurprisingly, then, the Board was keen to improve medical facilities within poorhouses. Larger urban poorhouses commonly had separate blocks for infectious cases, and even the smallest would have provided some separation. A more sophisticated



**Fig 4.8 Detail of Ravenscraig Hospital, Greenock, John Starforth, 1876-9.**

separation of the medical and non-medical functions of the poorhouse was introduced at Oldmill Poorhouse in Aberdeen (now Woodend Hospital). Designed by the local firm of Brown & Watt, it opened on 15th May 1907 and was one of the last poorhouses to be built in Scotland. It comprised two sections: the poorhouse and the hospital. The hospital section was further divided into two, with one part for infectious cases and the other for the non-infectious. The *Aberdeen Daily Journal* report on the plans for the Oldmill Poorhouse in 1901 noted that:

*As the general view of the poorhouse to most people will be from the Skene Road, a few hundred yards away, it is not intended that any expense should be put upon fine masonry details, and the effect of a satisfactory composition will, therefore, be obtained by means of the grouping of the various buildings and arranging them in such a fashion as to give a suitable yet dignified appearance to the whole.*

Surprisingly, the main poorhouse was still closely based on the 1847 model plan. It is perhaps not





*Fig 4.9 Elevation of Oldmill Poorhouse, Aberdeen, Brown & Watt, 1907.*

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insignificant that both Alexander Brown (1853–1925) and George Watt (1865–1931) had connections with Mackenzie & Matthews, the architects of the model plan. Brown had worked as an architectural surveyor for the firm early in his career at the same time that Watt was serving his articles there. The chief variation from the model plans is the addition of a tall clock tower. This elaborately decorated structure topped by a cupola housed the large water tanks. Despite its dated form, the original buildings

in sparkling grey granite form an impressive group, retaining many of their contemporary features. In the hospital block the diamond-shaped glazing patterns of the upper sashes add a dash to an otherwise severe building [4.9].

Oldmill was one of the first poor law institutions to have a separate nurses' home from the outset. This was a mark of the progress in poor law medical provision – in the early years nursing was done by the paupers.

By 1900 there was a general



realisation that the Poor Law was unsatisfactory. In 1905 a Royal Commission was appointed which, for the first time, looked into how the poor laws operated throughout the United Kingdom. The Commissioners examined the state of destitution and distress amongst the poor but were split in their recommendations, producing majority and minority reports, published in 1909. Although they could not agree on what course should be taken, they agreed on the failure of the poorhouse system, particularly to provide classified accommodation. The result had been an increasing number of mixed poorhouses, where non-medical and medical cases occupied the same standard of accommodation. Only the large urban poorhouses had fully embraced separate provision for medical cases but, as the Report pointed out, only in Glasgow had this been truly successful.

In 1904 three new hospitals for the poor opened in Glasgow – at Stobhill, Oakbank (Western District

Hospital) and Duke Street (Eastern District Hospital). Stobhill Hospital was the largest of the three, with 1,200 beds. A competition was held for the design which specified that the hospital should comprise four sections: a hospital of 800 beds with accommodation for mentally ill and epileptic cases, a children's section for 100 healthy children under five in 'separate or ordinary wards or detached cottages', a section for the ordinary infirm of 240 beds, and a section for 30 aged married couples. The competition was finally awarded to Thomson & Sandilands and the foundation stone was laid in September 1901.

The site is dominated by a giant water tower, built mainly in brick crowned with stone angle turrets and a bold domed cupola. Brick pilaster strips clasp the angles, and each face is finished with brick panels and a prominent clock. The two-storey administration block, with its richly carved stone above the entrance, has gabled end bays with mullioned-and-

transomed bay windows surmounted by carved panels. Much plainer were the red-brick ward pavilions.

The Medical Superintendent's house to the west of the administration block has quite a different character. It was designed as a charming Arts & Crafts-style domestic villa, with half-timbered gables and overhanging eaves capping the asymmetrical house.

Although the Royal Commission of 1905 had not resulted in any amendment to the poor laws, new legislation was introduced at the beginning of the 20th century which began to improve the conditions of the poor, directly or indirectly. The Old Age Pensions Act of 1908, which came into effect on 1st January 1909, introduced pensions for those over 70. Initially paupers were excluded – that is those who had been in receipt of poor relief within the past year – but this was dropped in 1911. That year also saw the National Insurance Act which introduced limited health and unemployment cover for those insured

under the scheme. These measures helped to reduce the numbers of poor seeking relief.

During the 1920s there was a discernible move towards broader municipal provision for health care. Under the Local Government Act of 1929, an attempt was made to remove the stigma of the poorhouse by changing the name to Public Assistance Institution and placing them under the management of newly created Public Assistance Departments. For the smaller rural poorhouses this made little real difference.

A major step forward in housing the poor, and in particular the elderly poor, came in the 1930s with the Crookston Cottage Homes on the outskirts of Glasgow [4.10]. Boundary changes in Glasgow resulting from the Local Government Act meant that Glasgow Corporation found itself responsible for a much larger area. This included the former Renfrew Combination Poorhouse, built in 1902 to designs by the Glasgow architects Ninian Macwhannell (1860–1939) and John Rogerson (c.1862–1930).

In 1936 William Barrie, architect to the Glasgow Public Assistance Department, prepared plans for a major development on this site to provide accommodation for the elderly, including married couples, which was an innovation long resisted by the Local Government Board. The Department of Health acknowledged the progressive step the Corporation was proposing and added a brief outline of what such a home should offer:

*An old people's home should usually be small, and the needs of populous areas should be met by multiplying the number of homes rather than by increasing the size of the institution. Such a home should be, if possible, near the old haunts of the people who are to occupy it, so that they may not feel exiled or be too far from their friends. Most of the accommodation should consist of rooms for private occupation by single people, with possibly one or more dormitories containing not more than four or five beds for inmates who prefer them or for whom they are adjudged more suitable. One good hot meal a day should be provided in a central dining room accessible*

*without exposure to the weather, but the inmates should be allowed to make their other meals in their own rooms if they so desire.*

Crookston Cottage Homes were officially opened on 8th September 1938. They comprised a symmetrical layout of two-storey blocks arranged around a horseshoe-shaped garden. There were 12 blocks each containing small flats with a living room, bedroom, kitchenette and bathroom. With the exception of dinner, residents had the facilities to make their own meals and were given rations to do so if they wished. The main building of the former poorhouse was altered to provide modern dining rooms and day rooms where the elderly could congregate to read newspapers or listen to the wireless. This was the first attempt to design accommodation tailored to the needs of elderly residents rather than for easy administration, and it became a model for subsequent developments throughout Britain.

Fig 4.10 Crookston Cottage Homes, near Glasgow, 1938.

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Opening ceremony, City Hospital, Edinburgh.

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# Infectious Diseases Hospitals and Sanatoria

Both Dr Leslie and Dr Nancie Stokoe trained in Edinburgh and worked their houseman years from 1944 to 1947.

They both vividly remember the outbreak of smallpox in 1942. A mass vaccination programme was instigated. The whole City Hospital was cordoned off to all except essential services. Dr Nancie Stokoe recalls: 'It was strictly against this rule that a senior doctor who was a family friend took me, a 4th-year student, particularly interested in public health, to see smallpox patients housed in two small stone observation cottages within the hospital grounds. Rapid renovation of the official smallpox hospital outwith the

City Hospital grounds was not complete which is why these cottages were used. I was gowned and masked and taken into one of the buildings. The experience is something I will never forget. It is a horrendous disease.' By 1979 smallpox had been eradicated worldwide.

She returned to the City as houseman in 1945. The hospital was made up of a number of separate wards linked by covered walkways, each ward catering for a different ailment. These illnesses were ones which are now much less common – diphtheria, scarlet fever and whooping cough, to name a few. Children and adults with the same condition were treated in the same ward. The

wards were positioned far apart to minimise cross-infection. 'I cycled from ward to ward along the walkways in order to save time when going to see patients.'



## Chapter 5: Infectious Diseases Hospitals and Sanatoria

Even before the identification of different infectious diseases or causes had been established, it was well understood that such cases could erupt quickly and multiply. Patients suffering from ‘fever’ – the usual catch-all for any illness considered infectious – were isolated from the healthy as far as possible. Isolation was practised at home where there was a spare room, but for the poor the early general hospitals mostly had fever wards. During epidemics temporary fever hospitals were sometimes set up in whatever accommodation could be acquired, but once the epidemic subsided, these hospitals closed. Similarly, local Boards of Health, set up following the 1831 cholera epidemic, were disbanded as the cholera abated. Ports were most vulnerable, with their influx of sailors who could bring new diseases from distant shores, and a number of temporary fever or small cholera hospitals were established to isolate sailors suspected of carrying diseases.



*Fig 5.1 Belvidere Hospital, Glasgow, photo, circa 1922. © Reproduced Courtesy of Glasgow City Archives and Special Collections*

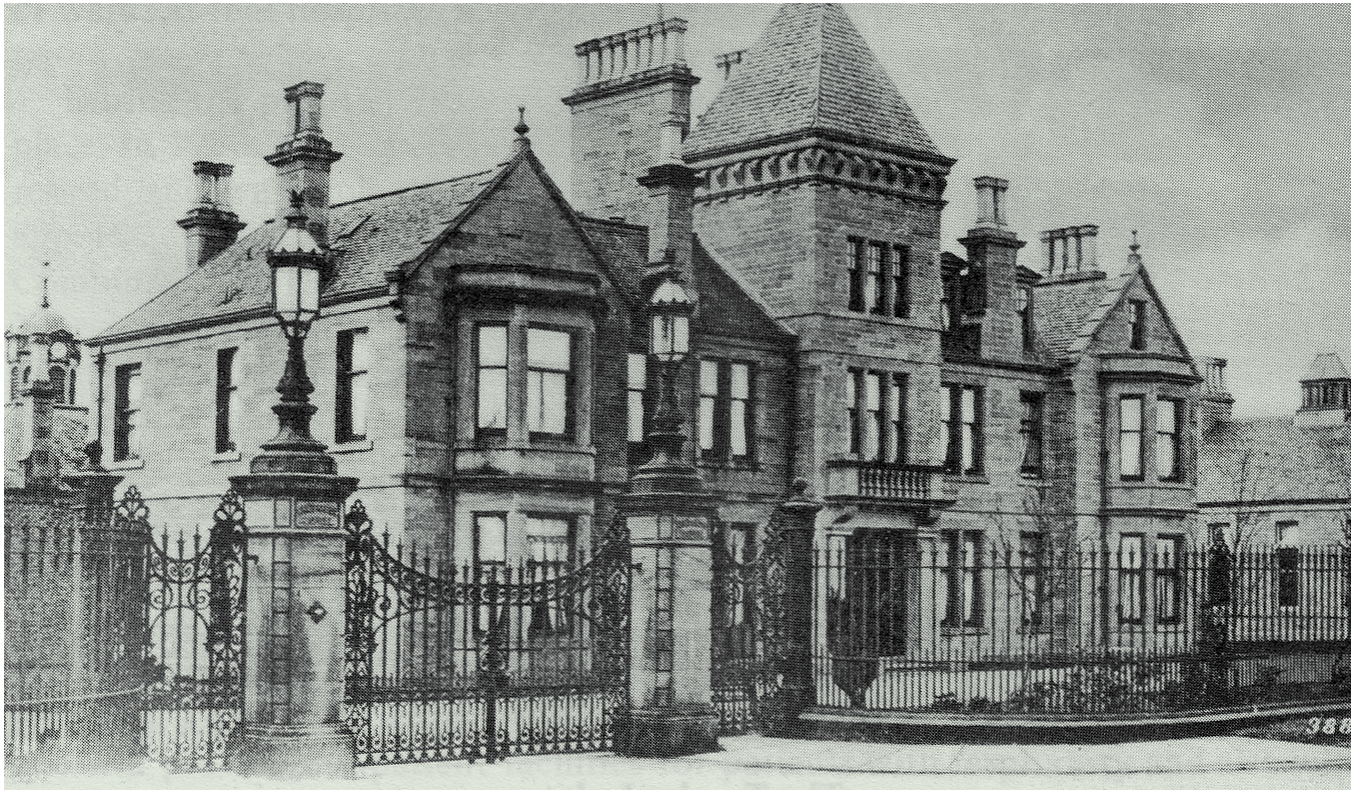
This reliance on the established voluntary general hospitals, and later poorhouses, to provide fever wards became increasingly inadequate as industrialisation got underway, seeing rising populations and greater densities of the urban poor, conditions in which infection could be rife. There was a need for more organised state intervention and a network of municipal hospitals. Glasgow led the way when the first permanent

municipal fever hospital was established in 1865 in Kennedy Street. This important first step was followed by a new Public Health (Scotland) Act in 1867 which paved the way for similar hospitals to be established throughout the country and to tackle the sources of infection – water supplies, sewers, overcrowding, filth and rubbish in the streets – and thus attempt to prevent disease breaking out in the first place. The Act also allowed Medical Officers of Health

to be appointed and for money to be raised through the rates for health purposes.

Most of the isolation hospitals built subsequently served the larger centres of population. Glasgow Town Council established a second fever hospital in 1870 in the grounds of Belvidere House, two years later building a separate smallpox hospital there [5.1]. Smallpox was one of the most readily identifiable, and most dreaded, infectious diseases. Although





**Fig 5.2 King's Cross Hospital, Dundee, William Mackinson and James Thomson, 1887-9.**

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a vaccine was discovered in the late 18th century, it was a long time before its use became widespread.

It was an outbreak of smallpox in the early 1870s in Aberdeen that prompted the Corporation to turn a disused match factory into a temporary hospital, while a permanent hospital was begun in 1874 designed by William Smith (1817–1891). Unusually it was constructed of concrete, with no wooden floors or walls, on the principle that the wards could be hosed down and

completely disinfected. It comprised four single-storey ward pavilions with accommodation for 72 patients, together with a reception block, administration building, laundry and disinfecting station. The hospital was doubled in size in 1891–5 under the City Architect, John Rust (1844–1919).

In Dundee, the Town Council provided a temporary hospital for smallpox in 1867, later extended to provide accommodation for typhus fever. In 1877 a further temporary



hospital was built to the south of Clepington Road. After abandoning the idea of establishing a floating hospital, plans were drawn up for permanent buildings on the existing site. The Burgh Engineer, William Mackinson (1833–1906), with his assistant James Thomson (1851–1927), designed the handsome new King's Cross Hospital, which was built in 1887–9. At first it consisted of just a rather grand, central administration block with two ward pavilions. The site was bounded by fine iron gates and railings of cast iron [5.2].

By the last decade of the 19th century, progress in building new isolation hospitals was disappointing, but a Public Health (Scotland) Act of 1897 transferred responsibility to the Local Government Board (LGB) and made providing hospitals an absolute requirement of local authorities. Two years later the Board issued guidelines on sites and plans for hospitals. In the years following the Act many new hospitals were built, and existing hospitals often extended or rebuilt. By this date the most common diseases



*Fig 5.3 Former Meadowside Hospital Kincaig, Alexander Cattanach, 1906.*

© NHS Highland Archive

for which isolation was necessary were scarlet fever, measles, diphtheria and enteric fever (typhoid). Smaller hospitals usually made provision for the treatment of three different diseases, while smallpox cases tended to be dealt with separate even from the main fever hospital. The number of notifiable diseases gradually increased (there were 37 by the mid-1920s), and special small isolation wards for observation and diagnosis had to be included.

The former Meadowside Hospital at Kincaig (near Kingussie) is a good example of the smaller isolation

hospitals serving rural districts. Alexander Cattanach (c.1857–1928), architect and contractor of Kingussie, produced the plans and the hospital opened in 1906 with accommodation for just 12 patients. These were plain and simple buildings solidly constructed of stone. The central two-storey administration block contained offices and matron's and doctor's rooms, together with five bedrooms, kitchen and services. Link corridors provided access to the single-storey ward blocks on either side [5.3].

By contrast the near contemporary Ruchill Hospital in



*Fig 5.4 Ruchill Hospital, Glasgow, A B McDonald, 1900.*  
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Glasgow and City Fever Hospital in Edinburgh were on a vast scale and designed with architectural flair. For Ruchill the City Surveyor, A B McDonald (1847–1915), drew up plans in 1892, Glasgow Corporation having purchased the lands of Ruchill for the joint purpose of laying out a public park and building a hospital for infectious diseases. The site was selected for its accessibility from numerous districts occupied by an expanding working class. Its position on a hill, with the park adjacent to

preserve the amenity, was chosen to ensure plenty of fresh air and sunshine to the patients, in an otherwise industrial area. It opened in 1900 with over four hundred beds in 16 brick-built ward pavilions with pleasingly shaped gables. In addition to the wards there were various ancillary buildings; an administration block which also contained the nurses' home was the only building of stone on the site [5.4]. The hospital was dominated by a lavishly ornamented water tower.

In Edinburgh the City Fever

Hospital was built in 1897–1903 to designs by the City Architect, Robert Morham (1839–1912). Of deep red sandstone, the buildings were arranged symmetrically, with two rows of two-storey ward pavilions, terminated by pairs of conical-roofed towers with sun balconies stretched between them. The hospital was originally designed to provide no less than 600 beds, and about half of these, on the west side of the central administration and service buildings, were allocated to scarlet fever cases. Usually the towers at the



*Fig 5.5 Opening ceremony, Hawkhead Hospital, Paisley, Thomas Tait, 1936.*

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ends of ward pavilions contained the patients' WCs and wash-hand basins, but here in the pavilions on the south side, the towers contained an escape stair and surgeon's rooms. This made rather better use of the sunny aspect, the WCs being more sensibly placed in a tower on one side of the pavilion about halfway along the length of the ward. The pavilions were linked at ground-floor level by a covered way, and set sufficiently far apart so as not to overshadow each other.

In the early years of the 20th

century, a major development took place in ward design that solved the problem of housing under one roof the large number of different diseases requiring treatment, some of which were difficult to diagnose. This was the cubicle isolation ward. In 1908 the Local Government Board in England published a simple plan for such a ward block with just four beds, in single rooms separated by a partly glazed partition, two on either side of a nurse's room. Small observation windows from this room allowed the

nurse to oversee the wards. Such ward blocks often formed part of larger isolation hospitals built between the wars, when improved transportation encouraged greater centralisation of hospitals. New infectious diseases hospitals of this period were often built to replace a number of the small rural hospitals.

Hawkhead Hospital in Paisley set a new standard in hospital architecture when it opened in 1936 [5.5]. The architect was Thomas Smith Tait (1882–1954), who was appointed as



*Fig 5.6 Ayrshire Central Hospital, Irvine, William Reid, 1935.*

a result of a limited competition in 1932. Tait's Modernist design could not have contrasted more strongly with the likes of Edinburgh's City Hospital in its sharp lines and cool white finish. There were six detached single-storey ward pavilions as well as a two-storey cubicle isolation block for doubtful cases, altogether providing 181 beds. On the north side of the cubicle block was an operating theatre, a relatively new requirement for such

hospitals, marking developments in the treatment of some infectious diseases such as the pneumothorax operation for tuberculosis widely practised in the interwar period.

Each of the main ward blocks was designed specifically for a different type of disease: pneumonia, diphtheria, measles, scarlet fever, whooping cough and, at the eastern edge of the site, tuberculosis. Verandas, solariums and floor-length windows maximised the



beneficial effects of sunlight and fresh air. At the entrance to the hospital was a dramatic curved gateway, looking more like the entrance to a Hollywood film set than a municipal isolation hospital. Beyond this was a porter's lodge, the administration block, nurses' home, cottages for male staff, laundry block, boiler house, and mortuary. Originally the buildings were rendered and painted white, with minimal strips of tile decoration in black, pale blue, yellow or green.

Inverurie Hospital in Aberdeenshire, which opened in 1940, and Ayrshire Central Hospital of 1941, took their inspiration from Hawkhead. Clean lines, smooth curves and flat roofs were particularly suited to the clinical ethos of a hospital. Ayrshire Central, in Irvine, is the larger of the two, designed in 1935 by William Reid, the County Architect, to replace the old, small isolation hospitals scattered over the county, and to meet the local authority's new responsibility for maternity cases [5.6]. The site was split into two halves to cater for the

disparate functions, with the isolation section opening first in 1941 followed by the maternity section in 1944.

A nurses' home occupied a central position between the two sections, and is a particularly notable example of its kind, with some good detailing such as the arcaded ground floor.

Inverurie Hospital replaced an earlier isolation hospital built in 1897. The architect R Leslie Rollo (1888–1948) drew up the plans in 1936 with advice from the Medical Officer of Health. Provision was made for 60 beds, 20 in a cubicle block of two storeys and 40 in two single-storey pavilions. These ward blocks were arranged about a square, with the nurses' home on the fourth side opposite the cubicle block. There was also an administration block with kitchen, stores and dining rooms and the usual service buildings. Space was reserved for additional pavilions if required.

Apart from the general improvement in sanitary conditions and the housing of the poorer classes,

improved methods of treatment and the discovery of new drugs led to a decline in mortality rates and the reduction of the length of time a patient needed to remain in hospital. Notably the mass production of penicillin after the Second World War dramatically reduced the need for these hospitals.

### **Hospitals for the treatment of consumption or tuberculosis**

Before Robert Koch discovered the tubercle bacillus in 1882, the cause and manner of spreading tuberculosis were unknown. Known as consumption or phthisis, it was a classless disease, striking rich and poor alike. There was no cure, though wealthy sufferers often derived benefit from mountain air, while the few hospitals that tried to treat consumptives merely offered small wards or single rooms that were often kept warm and airless. Once it had been realised that this was in fact an infectious disease, sanatoria were established which looked



**Fig 5.7 Revolving shelter at Royal Victoria Hospital, Edinburgh.**

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to the continent for methods of treatment. The discovery of X-rays in 1895 slowly improved diagnosis and attempts were made to treat the disease by surgery. Legislative changes from 1907 shifted responsibility for treating cases to local authorities. TB wards were added to isolation hospitals, asylums and poorhouses and in some areas publicly funded county sanatoria were built. Many of the first generation of sanatoria, particularly those catering for private

patients, were attractive buildings often designed with a hint of their Alpine counterparts. Planning evolved into a quite specific form, and with the early reliance on fresh air for treatment, balconies and verandas were conspicuous features.

In 1887 the first dispensary for tuberculosis was opened in Edinburgh under the impetus of Dr (later Sir) Robert Philip (1857–1939). This developed into the Royal Victoria Hospital for Consumption which

opened in 1894. The hospital was the principal element of a broader scheme for the control of tuberculosis which also included the dispensary, home treatment, education through the distribution of leaflets, and an asylum for advanced cases. It was the first co-ordinated attempt in Britain not only to treat but also to prevent the spread of TB, and was widely imitated.

At first the hospital occupied the converted Craighleith House, but from 1903 eight detached, single-storey ward pavilions were built in the grounds. Designed by A G Sydney Mitchell on a Y-shaped plan, they provided sunny and sheltered wards for the patients. Simple timber shelters in the grounds were used for open-air treatment; either rest or graduated exercise in the open air were the principal methods of treating TB [5.7].

In 1906 an administration block was built, designed in a pleasing Scots vernacular idiom by Sydney Mitchell & Wilson, with to the rear, services, kitchens and a striking Italianate dining hall, complete with campanile.

William Quarrier in Glasgow established the first hospital for tuberculosis in the west of Scotland, at Bridge of Weir. With his architect, Robert Alexander Bryden (1841–1906), Quarrier visited the Hospital for Consumptives at Ventnor on the Isle of Wight, which comprised a series of grand hotel-style villas for the patients. Something of this is evident at the Bridge of Weir Sanatorium, though on a more modest scale, with its detached ‘houses’ for the patients. Work began in 1894 and continued slowly until 1907, by which time their design was already outmoded.

After the foundation in 1898 of the National Association for the Prevention of Consumption, the Glasgow and District Branch established Bellefield Sanatorium at Lanark in 1904. Glasgow Corporation had donated £500 to the Society in 1901, the first municipal aid for work against tuberculosis in Scotland. Later the Corporation granted £5,500 towards the Sanatorium. Bellefield House had already been

used as a private sanatorium since 1895, but once it had been taken over by the National Association simple ward pavilions of wood-and-iron construction were put up in the grounds.

Open-air treatment had been developed on the continent, especially in Switzerland and Germany amid the pure air of the Alps and the Black Forest. Out of many influential figures, the work of one man in particular attracted attention in Britain: Dr Otto Walther (1853–1919). He established the Nordrach System in the late 1880s at a sanatorium in Nordrach-in-Baden. This produced a rash of similar sanatoria in Britain, such as Nordrach-upon-Mendip, and in Scotland Nordrach-on-Dee [5.8]. The latter was the first sanatorium in Scotland designed to operate on the open-air system of treatment. It opened in 1900 on a site high above the Dee in the middle of a pine forest, specifically chosen because of the favourable climate and the supposed beneficial effects of the scent of pine.



*Fig 5.8 Nordrach-on-Dee Hospital, Deeside, George Coufts, 1900. © Crown Copyright: RCAHMS. Licensor [www.rcahms.gov.uk](http://www.rcahms.gov.uk)*

It was founded as a private sanatorium by Dr David Lawson (c.1868–1952) of Banchory, who had a distinguished career, pioneering work in the treatment of pulmonary tuberculosis. It was one of the first sanatoria to use X-rays for diagnosis.

Plans for the sanatorium were

drawn up by George Coufts (c.1851–1924) of Aberdeen, for a building mainly of Black Forest timber with a central tower of Hill of Fare granite. Balconies and verandas were provided for all the rooms, facing south across the Dee. Initially there were 40 bedrooms, though later additions were





made. Each room was designed so as to admit a maximum of pure sunlight and fresh air. Windows occupied over two thirds of the outside wall space and were so arranged that they could be kept open in all weathers. Corridors and stairs were placed on the north side, and a dining hall

was situated at the eastern end. A recreation pavilion was added later near by.

In 1928 the sanatorium closed, later re-opening as a hotel under the name Glen o' Dee in 1934. During the Second World War the hotel was requisitioned by the army

and subsequently purchased by the Scottish Red Cross Society, which refitted it as a sanatorium for ex-service men and women suffering from tuberculosis. It was opened as such by Queen Mary in 1949.

Further private sanatoria were established at Kingussie in 1901, and Milnathort and Auchterhouse in 1902. As with Nordrach-on-Dee, the Grampian Sanatorium at Kingussie was founded by a medical practitioner, Dr de Watteville. It was a substantial two-storey stone building designed by the local architect and engineer Alexander Mackenzie, set amongst pine trees. Its main gabled front unusually featured arched windows, mostly in pairs, those on the lower floor reaching down to the ground. It was visited by a doctor from Leeds not long after it opened, and he was impressed by its superior sanitary arrangements as well as its position, comparing it favourably to some of the best Bavarian sanatoria. He was also delighted to discover that it could be reached from Euston or King's

Cross, without change of carriage, in less than 13 hours. In the 1930s it was taken over by the Sisters of Charity of St Vincent de Paul, and changed its name to the St Vincent's Home Hospital.

For the Dundee Sanatorium at Auchterhouse, the architect William Alexander (1841–1904) substituted wards for the more-usual single rooms – but arranged on the same principle of occupying the south front of the building with access to a balcony or veranda. This more economical plan reflected the original intention that it should be for the poor from Dundee, but despite generous bequests of the site and funds for building, it ran into financial difficulties and accepted fee-paying patients.

Aberchalder Sanatorium (Inverness-shire) was one of the earliest county sanatoria to be built, opening in 1907. It was a simple corrugated-iron and wooden structure providing 26 beds. In the same year the first municipal dispensary for tuberculosis in Scotland opened

in Dundee, attached to the Royal Infirmary there. Two years later the infirmary took over the Dundee Sanatorium, rescuing it from closure.

For the counties of Ross and Cromarty, a rich endowment from Colonel Stewart Mackenzie of Seaforth and his wife helped to provide a delightful and picturesque sanatorium on the edge of Maryburgh. Designed by Alexander Ross & Macbeth of Inverness, it opened in 1908. The patients' accommodation was in the two single-storey wings, angled southwards to maximise the amount of sunshine in the wards which also had tall and broad windows through which beds could be pushed on to the veranda. On the central two-storey block were elaborate armorials of the Stewart Mackenzies carved on the dormerheads.

One of the last sanatoria to be built in Scotland was Mearnskirk Hospital. Established by the Corporation of Glasgow's Public Health Department, the site had been



bought in 1913 and plans drawn up the following year for a sanatorium for 500 children. This was to be part of a wider scheme for the prevention and treatment of tuberculosis, but the outbreak of the First World War called a halt to building work and it was not resumed until 1921. The large complex of detached red-brick buildings was designed by J A T Houston (1878–1927) in a

neo-Georgian style that was more commonly favoured for hospitals during the interwar period than Modernism. A very pleasing ensemble was created, the buildings themselves had generous white-painted or stone dressings and the setting was carefully landscaped [5.9 and 7.2].

*Fig 5.9 Children at Mearns Kirk Hospital, Newton Mearns, J A T Houston, opened 1930. © Reproduced Courtesy of Glasgow City Archives and Special Collections*





The Royal Aberdeen Hospital for Sick Children, opened 1929.

© NHS Grampian Archives

WARDS, SICK CHILDREN'S HOSPITAL, ABERDEEN.



## Specialist Hospitals

The Royal Aberdeen Children's Hospital, where Pat Moir worked as the Sister in charge of the Accident & Emergency Department, was built in 1929. This hospital at Foresterhill replaced an older, more cramped building and comprised four wards, all single storey and each with a veranda to allow the children to be wheeled outside in their beds in fine weather. The hospital also had an operating theatre, an outpatient department and an isolation unit.

Pat is an advocate of specialist children's hospitals. 'Children are not little adults,' she says; 'they benefit from having specialist staff who can provide the treatments and drugs they require.' She also feels that caring for children in their own hospital protects them in some way from the wider world of adult wards, which can be busy and distressing places.

Pat has dealt with a great variety of accidents and emergencies over the years and remembers with affection the children she

cared for, many of whom still recognise her in the street. The environment she worked in changed over the course of her career, as play became an important part of the care given to children, and the once pristine walls gave way to ones brightly decorated with colourful murals.



## Chapter 6: Specialist Hospitals

**Although general hospitals treated and cared for a wide variety of patients, they commonly excluded certain cases, such as maternity, incurables and those with venereal diseases. There was also much debate as to whether children should be admitted. It was not long before separate hospitals were set up to cater for such patients.**

**F**or some medical practitioners a specialist hospital could offer the chance to study more effectively a particular type of disease or parts of the body – such as eyes, or ear, nose and throat. As such, establishing a specialist hospital might pave the way to fame and fortune. Other types of specialist hospital catered for distinct groups of people: women, the armed forces, French, German, Italian and Jewish communities. There were also specialist hospitals that provided alternative forms of treatment, such as sea bathing, mineral water or homeopathy. In the course of

the 20th century the movement towards founding specialist hospitals was reversed, as general hospitals, particularly the large teaching hospitals, set up their own specialist departments.

In terms of the architecture and design of specialist hospitals, they differed only in small ways from general hospitals. Often they began in converted premises, with limited accommodation for inpatients. They were almost exclusively established in the largest cities, with the most in Glasgow and Edinburgh. After maternity and lock hospitals (for venereal diseases), eye hospitals were



*Fig 6.1 Simpson Memorial Maternity Pavilion, Edinburgh, Thomas W Turnbull, 1935.*

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the earliest, responding to the rise in eye infections brought back by soldiers in the Napoleonic wars, and also to accidents sustained by granite hewers. Heavy industry may also lie behind the foundation of eye infirmaries at Greenock and Paisley in the late 19th

century. The latter, the former Royal Victoria Eye Infirmary, has whimsical 'spectacle' glazing bars.

Specialist hospitals for the connected diseases of ear, nose and throat began to appear in the second half of the 19th century, along with

a hospital for skin diseases founded in Glasgow in 1861, dental hospitals, and the Glasgow Cancer and Skin Institution founded in 1886 which developed into the Royal Beatson Memorial Hospital. There was also the homeopathic hospital in Glasgow

which began as a dispensary in 1909.

A few groups of specialist hospitals occurred in larger numbers and are worthy of separate consideration. Maternity hospitals have already been mentioned as one of the earliest types of specialist hospital to be established. Hospitals for children and women obviously link closely with these. There were also significant numbers of hospitals for ‘incurables’ and convalescent homes, often architecturally quite distinct from a standard medical building.

### **Maternity hospitals**

Perhaps the most widely established specialist hospital type, and the most enduring, was for maternity cases. The Glasgow Lying-in Hospital was the first in Scotland, opening around 1790, and set up by James Towers (d.1820), later Professor of Midwifery at the University of Glasgow. This was soon followed by one in Edinburgh founded by Dr Alexander Hamilton (c.1739–1802) in 1793. Both of these

establishments maintained links with the cities’ general infirmaries, and had been prompted at least in part by inadequate facilities there. Purpose-built accommodation for the renamed Edinburgh Royal Maternity and Simpson Memorial Hospital, designed by MacGibbon & Ross, opened in 1879 at No.79 Lauriston Place. Sir James Young Simpson (1811–1870) had been appointed Professor of Midwifery at Edinburgh University in 1840 and pioneered the use of ether as an anaesthetic in childbirth and later of chloroform, the effects of which he discovered by experimenting on himself and his assistants. He also held strong views on hospital reform and design. Unsurprisingly the maternity hospital in Edinburgh was designed ‘in accordance with the expressed views of Sir James Simpson as to what such a hospital should be’. Largely three-storey over a basement, and with an L-shaped plan, the main entrance was in Lauriston Place and led into a suite of four rooms: the dispensary, two sitting rooms (one

for the resident medical officer and one for the matron), and a delivery ward with three beds. In the wing running along the west side of the hospital there was a large ward of ten beds, with a small ward divided off at the south end containing two beds for patients and one for a nurse. A similar arrangement was followed on the first floor. The Lauriston Place building was eventually replaced by the Simpson Memorial Maternity Pavilion built next to the Royal Infirmary in 1935. The architect of this streamlined Moderne building was Thomas W Turnbull, with James Miller acting as consultant [6.1]. It too has been superseded by the new Royal Infirmary completed in 2003.

Glasgow’s early lying-in hospital proved short-lived, but was re-founded in the 1830s. Later in the century it moved to a new building in the Rottenrow, opened in 1881 and designed by Robert Baldie (c.1824–1890). A maternity hospital was founded in Aberdeen around 1893. It occupied adapted domestic buildings



until the 1930s when it moved into purpose-built accommodation designed as part of the Aberdeen's Joint Hospitals Scheme at Foresterhill.

By this time maternity homes and hospitals were on the increase throughout the country, reflecting changing legislation that placed responsibility for maternity cases and child welfare with the local authorities. Most were not purpose built, but were in simply adapted houses. Airdrie House Maternity Hospital, in Airdrie, was set up in 1919 in the Tudor-style house that had belonged to John Wilson, the MP for Falkirk. Barshaw House in Paisley was acquired by the Town Council and converted into a maternity and child welfare home in 1921, a maternity ward added to it in the 1930s. Perhaps one of the most lavish was Craigtoun House on the edge of St Andrews, converted into a maternity home by Fife County Architect, Robert Sorley Lawrie (d.1980), in 1949. The large Jacobean-style Edwardian house had been built for the brewer James



Younger in 1902 to designs by Paul Waterhouse (1861–1924) [6.2].

In addition to domestic conversions, maternity units were added to existing general and cottage hospitals such as at the John Martin Hospital at Uig on Skye. The cottage hospital had opened in 1905, designed by local architect from Portree, James A H Mackenzie, and a maternity annexe was added in 1936. Shortly afterwards it became solely a maternity hospital, continuing as such until 1964. Later it was taken over by the Youth Hostel Association. The house behind the present hostel was the original hospital.

*Fig 6.2 Craigtoun House, St Andrews, Paul Waterhouse, 1902.*

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There were also a number of separate purpose-built hospitals. Motherwell Maternity Hospital was the first large purpose-built maternity and child welfare centre in Scotland, opening in 1923. Designed by William Mair Bishop (1881–1941), it has an unassuming but attractive gable-fronted elevation to the main road. Its importance lay in providing care not only for women during childbirth, but also during pregnancy and for mother and baby after delivery, and continuing to offer treatment to children up to the age of five. There were also dental and skin clinics, plus lecture and demonstration rooms. John Wilson (1877–1959), the architect to the Scottish Board of Health, published plans of the centre as a model in an article on hospital planning in Scotland.

Other small purpose-built maternity hospitals were erected in Torphins (Kincardine O’Neil Hospital, built as a war memorial and opened in 1925); Helmsdale (General Pope Hospital, 1935); Forfar (Fyfe

Jamieson Hospital, built in 1937–9); and Dunfermline (built in 1934–6 to designs by Muirhead & Rutherford).

On a much bigger scale was the Elsie Inglis Memorial Hospital in Edinburgh. It was built in 1923–5 as a memorial to Dr Elsie Inglis (1864–1917), a pioneer in championing the cause of women doctors and in providing care for the poorer women of Edinburgh during pregnancy. She also worked with the Scottish

Women’s Hospitals movement during the First World War setting up units in France, Serbia, Russia, Corsica and Greece before her early death. The maternity hospital built in her memory was designed by Harold Ogle Tarbolton on a prime site overlooking Salisbury Crags. His plan made the most of this with its south-facing rooms and wards, some opening directly out onto a terrace [6.3].

**Fig 6.3 Elsie Inglis Memorial Hospital, Edinburgh, H O Tarbolton, 1923–5.**

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## Children's hospitals

The first children's hospital in Scotland was in Edinburgh, opening in 1860 in Lauriston Lane. At that time opinion was divided on the need for such hospitals. Florence Nightingale for one was a strong voice against. Certainly the speed and severity with which infections could spread amongst children were discouraging. Nevertheless, children's hospitals were also established at Aberdeen in 1877 and Glasgow in 1883, while the Dundee Infant Hospital began within the Royal Infirmary in 1883, moving to a house in Broughty Ferry after the First World War.

After a humble start, Edinburgh's Hospital for Sick Children was granted a royal charter in 1863 and moved twice more before its new premises in Sciennes Road were completed in 1895. George Washington Browne (1853–1939), one of Edinburgh's leading architects, produced the design of this handsome, Jacobean building. Browne adopted the accepted pavilion plan, placing a



ward pavilion on either side of the large centre block on a U-shaped layout. Many hospitals had chapels, used by staff and by patients who were able to do so, as well as by friends and relatives. Particularly poignant is the chapel here with its murals by Phoebe Traquair (1852–1936). They had been painted for the hospital's earlier home at Meadowside House and were transferred to the new building [6.4].

A country branch for chronic and convalescent cases was built at Gullane in 1906–9. Simply designed by Robert Lorimer, it had just two wards with 12 beds in each.

In the interwar period, legislation encouraged concerted

*Fig 6.4 Phoebe Traquair painted mural in chapel at Royal Hospital for Sick Children, Edinburgh, 1885–6.*

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*Fig 6.5 Children basking in the sun at the Princess Margaret Rose Hospital, Edinburgh.*

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efforts to improve the health of young children, a movement that went hand in hand with improved maternity and antenatal care. One area that required more specialist institutions was the treatment of crippled children, whose disability was most commonly caused by the non-pulmonary form of tuberculosis which attacked the joints. There was no known cure, treatment usually following that for pulmonary TB and comprising prolonged exposure to fresh air [6.5]. Sunlight, too, was

found to be beneficial. Surgical intervention was first popularised on the continent in the 19th century but was only really widely accepted here once X-rays and antiseptic surgery had become more current after 1900. The earliest and best-known hospital in Scotland, originally set up to treat crippled children, was the Princess Margaret Rose Orthopaedic Hospital at Fairmilehead in Edinburgh. It was built in 1929–32, designed by Reginald Fairlie (1883–1952), with wards that were completely open at the south end.

### **Women's hospitals**

The late 19th century saw the debate about women's education and training as doctors reach new heights, and a handful of women's hospitals founded from around that time offered either treatment of conditions commonly suffered by women, or treatment by an all-female staff. These perhaps have greater interest for their place in medical history than in the development of hospital architecture and design.

Of the latter type, Bruntsfield





**Fig 6.6 Royal Samaritan Hospital for Women, Glasgow, Macwhannell & Rogerson, 1895.**

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Hospital in Edinburgh is inextricably linked to two of the most influential women doctors Sophia Jex-Blake (1840–1912), the first female general practitioner in Scotland, and Elsie Inglis. Jex-Blake opened a Provident Dispensary for Women and Children in 1878 which expanded to take inpatients in 1885. When she retired in 1899 the hospital moved into her former home, Bruntsfield Lodge. In the same year Elsie Inglis and the Medical Women's Club opened a small hospital later known as the Hospice, and this amalgamated with the Bruntsfield in 1910.

Redlands Hospital in Glasgow also operated as a hospital for women run by women doctors. It started in 1902 as the Glasgow Women's Private

Hospital in West Cumberland (now Ashley) Street in a converted house, and moved first to Lynedoch Place and then to Redlands House in 1924.

The earliest purpose-built women's hospital was also in Glasgow: the Royal Samaritan Hospital for Women. This specialised in obstetrics and gynaecology, and began in a converted house in 1886. The new hospital designed by Macwhannell & Rogerson in 1895 was deliberately domestic in character, recognising the beneficial effects of familiar surroundings on the patients [6.6].

Similarly domestic in style was the new building for the Dundee Women's Hospital, designed by the architect James Findlay (1866–1943) and his chief assistant David Smith

(c.1878–1938) and opened in 1915. Set on rising ground near Victoria Park, the main front faced south with views towards the Tay and featured a sheltered veranda with balcony above. This pleasing red-brick and harled two-storey hospital replaced a converted house in Seafield Road, which itself had replaced a dispensary set up around 1891. The aim of the hospital was to treat diseases 'peculiar to women' and to offer treatment by women doctors.

### **Incurables**

The earliest attempts to provide hospitals for those suffering from incurable diseases came in the second half of the 19th century, with the first of such a kind founded in Aberdeen

in 1857. Others followed in the 1870s with the establishment of the Edinburgh Association for Incurables and the Scottish National Institution for the Relief of Incurables, both in 1874. For the latter, Broomhill House at Kirkintilloch was purchased and opened in 1876 for adults and children. It was substantially added to in the following decades. A cottage home for incurable consumptives built in 1904 and named the Lanfine Home amalgamated with Broomhill as late as 1960 under the National Health Service.

Hillside Hospital in Perth was founded in 1876, gradually expanding into larger premises, and also including a sanatorium; while in Dundee a home for incurables was first established in 1878. At the turn of the century Balgay House – then on the outskirts of Dundee – was turned into the Royal Victoria Hospital for Incurables, to which a cancer wing was added a few years later. Comfortable domestic surroundings were key features of this type of

hospital, where the priority was to keep the patients comfortable and free from pain. For those able to get about there might be pleasant garden grounds, sitting rooms, and even smoking rooms.

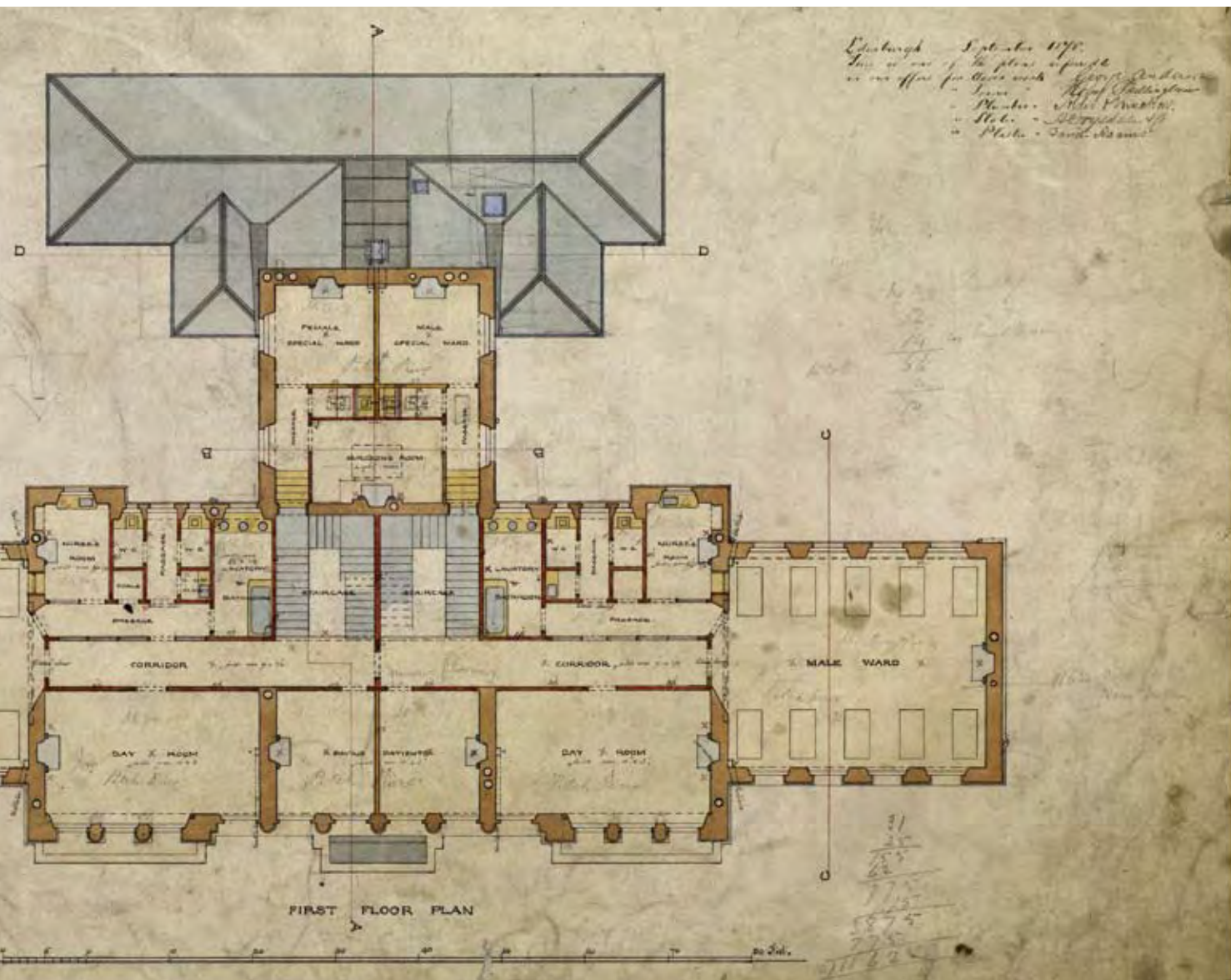
This can also be seen in the few purpose-built hospitals for incurables, a fine example of which is the former Longmore Hospital, the first part of which was built in 1880. The Hospital had been founded by the Edinburgh Association for Incurables and first opened in 1875. Generous funds left by J A Longmore allowed the new hospital to be built on the existing site in Salisbury Place. Plans were drawn up by John More Dick Peddie (1853–1921), who designed an imposing, classical-style building with a long, elegant frontage. As money permitted, additions were made. Within the hospital there was a mix of relatively small ten-bedded wards for the poorer patients in the side wings and more commodious rooms for paying patients in the central block [6.7]. It closed circa 1990 and since



Fig 6.7 First-floor plan for Longmore Hospital, Edinburgh, Kinnear and Peddie, 1878. Shown as originally built.

© RCAHMS (Dick Peddie and McKay Collection).

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*Fig 6.8 Schaw Convalescent Home, Bearsden, James Thomson, 1891.*

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1994 has been given a new life as the headquarters of Historic Scotland.

### **Auxiliary hospitals and convalescent homes**

As the pressure on beds steadily rose in the later 19th century, with ever-increasing numbers of patients seeking or requiring admission to hospital, one way to free beds more rapidly was to move patients not quite ready to go back to their own homes out to a place where they could convalesce. Most of the larger voluntary general hospitals went down this route, setting up convalescent homes, often on the edge of or outside the town so that the patients could benefit from fresh, clean air.

As might be expected, these were less institutional buildings, not unlike those for incurables, though here the patients were on the road to recovery. Some were in converted houses, or began that way – such as the Glasgow Royal Infirmary's, which originally opened in a rented house in 1866 – but most were purpose built. Lenzie Hospital was built in 1871 to replace the rented houses for Glasgow's Royal Infirmary, while Corstorphine Hospital was built as a convalescent home for the Edinburgh Royal Infirmary, opening in 1867. The latter was the more splendid architecturally, a fine Italianate building designed by the stalwart hospital architects Peddie & Kinnear. As originally built,

the home followed a similar plan to the infirmary with Nightingale-style wards. This was common for the earlier generation of convalescent homes. Later, smaller wards were preferred, together with day rooms and other more home-like spaces that could benefit patients not confined to bed. Early on, alterations and additions to the Corstorphine Hospital included an arcade (now obliterated by later alterations) which provided shelter on the ground floor and a terrace above. This allowed the patients to enjoy the fine views southwards, making the most of the splendid elevated situation of the building.

A similar story can be seen in Glasgow, where the Royal Infirmary's first convalescent home was a very plain affair, and contrasts vividly with its second home built twenty years later. Marjory Shanks Schaw gave an impressive £40,000 to build the new home in memory of her brother. James Thomson (1835–1905) had been the architect of the Lenzie home, and he also designed this building.



The Schaw Convalescent Home is riotously Gothic with a soaring tower at the centre, and contained a mix of small wards or dormitories and some single rooms, with sufficient space for about fifty patients. There was a central dining hall, recreation or day rooms, a smoking room for men and a large workroom for women as well as plentiful accommodation for the staff [6.8].

More than two dozen convalescent homes had been established by the end of the 1930s. In addition to those built by hospitals were a few that were set up by charities or societies including the Co-op (Abbotsview Convalescent Home at Galashiels) [6.9] and the Scottish Rural Workers' Friendly Society (Alderston Convalescent Home at Haddington).

There was also a railway workers' home at Blair Lodge on the Isle of Bute, which opened in about 1924–5. The miners, too, were particularly well organised in terms of welfare and health-care provision – a reflection of

their dangerous working conditions. Blair Castle, at Culross, was bought by the Fife Coal Company during the First World War to acquire mineral rights but was later given to the local welfare committee as a convalescent home, opening around 1927. At about the same date on the other side of the country in Ayrshire, another key mining area, a home was established at Kirkmichael House.

Functioning alongside convalescent homes, and often with a convalescent element, were a few auxiliary hospitals set up by some of the larger general hospitals. Philipshill Hospital at East Kilbride was a good example, built in the 1920s to serve the Victoria Infirmary in Glasgow.

*Fig 6.9 Abbotsview Convalescent Home, Galashiels, 1935.*

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# Architecture and Health in Post-war Scotland

The streamlined Canniesburn Hospital in Glasgow was designed by James Miller in the late 1930s and was built as an auxiliary hospital for Glasgow Royal Infirmary. The hospital closed in 2003 and was converted into housing in 2006 by the Glasgow architectural firm, Holmes Partnership.

Architect Douglas Jack worked on the project. Whilst there were the usual tensions between economics, planning requirements and maintaining the historical character of the building, it was, for him, an enjoyable experience.

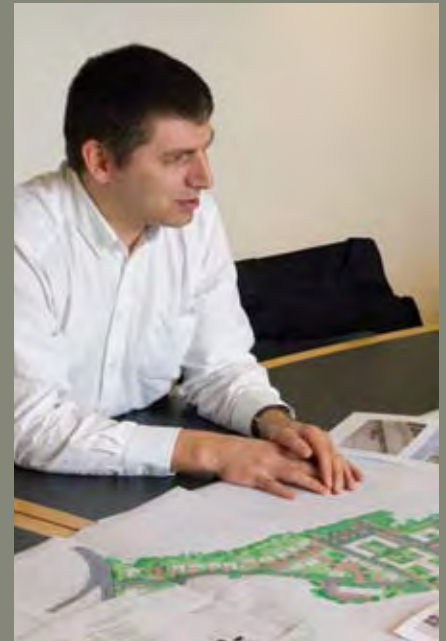
‘You are creating a community with a large hospital site like this. You have a number of buildings to work on and you also have to create the spaces in

between, working to establish pleasant pedestrian areas whilst managing the vehicle traffic.’

The overall design strategy of the project was to create courtyard spaces at each of the three original hospital blocks. To achieve this, new flats were designed to face the original buildings and enclose landscaped areas for recreation.

For Douglas, the visual integrity of the buildings was an important aspect of his vision for the project. Most of the original buildings have the clean lines of the Modernist style and this presented some challenges: the original Crittall windows, for example, had to be replaced in a way which would respect the striking horizontal emphasis, and the roofline had

to retain its original form. Now residential, Canniesburn continues to make a positive statement in Bearsden, anchoring the rich history of the area.



## Chapter 7: Architecture and Health in Post-war Scotland

**Hospitals and infirmaries are very often prominent – in every sense – within a community and beyond. They have an important place in the public consciousness. This presents particular challenges in relation to both the design of new facilities, and the question of what should be done with hospital buildings that are no longer considered suitable for their original use, due to scientific developments or changing attitudes to health care.**

**F**rom the 18th century, hospitals have been thought of as ‘state of the art’, purpose-built laboratories of well-being, their form and layout responding quickly to advances in technology, discoveries about infection and its control, and more theoretical ideas relating, for example, to grouping of conditions and their treatment. Broadly, by the beginning of the 19th century, their function had shifted dramatically

from places of last spiritual resort for the sick and dying to centres of hope for physical cure and recovery and, eventually, for bringing new life into the world. But what was perceived as the best form of treatment or patient accommodation in the 19th century is not necessarily viewed in the same way today. New research and developing social attitudes have informed the design of many pieces of exceptional hospital architecture





*Fig 7.1* Remnant arch of Rottenrow Maternity Hospital, Glasgow, demolished 2001.

in the post-war period. They have given us something of a dilemma: must hospitals simply be condemned to demolition when their original use has expired, wiping out not only the architecture but also the personal narratives associated with them; or can new uses be found so that they can be preserved for future generations?

### **Converting to conversion**

Glasgow Royal Maternity and Women's Hospital was one of the most celebrated in the city, on an

elevated, airy site high above the centre. The simple word 'Rottenrow' – the street on which it was located from the 1860s onwards, which was soon adopted as a nickname for the hospital – still means a great deal to thousands of people whose parents, brothers, sisters or they themselves were born there. In 2001, when the hospital moved on, the buildings were demolished (with commemorative pieces of rubble selling at £10 apiece) and GROSS.MAX landscape architects converted the site for

Strathclyde University to a garden/stepped public square with the surviving portico of the famous hospital preserved as an architectural feature. The whole project generated huge public interest and the resulting space reminds us very strongly of the power of place, architecture, and memory. It could hardly be thought of as a conversion and yet, although almost completely demolished, the huge complex of 19th-century buildings seem somehow almost present on the site [7.1].

The ambivalent yet powerful attitude to hospitals has played an important part in thinking about their future leading up to and following 'decommissioning'. Demolition at Rottenrow was a very public act, a kind of celebration of what the



*Fig 7.2* New and old buildings at the former Mearnskirk Hospital, Glasgow, converted 1999.

hospital had been and would continue to be in its new location at Glasgow Royal Infirmary. The alternative to demolition, of course, is reuse and renewal, and this section of the book demonstrates through examples that conversion can and does work. By retaining and reusing important historic buildings we honour the work of the architects, the clients, and the culture that produced them and we

also pass these irreplaceable assets on to future generations.

When the trend for conversion of redundant listed buildings began in earnest during the late 1970s and early 1980s, hospitals were among the last building type to be considered in Scotland. There had been some fairly large-scale hospital conversions in England, but these were mainly in rural locations and

therefore perhaps less challenging for the property market, since they were often set in country house-style designed landscapes or in protected suburban locations. Larger-scale, multi-apartment historic building conversions in Scotland have tended to be part of wider urban regeneration projects, and the building types most commonly converted in this way have been warehouses or other industrial structures. The idea of converting listed buildings was fully accepted within a fairly short time. The scale of conversion of industrial buildings – such as the former jute mills in Dundee or the bonded warehouses of Speirs Wharf in Glasgow – was quite remarkable and created vibrant new communities. The question now was: could this approach be extended to hospitals?

From the early 1980s, more or less all surviving listed buildings going out of their original use were considered for conversion. Some very successful schemes emerged, but a certain nervousness around the residential

conversion of hospitals persisted. However, even within the scope of the hospital building type some presented fewer ‘image’ problems than others. Big urban hospitals appeared to be the biggest challenge. The Royal Alexandra Hospital in Paisley, designed in 1900 by Thomas Graham Abercrombie, is an instantly identifiable ‘infirmery’ type with central core and radiating, balconied wings [1.10]. It was something of a showpiece near the centre of town: stone built and elaborately detailed. During the early 1990s, some of the main buildings were converted to flats while the remainder of the complex became a nursing home. Some new ‘enabling development’ (new buildings erected within the grounds to fund the conversion) was also put up between the hospital and the main street. In this way, the future of one of Paisley’s superb collection of late-19th/early-20th-century public buildings was assured. It was a bold step, taken at a time when the market for residential hospital conversions had

not been fully tested.

Around the same time, J A T Houston’s neat and compact complex at Mearnskirk Hospital, Newton Mearns, East Renfrewshire, was more promisingly located on the edge of an existing suburban community. In this case, there was a collection of very attractive ‘Wrenaissance’-style (evoking the work of Sir Christopher Wren (1632–1723)) buildings originally designed as a children’s tuberculosis hospital by Glasgow Corporation in the 1930s. In the 1990s, the site was sold to developers, who built 261 houses and 107 flats. Six of the listed buildings were converted for residential and two for community use. The hospital administrative unit was redeveloped as Hazeldene Nursery School, and another building was redeveloped as a long-term continuing care hospital called Mearnskirk House. John Dickie Homes won a Civic Trust Award in 1999 for the development of the former nurses’ home, now named Southwood Place [7.2].



*Fig 7.3* The Rutherford/McCowan Building at the University of Glasgow Dumfries Campus; part of the former Crichton Royal Hospital.







One of the most successful and wide-ranging hospital complex conversions has been at the Crichton in Dumfries. In this case the uses were business and educational, with some associated hotel provision. Set in a designed landscape on the edge of the town, the Crichton was developed from 1834 through the bequest of Elizabeth Crichton as a ‘lunatic asylum’, although, appropriately enough, the initial intention had been to create a university. The first asylum building – still in use as a hospital – was designed by William Burn, opened in 1839 and much extended. Over time, the site was added to with buildings of various dates and functions, including the Crichton Memorial Church by Sydney Mitchell & Wilson (1890–97) and many villa-planned patient blocks. The award-winning conversion of part of the site for Glasgow University’s Dumfries Campus has creatively mixed the old and the new, adding value to both [7.3].

Canniesburn Hospital was designed in the 1930s by James Miller as an auxiliary hospital for Glasgow Royal Infirmary and built in stages. The design is sweeping, streamlined and ocean liner-inspired, like many buildings of the period. The complex sat in a similar position to Mearnskirk, on the edge of the city of Glasgow, in Bearsden, Dunbartonshire, but was gradually surrounded by suburban development. The conversion to flats, along with ‘enabling development’ has been very successful, preserving and conserving the hospital buildings and giving them a bright new future as a thriving residential community.

Hawkhead Hospital was a contemporary of Canniesburn’s, designed by Thomas Smith Tait in the 1930s for his native town of Paisley. The infectious diseases hospital complex with its separate nurses’ home, isolation unit, boilerhouse and wards was built on a grandiose Beaux-Arts plan similar to Tait’s 1938 Empire Exhibition in Bellahouston Park, Glasgow. Medical discoveries

soon rendered Hawkhead’s plan obsolete and it was adapted for other medical purposes. Over time, the hospital gradually became surplus to requirements and finally fell into a state of disrepair. Sold to housing developers, the entire complex will be converted by the Burrell Company with architects Elder & Cannon to 131 flats and houses, with new build on the north of the site adjacent to existing development. However, the individual single-storey hospital wards were found too difficult to convert, and consent was given for their demolition and replacement with high-quality new build that respected the formal layout of the original hospital. In this case the presence or, again, ‘memory’ of the listed buildings has informed an inspiring new design.

There have been several other conversions (or planned conversions) of hospital complexes on the outskirts of Scottish cities. Leverndale Hospital (originally Govan District Asylum) in Renfrewshire, whose buildings have partly been converted to residential

accommodation with some remaining in health use, has also seen enabling development of housing in its former grounds. The former City of Glasgow District Asylum at Gartloch, a superb setpiece complex of architecturally exuberant buildings to the north-east of Glasgow (Thomson & Sandilands, from 1889) has, since 2003, been undergoing full conversion to residential use within a planned new community [7.4]. The complex sits in rolling countryside, clustered around the Bishop’s Loch, a Site of Special Scientific Interest.

Most of these out-of-town sites were built in a closely organised cluster, dominated by a central hall containing administration offices, board rooms and a large assembly hall and/or chapel. They were generally given a grandiose architectural treatment, typically with a tower or twin towers to broadcast their existence and function widely beyond their immediate setting. Not all of these complexes have survived in a condition which would permit



*Fig 7.4* Former City of Glasgow District Asylum, Gartloch, converted from 2003.



*Fig 7.5 Former City Hospital, Aberdeen, converted 2004.*

conversion. Woodilee at Lenzie, designed in phases as a mental hospital by the Salmon dynasty of architects and well known to commuters on the Glasgow–Edinburgh railway line, has lost its central hall and chapel. Rather forlornly, two wings of the missing block remain and are to be incorporated as managed relics within a housing development at the site, another example of a fragment standing as a monument to a lost institution. There are other historic hospital complexes which, clearly, will not survive decommissioning. However, there are many examples, as we have seen, that demonstrate how,

if conditions are favourable, we can creatively conserve and reuse the huge cultural resource that is our surviving health estate.

In 2004 the City Hospital, Aberdeen – which had been built near Aberdeen Beach in 1874–7 by William Smith as an Infectious Diseases Hospital and extended and enlarged by John Rust in the early 1890s – was partly converted to flats. The slightly out-of-town, seaside location made it an attractive proposition for buyers [7.5]. Similarly, a peaceful rural location near Aberdeen, Kingseat Hospital at Newmachar was designed on a

continental village hospital system by Alexander Marshall Mackenzie and opened in 1904. As a self-contained community set on its own, there are similarities with contemporary institutions such as Gartloch or Woodilee, but these harked back to the older idea of a grandiose central building complete with board room and central hall set in a landscape with lesser wards and ancillary structures. Kingseat has more of a ‘village’ atmosphere, similar to Bangour Hospital near Edinburgh, but using ‘villas’ on a segregated system according to age, sex and disorder. The hospital closed in 1994, but this beautifully built and maintained surviving complex was recognised as a major heritage and community asset and a mixed, sustainable development is being created, with converted listed buildings and new build providing community facilities and a district heating system.

Many of these conversion schemes have natural advantages such as a suburban location near an existing





*Fig 7.6 Quatermile development, former Royal Infirmary of Edinburgh, conversion started 2001.*

settlement, flexible buildings or an open layout which lends itself to the much-desired ideal of community. However, the principle of converting and reusing big, city hospital buildings was greeted sceptically at first by some. The Royal Infirmary of Edinburgh is a complex site centred around David Bryce's superb main block and pavilions, designed in the 1870s. To this initial group were added several significant buildings, including Sydney Mitchell & Wilson's Queen Anne-style

Nurses' Homes (1890–2) and the same firm's Ear Nose and Throat Hospital (1900). The Quatermile development, begun in 2001, seeks to retain and restore most of the surviving buildings (nine listed buildings) on this large brownfield site while introducing new development in the form of offices, shops, flats and leisure outlets. Bryce's romantically detailed pavilions seen from the Meadows above the tree line are now dynamically contrasted with Foster & Partners' shimmering glazed

towers. The success of the project has demonstrated the significant cultural and economic value of these historic assets whose form and function has played such an important part in the life of the city. A familiar scene has fundamentally changed, but the creation of the new quarter has provided a new destination and a new community in the heart of the city [7.6].

Quatermile is one of the most ambitious privately funded



*Fig 7.7 Former Edinburgh Hospital for Incurables, Longmore House, Edinburgh, converted 1993-4.*

developments ever attempted. At the other end of scale – individual hospital buildings set within a city – there have been some interesting conversions, often hardly noticed. Historic Scotland’s conversion of J M Dick Peddie’s 1882 Edinburgh Royal Hospital for Incurables (Longmore House) in 1993–4 as a headquarters building was intended as a demonstration project [7.7], and there have been several other examples

throughout the country including Glasgow’s Duke Street Hospital (Alfred H Tiltman (1854–1910) of London, 1904) which was converted to offices and housing by Cooper Cromar in 2000.

Conversion of 19th- and earlier-20th-century hospitals is one thing. Mostly historicist in style, the function of these hospitals was to a large extent masked by their stylistic dress. In designing Donaldson’s Hospital in 1841 (confusingly a school, and not a medical hospital, in the manner of George Heriot’s or George Watson’s), the architect William Henry Playfair (1790–1857) wrote that he wanted to create a place ‘where Henry VIII might have met Anne Boleyn’. Conversion of such a block to residential use has its challenges, but the historical romantic architecture of the block is strongly in its favour. After the Second World War, there were no such historical references to the architecture of the past. Everything was to be bright, modern and, above all, scientific.

### Post-war hospitals

With the creation of the National Health Service in 1948 came a massive expansion in hospital building. This was a key part of what Jack Coia (1898–1981), one of Scotland's leading post-war architects and founder of Gillespie Kidd & Coia, had called the 'crusade' of new Scotland. Health was an area, perhaps more than any other, where Modernism in architecture would equate directly with improvement. It was no coincidence that in the 1930s the influential Modernist émigré Berthold Lubetkin (1901–1990) had chosen a 'health centre' (Finsbury Health Centre, London, 1938) – itself a new concept – to demonstrate visually what he felt was the absurdity of dressing up modern facilities with pompous, historicist architecture. Here was an opportunity for form to follow function in a science-based way. Scotland had already experimented widely with a rationalist approach to hospital architecture in schemes such as Hawkhead, Ayrshire Central

and Canniesburn, but to some extent the older concerns with hierarchy, symmetry and composition were still evident. After the Second World War, when so much hope rested on new facilities and infrastructure, new hospitals began to appear which seemed at the same time scientific, glamorous and functional. The first of the new general hospitals in Scotland was at Vale of Leven, Alexandria, designed by Keppie Henderson & Gleave (1952–6). As with new university planning, the new hospitals focused on open-ended planning, allowing for expansion on a 'campus' basis.

The general shift in hospital design after the Second World War was away from 'pavilions' for controlling infection and towards compact blocks, often multi-storey, on a large urban scale with centralised services on a 'racetrack' plan. The first of these was Bellshill Maternity Hospital, designed by Gillespie Kidd & Coia (1959–62) [7.8]. The type proved successful and, following an

experimental prototype at Falkirk Royal Hospital (designed by Keppie Henderson & Partners in association with a team from the Scottish Home and Health Department, 1963–6), the multi-storey hospital block was rolled out across the country at Gartnavel General Hospital (Keppie Henderson & Partners, 1968–73), Aberdeen Royal Infirmary at Foresterhill (Charles C Wright, from 1964), and the hilltop 'citadel' block of Inverclyde Royal Hospital (Boswell, Mitchell & Johnston, 1977–9). Similar blocks were built at Glasgow's Western Infirmary (Keppie Henderson & Partners, 1965–74) and at Glasgow Royal Infirmary (Spence, Glover & Ferguson, 1971–82).

Ninewells Hospital in Dundee (Robert Matthew, Johnson-Marshall & Partners (latterly RMJM), begun 1961, completed 1974) represented a continuation of the campus principle. With no big central unit, the blocks were designed to achieve separated functions along a central service core. The huge Crosshouse Hospital near

Kilmarnock, Ayrshire (built as North Ayrshire District General Hospital to designs by Boissevain & Osmond, from 1968) followed a similar pattern. Sitting on a wide plain with sparse development nearby, Crosshouse presents an imposing image.

In terms of noteworthy individual health-care buildings, Peter Wormersley's (1923–1993) Nuffield Transplant Unit at the Western General Hospital, Edinburgh (1963–5) stands out as an early concrete 'sculptural' block, international in flavour. However, the same architect's Group Practice Surgery at Edenside, Kelso (1967), with its clustered layout of harled buildings, focused much more on the locality, pointing to an awakening interest in the vernacular.

More recently, the five Scottish Maggie's Centres for people affected by cancer were commissioned from some of Scotland's and the world's most acclaimed architects: Edinburgh, Western General Hospital (Richard Murphy, 1996); Highlands, Raigmore Hospital, Inverness (Page & Park,

2005); Glasgow, Western Infirmary (Page & Park, 2002); Dundee, Ninewells Hospital (Frank Gehry, 2003); and Fife, Victoria Hospital, Kirkcaldy (Zaha Hadid, 2006). Clearly, the exuberant architectural form and layout of these important centres has been closely linked to their success as uplifting places.

After recent years of cost-driven commodification of hospital design – which has been criticised in some quarters – inspiring design is once again on the agenda, achieved through a restructuring of the procurement process. Reiach & Hall's New Stobhill Hospital (begun 2006) makes a strong but not overpowering architectural statement with a central atrium/'street' flooded with light and offering clear access to services. Archial's Plein Street Centre for Health and Care (2008) is a compact version of this approach. In contrast, Austin-Smith:Lord's new Community Hospital at Girvan, with its brightly clad, jutting frontage, will be something of a landmark

building for the town. The greatest challenge and opportunity of all, however, will come with the New South Glasgow Hospital, a massive complex on the site of the Southern General Hospital costing £600million and accommodating 30,000 people on a daily basis. NHS Scotland's recent publication, enabled by Architecture and Design Scotland, *A Vision of Health* (2009), puts design at the heart of new architecture, the aspiration for which is 'a level of care and thought which conveys respect'. The new approach hopes to avoid both imposing grandiose design solutions and construction-orientated buildings where architecture in the traditional sense has been given a low priority. Keppie's new Maternity Unit at Crosshouse Hospital, with its figure-of-8 layout, builds on that firm's long association with hospital planning. Less imposing now than the confident slab blocks of the 1960s and 1970s, the new building responds to its local context, mediating between the existing large hospital, to which it





Fig 7.8 Bellshill Maternity Hospital, Gillespie Kidd and Coia, 1959–62.

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acts as a bookend, and nearby housing where its scale drops.

NHS health boards have committed themselves to producing ‘high-quality design solutions’. The

results so far have demonstrated that the long tradition in Scotland of prestige hospital architecture – stretching back to William Adam’s Royal Infirmary of Edinburgh or

his son Robert’s Glasgow Royal Infirmary (both demolished) – has been reinvigorated for the benefit of all.

## Select Bibliography and a Note on Sources

**The following is a guide to the key sources which informed this publication. Further online sources are now available, outstanding amongst which is Peter Higginbotham's on workhouses (see below) a truly remarkable fund of information on all things relating to the poor laws.**

### **Primary Sources**

Many of the archives in Scotland have records relating to hospitals, from the National Archives of Scotland to local history libraries. City and University Archives as well as Health Service Archives were also widely used. For photographs and plans of buildings the National Monuments Record of Scotland, the National Archives of Scotland and Health Services Archives were the principal sources. Some material remained with the hospitals themselves. Parliamentary Papers were also widely used, notably annual reports of the Poor Law Commissioners; Commissioners in Lunacy for Scotland, Local Government Board and Board of Control.

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## Journals

The following is a list of the principal newspapers and journals used:

*Aberdeen Journal, Aberdeen Daily Journal, Architect & Buildings News, Architects Journal, British Medical Journal, The Builder, Building News, Glasgow Herald, Glasgow Medical Journal, The Hospital, Journal of the Royal Institute of British Architects, Journal of Mental Science, Lancet, Medical Directory.*

## Websites

Dictionary of Scottish Architects **[www.scottisharchitects.org.uk](http://www.scottisharchitects.org.uk)**

Glasgow Digital Library **<http://gdl.cdlr.strath.ac.uk/>**

Higginbotham, Peter “The Workhouse” **<http://www.workhouses.org.uk/>**

Lothian Health Services Archives **<http://www.lhsa.lib.ed.ac.uk/>**

The Mitchell Library, Glasgow **<http://www.mitchelllibrary.org/virtualmitchell/>**

Royal Commission on the Ancient and Historical Monuments of Scotland  
**<http://www.rcahms.gov.uk/search.html>**

The Royal College of Surgeons of Edinburgh, history of the college  
**<http://www.rcsed.ac.uk/site/345/default.aspx>**.

Scottish Archive Network website **<http://scan.org.uk/>**

Scottish Cultural Resources Access Network **<http://www.scran.ac.uk/>**

Unlocking the Medicine Chest **<http://134.36.1.31/dserve/dserve2/search/search.html>**

## Historic Scotland

Historic Scotland is an executive agency of the Scottish Government. It is charged with safeguarding the nation's historic environment and promoting its understanding and enjoyment. Many of the hospitals featured in this book are listed buildings (although inclusion in this book does not imply open access). Listing recognises a structure's special architectural and historic interest and secures its protection under law through the planning system. Listing is intended to inform the management of the historic environment to reinforce sustainable development and, from this greater understanding, serves to protect Scotland's defining character and its sense of place.

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From the day we are born we all have reason to visit the many hospitals which distinguish our towns, cities and villages. They have evolved from the almshouse and the philanthropic initiative of local lairds, to the municipal benefaction of the Victorian Infirmary and the streamlined designs tailored for today, contributing significantly throughout to our national identity. Whether we prefer the homely scale of the cottage hospital or the vast microcosm of a nineteenth century sanatorium, this richly illustrated book shows how hospital architecture has adapted over the centuries in response to medical advances, changing philosophies and the necessities of their day. The informative overview closes with a look at their continued evolution to a sustainable future.

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