The ‘Connexion’ between the Royal and Queen’s 1849-1949. Alliance or Special Relationship?

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Introduction

In April 1797 faced with epidemics of those hoary Belfast familiars, typhus fever and seditious activity, the five-year old ‘Belfast General Dispensary’ decided to take action against the typhus; the sedition was beyond their remit! On the 14th it resolved to provide some in-patient fever beds and rented, for one year at £20, a small terrace house in Factory Row (later Berry Street; now the side entrance to Castlecourt) and squeezed into it: six bedsteads and bedclothes, sanitary accoutrements, cooking utensils, medicines, a resident nurse, visiting doctors’ facilities, 60 patients in the first five months (with only one death) and also space for the General Dispensary’s apothecary on his visits from the Dispensary’s rooms at the Belfast Charitable Society at North Queen Street. On 4th May, Dr James MacDonnell, the senior Dispensary physician, and four colleagues took up their duties at Factory Row and the impressively named ‘Belfast General Dispensary and Fever Hospital’ was born. These humble premises were the ancestor of to-day’s Royal Victoria Hospital in a line unbroken except for a year or so during the ‘troubles’ surrounding the ‘98’ when Belfast’s charitable classes had other things on their mind and other calls on their pocket.

On 4th November 1849, 52 years later, during epidemics this time of cholera rather than typhus, and political controversy rather than overt rebellion, and with the sombre increments produced by the great famine and its accompanying diseases, the Queen’s College Belfast opened with 195 students (including 55 medical ones) and with the Royal’s ancestor - then the Belfast General Hospital in Frederick Street - as its clinical partner, the whole called somewhat optimistically ‘the Belfast medical school’. The ‘partners’ however were far from equal, the ‘partnership’ was far from integrated, and the ‘medical school’ was not strictly a school at all! In this it evoked the Holy Roman Empire, neither holy, Roman, nor an empire, although more faithfully descriptive in that the ‘Belfast medical school’ was unquestionably in Belfast!

Exactly 100 years later, on 11th May 1949, Queen’s and the new Northern Ireland Hospitals Authority reached a formal agreement following the radical changes in the health services and in clinical medical education in the post-World War II period and which paved the way for the high degree of integration which we know to-day. ‘The Royal’s close association with Queen’s was by then firmly cemented since the Grosvenor Road site had earlier been proposed to house the first new major full-time clinical academic units, viz. medicine, surgery, child health, obstetrics and gynaecology, ophthalmology, and therapeutics and pharmacology (later to be joined by anaesthetics), with associated ‘professorial’ beds in the Royal group, though not exclusively. The hundred years, 1849 to 1949, is therefore a distinct and distinctive period in the Royal/Queen’s association.

This paper deals with this association, or ‘connexion’ as it was usually called. Others have told the stories of each partner separately notably Sydney Allison1 and Richard Clarke4 for the Royal, and Moody and Beckett for Queen’s; and your humble servant has dealt with some conjoint aspects5,6. Nevertheless, even on this constricted historical canvas, a century is a long time, longer even than a week in politics, and I have had to be in places somewhat sketchy though not I hope more superficial or opaque than usual! There are inevitable casualties - dentistry for one, ‘professions allied to medicine’ for another - but in fact their stories are mainly those of the post-1949 period.

A point on nomenclature. Over the period Queen’s had two names and one site - Queen’s College Belfast until 1908; and The Queen’s University of Belfast thereafter. The Royal had three names and two sites: in 1849 it was the Belfast General Hospital, from 1875 the Belfast Royal Hospital, and from 1899 the Royal
Victoria Hospital. All were in Frederick Street until the move in 1903 to Grosvenor Road. Both had several constitutions and many physical additions. I will refer to them conveniently as ‘Queen’s’ and ‘the Royal’ throughout. I will omit detailing the politics of Irish higher education and the Irish medical charities, which provide the backdrop to the stage on which this story is played out, because these are labyrinthine. I will refer to them only where necessary. For details the resolute reader is referred elsewhere. Finally, acknowledgments (or apologies!) to John Milton for the idea for the section headings.

Paradise Perceived

The pre-Queen’s situation: the first Belfast medical school (1835-1849)

The Queen’s medical school was Belfast’s second; the first was at the Royal Belfast Academical Institution (Belfast ‘Inst’) from 1835 to 1849. At the time Inst combined a boys’ school with a ‘college’ mainly for aspiring Presbyterian ordinands but also offering vocational classes for the burgeoning infra-structure of Ulster’s prosperous agriculture, industry, and commerce. Its name, ‘The Belfast Academical Institution’ (‘Royal’ from 1831), was unwieldy but apt. It had originally planned to include a medical school but this was delayed until 1835, a story which I have told elsewhere. Preceding Queen’s, as it did, Inst conveniently identified, defined, and indeed tackled, most of the issues facing an embryo comprehensive medical school, and this experience enabled it to act as prototype and pathfinder for Queen’s so successfully that in 1849 the new Queen’s school was able to hit the ground running. This athletic feat also owed something to the skills of the great chemist and gifted administrator, Thomas Andrews, who was already a member of both the Inst and Royal medical staffs when he was appointed in December 1845 to be the key planner of the new medical school as the first vice-president of Queen’s (and incidentally the last until Michael Grant’s vice-chancellorship) and he was critically placed to act as catalyst and fulcrum as was another key figure, Sir John Henry Biggart, a century later. When the Inst medical school closed in 1849 it gave to Queen’s most of its medical students, three of its seven medical professors (plus Andrews), morbid specimens and books, the lease of its dissecting room at £25 p.a. until 1863, a coherent and viable curriculum, an enlightened educational philosophy and above all a ready-made ‘connexion’ with the Royal which was to prove remarkably robust.

The key issues emerged in November 1826 when James Lawson Drummond, professor of anatomy at Inst and a former attending physician at the Royal, called publicly for a comprehensive ‘preparatory’ Belfast medical school, viz. a school which would be recognised by the various chartered medical bodies (Colleges of Surgeons, Societies of Apothecaries, Army and Navy Medical Boards, some universities, etc) for the ‘preparation’ of students to sit their examinations rather than be a licensing body itself, though Drummond had hopes that Inst would ultimately achieve ‘licensing’ or even degree status. Drummond wrote:

‘[After anatomy, chemistry and materia medica] ... it is of early importance to the student to have an opportunity of observing disease in its various aspects ... a ward in the hospital should be appropriated to the reception of a certain number of patients to be placed under the care of one or two physicians and that clinical lectures be delivered twice a week on said patients ... A weekly lecture or two on the surgical cases ... would be of great importance ... and students

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This was in addition to students ‘walking the wards’ and serving as clerks and dressers to the hospital staff which was then the usual means of clinical instruction and which had been introduced to the Royal in 1821. What was Drummond actually advocating? Though his letter (above) does not spell it out, it is clear from subsequent Inst/Royal discussions that he was advocating nothing less than professorial teaching wards with associated clinical lectures and systematic bedside teaching conducted by the professors who would be appointed by Inst but admitted to the use of the Royal facilities and responsibilities for patient care purely on that basis. This would be the core of the clinical curriculum; attendance by students on, and teaching by, Royal staff acting in that capacity would be additional and complementary and, hopefully, co-ordinated.

The Royal accepted the ends of a comprehensive ‘preparatory’ school but balked at the means. Why? There were two major problems which like the dreary steeples of Fermanagh and Tyrone, in Churchill’s deathless phrase, remained for many years to threaten the health of Royal/Queen’s relationships, the second in fact endured throughout the entire period. The first was to do with money. Under an act of parliament of 1807 (47 Geo. III, c.44) initially about a quarter, later up to a half, of the Royal’s income came from the rates (to use a later term) and was earmarked exclusively for ‘fever’ cases but actually was used as a useful subsidy for general expenditure: the Royal understandably does not want to jeopardise this lucrative arrangement by associating as closely as Drummond had suggested with an independent incorporated college itself in receipt of a government grant and accountable only to its proprietors. The second was to do with accountability and power. Put simply: the Royal staff wouldn’t countenance teaching in the hospital under the auspices of any outside body, still less tolerate any of their patients (especially ‘non-fever’ ones) being congregated in special wards under the care of an ‘outsider’ with ultimate clinical responsibility, least of all appoint the outsider ex officio to be a member of staff especially since Inst professors were long-term appointees while Royal staff were elected annually and mainly on the basis of a seniority established though prior service in the General Dispensary. In 1949, when introducing the joint appointment system between the Northern Ireland Hospitals Authority and Queen’s, the Authority’s secretary (Mr E H Jones) put the kernel of this enduring problem nicely: ‘... the [Hospitals] Authority take the view that it is unsatisfactory for a public body ... to require and use the services of persons who are not [selected and] remunerated by them and with whom they have not specific contracted arrangements’. Instead, the Royal decided to run the clinical teaching and the clinical lectures themselves and on 3 June 1827, exactly 170 years ago, the 65-year-old James MacDonnell, doyen of the Royal staff and the man who had taken charge of the six beds in Factory Row 30 years before, gave the first in a series of hospital-organised clinical lectures. The event is symbolised in the Oration each October at the start of the Royal teaching year and given by a member of the Royal staff without any undue (or even due!) attention to Queen’s, perhaps symbolically!

Despite lofty principles getting in the way both Inst and the Royal were keen to reach a permanent ‘connexion’. Inst sought a deal just short of sacrificing open eligibility to their professoriate and their prerogative of seeking and appointing their own professors from the widest possible pool of talent. The Royal were more locally focused and, after suggesting grandiose unacceptable ways of subordinating Inst’s prerogative, they sought damage-limitation by seeking to persuade Inst to appoint only professors from the Belfast medical fraternity; they shrank from the increasing medical competition which able medical imports to Belfast would provide which they considered would be ‘an act of unkindness if not injustice’. The negotiations were tough and protracted; the manoeuvring by the Royal (and Inst) skillful and ingenious. Both sides were confident of an ultimate accommodation - after all it was in their common interests to reach one, and surely this could be brokered given the compactness and cohesion of the local profession and their frequent common membership of staffs and governing bodies of both institutions.

However, for reasons I have examined elsewhere it was not to be, or rather not completely to be; ‘Plans’ were agreed in 1831 and 1835, but a small minority of dissidents remained. Inst now divided into two camps - those (mainly among the ‘Plans’ supporters) who favoured expediency and those (mainly among the dissidents) who favoured principle; but the two were certainly not mutually exclusive. Though the recruitment fields were admittedly sorely limited as was nearly always the case at the time, the former group had a hand in ensuring that all of the first nine medical professors appointed through ‘open
eligibility’ just happened to be Belfast doctors and all but two were either already members of the Royal staff or soon would be.\textsuperscript{9,10} The exceptions were John MacDonnell, a son of the doyen, James, but who conveniently moved to the Richmond Hospital in Dublin before seeking a bed or giving a lecture;\textsuperscript{7} and Thomas Ferrar, professor of surgery for a few months in 1836, but who spuriously failed to report for duty and was discharged \textit{in absentia}.\textsuperscript{8} (Ferrer was not in practice in Belfast but was the son of a prominent Belfast citizen and had been schooled at the Belfast Academy (‘Bruce’s Academy’).) Queen’s did not forget this lesson: between opening in 1849 and appointing the Englishman from Barts, Harold Rodgers, to the chair of surgery in 1947, a period of 98 years, all but one of the \textit{clinical} professors (the exception was John Creery Ferguson) were drawn from the Belfast medical fraternity, and all but three (Ferguson, Alexander Gordon and RF Dill) were already on the staff of the Royal and Dill and Gordon recently had been and Ferguson soon would be. In contrast, in the same 98-year period, 14 of the 16 professors in \textit{non-clinical} medical subjects were exotic, some figuratively as well as literally; only William James Wilson and John Henry Biggart were from Ulster. This yawning gulf, 18 out of 19 local clinical as against only two out of 16 local non-clinical, neither statistically nor indeed intentionally arose by chance. Professors were appointed by the crown (by warrant under the sign manual, except for the foundation creations who were made by the lord-lieutenant) on the advice of the lord-lieutenant - effectively the advice of the chief secretary for Ireland - on the basis of a priority list prepared by the College president and vice-president who had to justify the ranking. The presidents, like the Royal staff, took the robust but common contemporary view that nepotism, protegeïsme, oligarchism and pragmatism in clinical appointments were acceptable if they ensured symbiosis, synergy, and co-operation between Queen’s and the Royal and thus were beneficial to the school, and indeed on this basis the school remained remarkably successful and cohesive even if at the price of forfeiting cosmopolitanism among the medical professorate and - dare I say it - even some intellectual distinction through fracturing any sturdy adherence to meritocracy. As the Queen’s president in 1853 tactfully remarked of Professor Ferguson’s appointment that year to the Royal staff, four years after his appointment to the chair of the practice of medicine, ‘... his present connexion with the [Royal] adds greatly to the means of making his course more useful and interesting to students’;\textsuperscript{9} and as the Queen’s Colleges commissioners in 1858 bluntly stated ‘... and although [Queen’s] has no direct connexion with the [Royal], the arrangements of the Medical School [in Queen’s] has reference to the arrangements in the [Royal]’.\textsuperscript{10} The official historians of Queen’s put it equally plainly if more delicately: ‘Appointment of local men occurred mainly in the medical faculty where established connections with [local] hospitals were of great importance’; and again ‘the medical school thus developed as a local institution in a way that had no parallel in the other [faculties] ... and it was therefore of special importance that [clinical] medical chairs should be held by men acceptable to the local medical community ...’.\textsuperscript{11} Not that the likes of the esteemed James Cuming (professor of medicine, 1865-1899) first Ulsterman to be president of the BMA, and possessor of a lofty intellect and wide reputation; the much-travelled sophisticate Thomas Sinclair (professor of surgery, 1886-1923); Andrew Fullerton (professor of surgery, 1923-1933), with his 77 research publications, presidency of the Royal College of Surgeons in Ireland and who was formerly in charge of a great base hospital in France in World War I; and the courtly and much-loved WWD Thomson (professor of medicine, 1923-1950) could be dismissed as national nonentities, still less as mere provincials, to say nothing of William Whita. Whita (professor of materia medica, 1890-1919), was widely travelled and an outstandingly successful medical author with such intellectually challenging interests as being a rigorous commentator on Newton’s \textit{Daniel and the Apocalypse}, such materially rewarding ones as being an enthusiastic investor in the stock market, and such spiritually uplifting ones as being married to a senior Salvationist, and being president of the BMA and a Westminster MP to boot - though who could say that the book of Daniel, the stock-market, evangelical zeal, and political adherence were not quintessentially Ulster rather than national characteristics? Neither should we be too toffee-nosed about such pragmatism especially before the arrival of the Fair Employment
Commission! Clinical chairs were part-time and paid, until 1909, £100 or £120 p.a. which, with student class fees, gave an average total of only some £200 p.a. compared to, say, the full-time professor of anatomy whose annual emoluments often exceeded £1000 (£60,000 in to-day’s money), was once as high as £1464, and was handsomely in excess of the £800 salary of the Queen’s president! A clinical professor had therefore to build a successful practice and this was easier for a local man - who was more welcome to the local fraternity for obvious reasons - and most medical schools at the time were parochial in their clinical appointments. In fairness Queen’s showed frequent propriety (and loyalty to the spirit of its charter!): when there was a clearly superior alternative to a local candidate they usually chose the better man. Thus, as foundation professor of medicine they appointed the Dublin- based (though Tandragee-born) luminary, John Creery Ferguson, who at the time had no connection with the Royal or indeed with Belfast, in preference to the Inst incumbent the flamboyant Henry McCormac, in his prime in 1848 at age 48, an impressive scholar and prolific author of admittedly indifferent and quixotic books, and a veteran member of the Royal staff, and who was so keen for a Queen’s chair that he applied in 1848, 1857 and again in 1865 just after his 65th birthday And for the foundation chair of materia medica they chose the brilliant Munsterman, Thomas O’Meara, from a field of 25 passing over inter alia the Inst incumbent, James Drummond Marshall, despite the support of an impressive local mafia including the Queen’s vice-president, Thomas Andrews, who Marshall named as his sole referee; Marshall’s father, Andrew Marshall, senior consulting surgeon at the Royal; his uncle and Inst professor of anatomy, James Lawson Drummond; and his brother-in-law, W.J. Campbell Allen, who was the Queen’s foundation registrar-designate O’Meara actually declined the post but Queen’s again passed over Marshall to pick the 29-year-old Horatio Agnew Stewart who had been earlier unsuccessful for the chair of surgery despite being a favoured member of the Royal staff, the successful applicant - Gordon - was also at the time a Royal staff member which levelled that particular playing-field. Perhaps it was partly pedigree (Stewart was the son of a redoubtable and influential Presbyterian clergyman in Broughshane), partly pragmatism (Marshall unlike Stewart was not on the Royal staff), and partly a certain repugnance with involvement in ‘trade’ (Marshall was a successful retail chemist in partnership with his brother in High Street) which saw Stewart through even though [although] he was very well thought of as a surgeon [he] does not appear to have had any particular qualifications in the subject of his chair. He didn’t live long to enjoy it dying of tuberculosis seven years later.

So much for the advantages of pragmatism with a lacing of expediency. Queen’s, however, learned another lesson from Inst this time from those who favoured principle. Inst, as we have seen, was unable to reach full accommodation with the Royal without the sacrifice or threatened sacrifice of some cherished autonomy. Uneasy with this situation the ‘constitutionalists’ logically, if in hindsight scarcely believably, decided to found a ‘teaching’ hospital to be wholly owned, run, and staffed by Inst, and where Inst would need to bend their knee to no-one. A (reasonably) suitable building was available and in this they saw, and not for the first time, the hand of a guiding Providence and they bought the ‘old cavalry barracks’ in Barrack Street - now a Christian Brothers school - and refurbished it as the ‘Belfast Institution Hospital’ (or ‘The College Hospital’), a sparten 100-bed building which they opened in 1837 during a fever epidemic which meant that the rate-payer conveniently paid for the equipment and would contribute to the running costs, and the government paid half the purchase price. Providence smiling on Inst again. But it was never a viable scheme (despite divine support), and it was soon effectively closed, leased, and later sold off. Again the lesson wasn’t lost on Queen’s: whatever you do don’t buy a hospital; work with those who will work with you! Wise words especially with the Royal committed in its Frederick Street launch to medical teaching - ‘Hoc nosocomium aegrotis et arti medicae sacrum ...’ (‘This hospital is devoted to the sick and to the art of medicine’), and with a fine lecture theatre suite opened in 1847.

Paradise Sought

The Queen’s Colleges and the Queen’s University in Ireland (1849-1882)

The Inst experience had taught that a viable college/hospital ‘connexion’ was possible. I now turn to its pursuit by Queen’s and the Royal.

Queen’s had two categories of medical student - the non-matriculated and the matriculated. The non-matriculated student enrolled at Queen’s simply to gain the necessary class credits to allow him to sit for the parchments of various professional bodies (and the occasional university) most commonly the licence of the Royal College of Surgeons (RCS) of either England or Edinburgh, less commonly that of the...
Royal College of Surgeons in Ireland which (unlike the other two) required up to two years' metropolitan attendance which was inconvenient and expensive to Ulstermen. The matriculated student on the other hand was the true, modern undergraduate, enrolled at entry for the four-year Queen's University in Ireland (QUI) degree course though in the event he often found it too exacting or expensive and down-graded to the more vocational, shorter, Royal College course. Furthermore, the QUI primary degree was MD à la Edinburgh and because it was adjudged to have an inadequate surgical content it did not qualify its holder for any of the estimated 1000 posts in Ireland in the poor law dispensaries, fever hospitals and infirmaries, nor be accepted by the Army and Navy Medical Boards, the East India Company Medical Service or the Indian Medical Service, nor hold any surgical post;\(^8\) in consequence the great majority of the students in the Faculty of Medicine proceed to London for their surgical diploma [either with or without the MD]\(^9\) The academic standard was high and the education broad: the matriculation examination included \textit{inter alia} Latin and Greek, classical history, and English composition, and the student had also to pass examinations in a modern language and natural philosophy (physics) before sitting finals.\(^{10}\) Fees were also high, and if not living at home or with a guardian or close relatives the student had to live in 'licensed premises', less ambiguously approved categories of residence 'licensed for the purpose by the [Queen's] President'.\(^{31}\) And there were other differences. The proportion of matriculated students, 50 per cent in 1849, rose to over 80 per cent by 1870 as the course became established, as the quality of entrants improved, and under pressure from the General Medical Council (GMC). Less than one-half however sat the QUI degree: a few dropped out while others down-graded to a Royal College 'licence' course, unsurprising in view of the formidable deterrents (above) to persisting with the degree.\(^{32}\)

A key requirement in the Queen's curriculum from 1852 (there were transitional arrangements before that) was 24 months' attendance at a 'medico-chirurgical hospital containing at least 60 beds, together with the clinical lectures therein delivered, at least two each week', the hospital to be 'recognised' by the senate of QUI which sat in Dublin. Six of the months were required to be taken in the 'first period' of the curriculum, viz. first and second years; the remaining 18 months in the 'second period', viz. the third and fourth years. The external professional bodies had broadly similar requirements though a shorter course. The Royal had therefore to meet the 'recognition' requirements of Queen's and these professional bodies. The Royal therefore saw no formal distinction between their relationship with Queen's and with, say, RCS England. It cut the other way also: Queen's saw no formal distinction between a student's attendance at the Royal and at another 'recognised' hospital of which there were many (see Table). Furthermore, QUI required at least one-third of its medical course lectures to be taken in one of the three Queen's Colleges (Belfast, Cork or Galway); the other two-thirds could be taken at other 'recognised' universities, colleges or schools.\(^{33}\) It could therefore be said that QUI saw no formal distinction between attendance at a Queen's College and a 'recognised' college for two-thirds of the academic course. Neither the Royal nor Queen's was exclusive to the other and so to the lofty idealists and strict logicians at Queen's a formal 'connexion' with the Royal seemed unnecessary and even inequitable to others.

This lack of a distinct formal and explicit 'connexion' between Queen's and the Royal was much deplored by the Royal and by some Queen's staff. A.G. Malcolm, the most active and innovatory teacher on the Royal staff, spoke for many of his colleagues when he said: 'The Hospital must be admitted to be the very life of a Medical School: without incorporation with which no college, however inherently distinguished, can every hope to flourish as a seat of medical instruction; and we cannot consider it as otherwise than an oversight in the establishment of the Queen's Colleges that medical

\[\text{Table}\]

| Queen's University in Ireland |
|-----------------------------|
| **Jervis Street** | Meath |
| **City of Dublin** | Belfast (Royal) |
| **House of Industry** | Mercer's |
| **St. Vincent's** | Infirmary, Galway |
| **South Infirmary Cork** | (Westminster) |
| **North Infirmary Cork** | (Others) |

\[\text{Facts in the annual report of the QUI vice-chancellor for the year ending 19 June 1852 (H.C. 1852-3 [1561] xliii. 477-515, App. IX) and September 1853 (H.C. 1854 [1707] xx. 83-161, App. VIII) and subsequent reports. The presence, for example, of the Westminster Hospital means that one or more students attended there possibility 'out-of-term'; it does not mean that St. Bartholomews, Guy's, St. Thomas's etc were not worthy of recognition!}\]

\[\text{Connection 113}\]
interests had not been better attended to, and especially the principle of associating clinical with theoretical instruction ...’.34 (‘Connexion’ in his lexicon had now been up-graded to ‘incorporation’). Meanwhile Queen’s aloofly disposed such crumbs as inviting the Royal staff to the College’s opening ceremony in December 1849, along with hundreds of other.35

The de facto position, however, was very different and for good reasons. Firstly, some 95 per cent of Queen’s medical students were from Ulster; though free to attend any (‘recognised’) hospital, economics and geography kept them at home, and ‘home’ meant the Royal which was the only ‘recognised’ medical and surgical hospital in Ulster. Some may have attended for a few months elsewhere, possibly during vacations and/or the ‘summer session’ (Table) - the lecture session was November to April inclusive which kept most students at base; the ‘summer session’ was May-July inclusive and usually lecture-free - but there are no data on this. For similar reasons very few students from outside Ulster attended the Royal.36 But Ulster students certainly crowded into the Royal - 27 in 1850 had grown by the 1880s to the staggering average number of well over 200 during the six-month winter session and often over 150 during the three-month summer session36, and this in a hospital of only some 180 total beds and 2000 intern and 10,000 extern patients per year by the later century. Secondly, there were the curricular logistics. The course of lectures at Queen’s and the requisite hospital attendance were normally concurrent or at least interdigitated. From 1852, during the teaching session (November-April inclusive) in the final two years, lectures in medicine, surgery and materia medica occupied 4.00 pm to 6.00 pm each afternoon including Saturday, midwifery was at 3.00 pm on Mondays, Wednesdays and Fridays, anatomy was on Mondays to Fridays (‘demonstrations’ at 11.15 am; lectures at 2.00 pm; dissections ‘daily’), and medical jurisprudence was 3.00 pm Tuesdays and Saturdays.35 Students had to attend each course for six months during the final two years (three months for medical jurisprudence), normally three lectures per week other than anatomy which required five, as well as the required hospital attendance (as above) and a three-month course in the practice of compounding under a qualified apothecary, and although they could logistically have arranged their courses so as to have the opportunity for attendance at hospitals other than the Royal this was little practised if at all. Thirdly, most clinical professors, as we have seen, were on the Royal staff and they could co-ordinate their hospital instruction with their classroom lectures into a coherent course. Fourthly, Queen’s and the Royal staffs had a common purpose, were colleagues in the Ulster Medical Society and other societies, had the same provincial roots and a shared culture so that symbiosis and synergy could thrive.

Reliance on de facto arrangements, however, no matter how strong and operationally effective, is usually constitutionally unsatisfactory; hence the Royal staff’s concern as voiced by Malcolm, and the concern also of some at Queen’s. Nevertheless, there is no doubt as to the keenness of both institutions for success. In 1847, even before Queen’s opened, a new lecture room and operating theatre had been opened in the Royal; in 1849 the hospital lectures, under Malcolm’s guidance, were systematised; and the Royal’s Annual Reports throughout the 1850s habitually eulogised the Queen’s students for their attributes and even dress and comportment! The pride in the ‘connexion’ is tangible. Despite, or perhaps because of, the lack of formal structures the partners were at this time getting on famously! However the honeymoon was soon to end. The complete lack of, or progress towards, formal ties let alone to what Malcolm had called ‘incorporation’, increasingly worried many and for cogent reasons. The clinical professors had no standing in the Royal as professors, only as members of the Royal staff and as such subject to annual election; and the other members of the Royal staff gave clinical instruction, good or bad, to Queen’s students without any accountability to Queen’s and without even being chosen by Queen’s. Other colleges or schools seeking ‘recognition’ by QUI (for not more than two-thirds of the course - see above) had to submit the names and qualifications of the ‘several lecturers whose lectures are required to be recognised’, but hospitals did not have to do so with respect to achieving ‘recognition’ for ‘attendance’ or ‘the clinical lectures therein delivered’.33 Hospitals did supply lists of ‘clinical teachers’ but ‘recognition’ was based on the criteria of number of beds, bed-occupancy and case-mix rather than the academic or even professional abilities of the staff.37 Similarly, the Royal staff as staff members had no input to, or say in, the academic affairs of Queen’s: not in the structure of the curriculum nor in the selection of students, still less in the process of examining, least of all in the appointment of the professors. These were matters for the faculty of medicine, which consisted exclusively of professors in the medical subjects of the faculty; for the (college) council, which had only one member from the faculty of medicine, the dean; or ultimately for the QUI senate or the crown. In fact the senate,
which sat in Dublin, and *a fortiori* the crown, were aloof from staff, students and the professoriate alike and completely remote from the Royal and its likes. True, by 1866 the QUI senate included seven members of the growing QUI convolution, viz. graduates. True also that two of these were Belfast medical men - Dr (later Sir) William McCormac, son of that Henry McCormac who had three times failed to obtain a Queen’s chair, and Dr W.A. McKeown, an ophthalmologist, who with Peter Red fern, professor of anatomy (a Queen’s Belfast nominee), made three local medicos; but their influence was small. Senate *did* appoint examiners and the in-put by the medical senators could have been influential, but initially only one examiner in each clinical subject was appointed and the majority were from Dublin: Queen’s College examiners were in a minority and moreover were rotated among the three Colleges. In any event the examinations were exclusively papers and orals until 1869 (when clinical examinations were inaugurated in the South Dublin Workhouse Hospital) and were sat in Dublin Castle until 1877. GMC visitations took place pursuant to the 1858 Medical Act but they did not lead to any formalised Royal/Queen’s ‘connexion’ and this period closed in 1882 in a general feeling of frustration and missed opportunities with Queen’s somewhat arrogantly rejecting some GMC curricular recommendations, the only licensing body to do so, and with no changes in substance to the 1852 curriculum, and this had led at one bleak period to the GMC advising the privy council not to register Queen’s graduates. Against this backdrop and with mounting politico-educational upheavals in the country generally, it was time for QUI to go, and in 1882 it did.

Before leaving QUI a short postscript on the Belfast Lying-in Hospital is instructive. The Queen’s curriculum from 1852 required attendance at a six-month course of three lectures a week in midwifery and diseases of women and children plus three months practical midwifery at a ‘recognised’ hospital ‘with the clinical lectures therein delivered’, if of 30 beds, and six months if of 15. William Burden the professor (1849-1867), was, conveniently, from 1837 physician to the Belfast Lying-in Hospital in Clifton Street, and was even described as ‘the master’. His successor in 1868, Robert Foster Dill, was a substantial figure in Belfast medical and social circles but had resigned from the hospital staff in 1861 over some *contretemps* with the ladies’ committee and so had to give his clinical instruction on district and in his own ample house at 3 Fisherwick Place. This was inconvenient and flew in the face of normal Queen’s practice. Why had Queen’s abandoned the pragmatism that had served them so well? There is a simple answer. They had not abandoned it. Following their usual practice they had chosen for the chair the outstanding Dr John M Pirrie, attending physician at the Royal and effectively acting-master at the Lying-in Hospital who had frequently deputised for Burden. But Pirrie was a staunch liberal and Dill an impeccable conservative, the conservatives were then in power, the Dill clan was remarkably influential none more than Professor Dill’s cousin, Dr John Dill, of Brighton, who secured the support of the Irish government for his cousin as ‘the only conservative candidate’, and the lord-lieutenant overrode the first choice of the president of Queen’s of Pirrie and instead had Dill appointed. Dill’s grandson the neurologist, Robert Foster Kennedy, is only one of two Queensmen to be eponymously remembered through a disease - the Foster Kennedy syndrome; the other is Ashton Morrison who shares with JV Verner, the Verner-Morrison syndrome.

**Paradise Lost**

The Queen’s Colleges and the Royal University of Ireland (1882-1909)

In 1882 the Queen’s University in Ireland (QUI) was replaced by the Royal University of Ireland (RUI), a purely examining body centred at Earlsfort Terrace in Dublin, now the National Concert Hall where great music fills the auditoria where once students were examined. The three Queen’s Colleges remained though now as external not constituent colleges. This was a monumental structural upheaval in response, as often in Ireland, to politically-sensitive academic imperatives, or possibly academic-sensitive political imperatives, but as regards the Queen’s/Royal ‘connexion’ it was more a high jump than a long jump: a great flurry and prodigious leap but a return to earth close to the take-off point. Medically this period saw the mushrooming of knowledge which led, under the eye now of the GMC, to the compartmentalising of the former general umbrella disciplines into the more discrete specialties familiar to-day. The degree curriculum became even more crowded reaching five years from 1887 and even six years from 1892 including a mandatory arts year, an effective deterrent which as in the case of the former (QUI) MD course, drove increasing numbers into the shorter, cheaper, and - dare I say it - less demanding course for the examinations of the newly founded conjoint boards of the various Royal Colleges while remaining in Queen’s for their course instruction. Mandatory
hospital attendance was widened to include the emerging specialties: three months at a fever hospital or fever wards in a general hospital; three months at an eye and ear hospital or in an eye and ear unit of more than ten beds in a general hospital; three months at a ‘lunatic asylum where clinical teaching is given’; three months at a pathology unit in a general hospital; 24 days at operative surgery; three months at practical pharmacy under a qualified apothecary; and two months as a clinical clerk and surgical dresser, all in addition to six months practical midwifery in a hospital with at least 15 midwifery beds in regular occupation, and 24 months at a general hospital of which 18 would be taken as three winter sessions of six months each and two summer sessions of three months each. This meant that specialist hospitals or specialist units within general hospitals, as well as general hospitals themselves, had now to be ‘recognised’ by the RUI senate, and Queen’s prudently decided to arrange teaching provisions in these specialties. This increased the complexity of the logistics of the ‘new’ curriculum which cried out as never before for formal rather than ad hoc joint arrangements and this became a recurrent cri de coeur.

Initially much of the specialist teaching fell on the Royal since the requisite specialist hospitals in Belfast were either unbuilt, inadequate, or for various reasons were unsuccessful in attracting students. The Royal rose to the challenge; indeed they welcomed it and as early as 5 May 1882, before the RUI requirements were in force, the medical staff unanimously agreed ‘that the Royal Hospital should endeavour to embrace within itself the power of granting certificates for clinical teaching to meet all the requirements [other than those for mental diseases] of the examining bodies’. (My italics). This meant in practice upgrading the fever facilities, re-organising the teaching programmes, tightening the teaching obligations of the staff, and creating new departments of gynaecology and of eye and ear diseases. (It also meant reaching an arrangement with the Belfast Lying-in Hospital about joint midwifery teaching, but this fell through!). These were soon done and with an altruistic eye to Belfast’s interests as well as their own, or perhaps just in a burst of the Belfast chauvinism of the time, the medical staff were writing in June 1884 direct to RUI in Dublin pointing out that the Belfast facilities constituted ‘a field ... which is hardly possible to conceive could be utilised or exhausted by any University or number of students’.’ When more stringent regulations came into force in 1887 pursuant to the 1886 Medical Act the Royal effectively had to abandon their earlier ambitions for a comprehensive clinical teaching service (other than in midwifery and mental disease) and many specialist hospitals were soon recognised: in 1888 both the Belfast Ophthalmic in Great Victoria Street, and the Ulster Eye, Ear and Throat (the Benn) Hospital in Clifton Street, both with 30 beds against only four at the Royal when a unit of ten beds was strictly required; in 1890 the Belfast Hospital for Sick Children in Queen Street on foot of new RUI requirements for attendance on diseases of children; and in 1899 the Belfast Union Hospital on Lisburn Road (now the Belfast City Hospital) but only for ‘fevers’ (and for ‘vaccination’), increasingly uniquely appropriate with its large 250+ bed fever hospital, from 1906 at Purdysburn, as against the original 55-bed fever wards in the Royal in Frederick Street, and the reduced 24-bed facility planned for the Grosvenor Road site but ultimately whittled down to only eight.54

Queen’s also had its academic role to play in these ‘minor specialties’ (to use a later term) but not so pressingly since the academic, as distinct from the clinical attachment, parts of the RUI curriculum were not operative until 1893 rather than 1887. Extension of academic posts in the ‘new’ minor specialties were therefore delayed, but when operative Queen’s followed the successful tactic of appointing established Belfast doctors, this time not to tenured professorships, which would hardly be justified, but to (part-time) lectureships on annual appointment which not being professorships gave the incumbent no university standing, no university stipend other than the class fees of the students, and such little status that they were not even consulted by Queen’s when preparing its crucial submission to the Royal Commission (the ‘Robertson Commission’) on its own future in 1902. The first such part-time lecturers were: William Barrett in 1892 in pathology (he received a small stipend since he travelled from Edinburgh for his teaching blocks); William McKeown from the Benn Hospital in 1896 in ophthalmology and otology; Henry Whittaker, medical officer of health for Belfast,
in 1896 in sanitary science; (Victor Fielden soon to be first consultant anaesthetist to the Royal, had been appointed demonstrator in practical pharmacy in 1893); while in 1903, John McLeish, superintendent of the fever hospital, was appointed teacher in vaccination, a post which surprisingly survived up to 1949.49

The centrifugal dispersion away from the Royal and its consequent logistical, administrative and operational complexities, demanded the integrated approach which the Belfast medical fraternity increasingly wanted. In 1899 they were potentially compounded when RUI, on the application of the MaterInfirorum staff, recognised (from 1900) the recently much enlarged MaterInfirorum Hospital for general medical and surgery teaching, the only general hospital other than the Royal to be so recognised in Ulster, indeed outside Dublin, Cork and Galway, and breaking - if you like - the Royal's monopoly in place since 1835.50 This was a very sizeable cheque for the new Mater but in the event they did not present it for another eight years because Henry, Bishop of Down and Connor, chairman of trustees refused to sanction this 'connexion' with RUI and with Queen's because of the opposition of the catholic prelacy, now more rigorous than ever, to the Queen's College system, and in his own words 'until we can see our way to have a medical school in Belfast under Catholic auspices'.51 Despite repeated efforts by the staff to have this decision reversed, it was not until October 1908 that Bishop Tohill, Henry's recent successor, acquiesced52 though whether this was due more to the passing of the conciliatory Irish Universities Act in August that year or the passing of Bishop Henry in March, is a moot point! Within a few years an average of some 20-30 students were attending the Mater,53 and until the end of our period the hospital continued to attract a loyal cadre54.

No such specific de jure 'connexion' resulted and this deepened RUI's unpopularity with the Royal staff and many at Queen's. Some had seen a ray of hope in the creation of RUI medical fellows and a panel of examiners, but the fellows were non-teaching, attracted only some £150 pa stipend, and only four were allotted in total to the three Queen's Colleges.13 But in truth RUI was deeply unpopular in the country generally and with the Queen's Colleges notably with their students who now voted with their feet. The reasons were basic. The examiners were mainly Dublin-based and the examinations were held in Dublin where Belfast (and Cork and Galway) students were examined in unfamiliar hospitals by unfamiliar examiners many of whom had taught the Dublin-based students who were often enrolled at colleges other than the Queen's Colleges, especially at the Catholic University Medical School (a component of the Catholic University of Ireland) which by 1900 had overtaken Queen's (Belfast) as the largest medical school in Ireland. The Queen's Colleges naturally raised the question of an uneven playing-field biased against them including allegations by staff and others at the 'Robertson Committee' in 1902. This was energetically if not completely convincingly rebutted but the hostility lingered.55 It was of small future consequence since the days of RUI were numbered. The Royal staff anticipated this approaching demise and in a letter to RUI as early as 1903 they noted: 'While the Royal ... is an integral part of the Belfast Medical School there is at present no definite official connection between the Hospital and Queen's ... In any re-organisation of the Queen's Colleges this might be accompanied by the formation of a joint board ... to supervise education'.56 Such a ‘joint board’, long sought by the Royal, was now crucial in a thriving, trusting city of 350,000 people, bereft of the compactness, cosy oligarchies, and curricular simplicity of the past, and with mushrooming hospitals the existing de facto relationships were patently inadequate and the Royal was right to press for something more formal. Had Queen's had a faculty of medicine during the RUI years some form of improved liaison machinery would likely have emerged, but deans and faculties had been swept away in the second Queen's charter in 1863, the title 'faculty' being preserved in the records only as a taxonomic convenience. In its place was a cosily informal non-statutory 'committee of medical professors' which was rarely convened and in fact only once met with the Royal staff in joint conclave (on 6 January 1902), but the business was not to do with collaboration, only pernickety detail of RAMC examinations and the proposed holding of the (Irish) conjoint board examinations in Belfast.57 It was the darkest before the dawn, with paradise nowhere in sight.

Paradise (Re-)Gained
The Queen's University of Belfast (1908-1949)

In 1908 the pressures which were later to lead to the partition of Ireland led to the partition of its higher education bodies. Queen’s Belfast was cut off from the other Queen's Colleges - or if you prefer the other

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Queen’s Colleges were cut off from Queen’s Belfast - and on 2nd December Queen’s Belfast was given independence and up-graded to a university in its own right as from the following year. The results for institutional medical collaboration in Belfast were little short of electric.

The Queen’s governing body, the senate, was for the first time situated in Belfast and now represented exclusively Ulster (later, Northern Ireland) interests. One of its 44 members was to be ‘a person elected by the board of management of the Royal Victoria Hospital’, and the first nominee was Sir William Crawford, chairman of the Royal board and who was also honorary treasurer of Queen’s and chairman of its finance committee, a powerful and pivotal position. Never before had one person held such influential administrative offices in both Queen’s and the Royal. Six professors from academic council, eight members of convocation, four crown nominees, and up to four co-optees were also members of senate and each category either invariably (in the case of the council members) or usually included several medical men (including Royal staff members) though appointed or elected in their own right unlike Crawford who was appointed to senate as the Royal’s nominee. Faculties were re-created now as powerful bodies, the medical faculty being far wider in membership than the exclusively professorial bodies of 1849-1863, and 1863-1908. As well as the ‘professors in the subject of the faculty’, the lecturers in these subjects were now also members and that included the part-time lecturers in the ‘minor specialties’ already referred to. Crucially, however, a new category of teacher was created - the ‘clinical lecturer and examiner’ (who still survives) - who was ex officio a member of faculty and also an internal clinical examiner. Holders were annual appointments and there were initially four, one in each of medicine, surgery, gynaecology, and ophthalmology, each (almost) invariably a senior attending consultant and nominated by the ‘recognised’ hospital concerned (not necessarily the Royal), and rotated so that many clinicians became involved in the business of the medical school. In the first five years, 1909-1914, for example, 17 different doctors filled the 20 available posts (4 posts, 5 years) and included, in 1912, and for the first time, a staff member of the Belfast Union Hospital, Dr Robert Hall,7 the Union Hospital having been ‘recognised’ for general teaching since 1910, though for ‘fevers’ and ‘vaccination’ earlier (in 1899). (I should add, parenthetically, that the question of clinical teaching in the Union Hospitals in Belfast, Dublin, Cork and Galway, was a lively issue during the nineteenth century. In Belfast the professor of materia medica (1857-1890), James Seaton Reid, formerly an attending physician at the Royal until appointed medical officer at the Belfast Union Hospital, and then until the year he died a consulting physician at the Royal, was allowed by the board of guardians to teach students in the Union Hospital, but this was an ex gratia personal concession which he only exercised for five years up to 1862. There was some further sporadic and spasmodic teaching from 1924, but systematic teaching was not instigated until after World War II). Some clinical lecturers and examiners were members of the staff of more than one hospital so that the number of hospitals represented at the faculty of medicine was greater than the number of representatives. The annual number of posts was increased to six or seven from 1921,79 and in 1941 increased again to sixteen,80 (four in each of medicine, surgery, obstetrics and gynaecology, and ophthalmology, the major final MB subjects) to reflect the number of teaching units and hospitals and the growing need for internal examiners.

These changes must be seen against a European and American backdrop of closer college/hospital relations generally arising from the seminal Flexner Reports in USA81-82 and R.B. Haldane’s Royal Commission in UK in 191383 which inter alia led to the creation of full-time university professorial clinical units housed adjacent to, or even ‘embedded’ in (to use the later University Grants Committee jargon) the general teaching hospital as we see in Belfast to-day (first) at the Royal and (later) at the City. Just as every schoolboy knows (as Macauley has it) who imprisoned Montezuma and who strangled Atahualpa, so every doctor knows, or should do, that the first such academic clinical units in the English-speaking world were in Johns Hopkins in 1913 under Halsted (surgery), Janeway (medicine - Llewellys Barker, the first choice, declined84), and Howland (paediatrics)85. Because of World War I no unit was created in Britain until 1920 when full-time chairs of medicine and surgery were established not in London, as Haldane had expected, but in the newly founded Welsh National School of Medicine (the prime minister, Lloyd George, was Welsh!) occupied by respectively Professor Kennedy and Professor Sheen86.87 Few followed until the nineteen-forties and though essentially a pre-World War I concept they were in Britain mainly a post-World War II creation. It was partly in line with this Flexnerian/Haldanian concept that the Royal staff in August 1909 wrote to Queen’s expressing ‘its approval and appreciation of the principle of the association of ... clinical hospitals ...
It is easy to be hagiological about Biggart and equally
easy to shrink from understanding the competing
antinomies in his nature. He was a product of the
Queen’s/Royal system and he loved them both, as he
did his profession, to the point of a romanticism at
which few could only then as now guess. He was an
able scholar proud of his cultural background taking at
Inst the Sullivan (for mathematics), the Hyndman (for
Latin and Greek), the Musgrave (for French) as well as
the Blair Prize (for physics and chemistry), followed
by many awards at Queen’s and second place in his
final year behind the late Freddie Kane, former
superintendent of Purdysburn Fever Hospital. For his
Ulster Medical Society presidential address as late as

Figure 5 Sir John Henry
Biggart (1905-1979). Professor
of pathology at Queen’s and
pathologist to the Royal, 1937-
1971, director of the Institute
of Pathology, 1948-1971, dean
of the medical faculty, 1944-
1971, pro-vice-chancellor and
then pro-chancellor of Queen’s,
and much more besides. The
most significant figure in recent
Ulster medicine. (Courtesy, the
Royal Victoria Hospital).

1971 he chose as his topic the competing philosophies
of the various schools of medicine of ancient Greece.
He combined the scholar’s perspective with high
executive skills and he had a very clear vision of the
future of medicine in Ulster around an integrated
Queen’s/Royal axis though with the due autonomies
of each partner preserved. He was a superb judge
of people and though a quintessential Ulsterman he was
also by intellectual inclination and personal
experience an internationalist, an especial enthusiast
for Johns Hopkins in Baltimore (who had been the
pioneers of full-time academic clinical units) where he
himself had worked for two years. In consequence
he did much to influence Queen’s, and indeed more
directly to reverse the century-old practice of
appointing clinical professors exclusively from among
the local fraternity (see below). As dean of the faculty
of medicine from 1944 he ensured a smooth adoption
by Queen’s of the radical Goodenough Report
proposals for introducing such academic clinical units
and their ‘appropriating’ of teaching beds. As early as
1946, on Biggart’s prompting, the Royal Belfast
Hospital for Sick Children discussed whether if the
new full-time professor of child health was not a
member of staff he or she should automatically be
made one and given appropriate clinical facilities? (in

Royal, Queen’s Connection

with [Queen’s], and the new faculty of medicine at
its very first meeting resolved ‘It is the earnest desire
of the Faculty to associate more closely than in the
past the ... clinical hospitals with the University’. Little
happened either on-stage or behind the scenes
for another dozen years: World War I and its aftermath
saw to it that the social and economic climates were
unpropitious. Then in 1921 the Belfast Lunatic Asylum
relinquished to the Royal the lease on the last six acres
of its Falls Road/Grosvenor Road site and was finally
demolished in 1930 leaving a substantial acreage onto
which moved the Belfast Hospital for Sick Children
(from Queen Street) in 1931 and the Royal Maternity
Hospital (from Clifton Street) in 1933 forming, with
the Royal, a formidable concentration of clinical
facilities yet leaving considerable space for the further
developments which have since taken place. This
potential for concentration on such a large site
adjacent to the Royal was not lost on Queen’s and on
11 July 1928 they resolved to move their existing
department of pathology and bacteriology from
University Road to the Royal site ‘in view of the close
interdependence between the practical work of
hospitals and the scientific study of the phenomena
and causes of disease ...’ There were only two
dissentients at senate - Rev J McCaughan, president of
St Malachy’s College and a crown nominee, and Mr J
B Moore, FRCSI, a co-opted member, former
consultant surgeon at the Mater and father of Brian
Moore, the distinguished novelist. Clearly they saw
this proposed development as inimicable to the
Mater’s interests since it physically joined a core
Queen’s department with the Royal. This Institute
of Pathology was opened in 1933 as a two-storey
building (the present third storey was added after
World War II) and came to house both the Queen’s
facilities and those of the hospital pathology and
bacteriological services as a joint enterprise. In 1937
John Henry Biggart was appointed as professor,
consultant pathologist, and de facto director of the
Institute (the de jure post was not created until 1948),
an event of incalculable importance. Biggart was not
the first professor of pathology to be a consultant at
the Royal - all his predecessors had been - but with the
unimportant exception of his immediate predecessor,
the Scotsman, John Young, he was the first full-time
professor in the medical school to go to his daily work
at the Royal and not at Queen’s. The opening of the
Institute in fact marked a crucial and not just a
symbolic shift in the clinical medical schools’ centre
of gravity from being university-based to being
hospital-based.

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fact this was not tested as, true to the then form, in 1948 the senior consultant F.M.B. Allen was appointed!). But it soon was tested, and the decision of the Royal staff on 24 July 1947 automatically to appoint the new professor of surgery, the Englishman Harold Rodgers, to the Royal staff (with 25 beds in wards 11 and 12) opened the way for other imports to senior clinical posts - Dick Welbourn, Graham Bull, Richard Womersley, Owen Wade, Philip Stoy, Peter Elmes, Ivo Carré, and others, who would most assuredly not have been appointed before the war. When a local graduate was preferred he or she was expected to have had significant experience abroad, a credential, as we have seen, which Biggart valued and actively promoted - Jack Pinkerton, John Dundee, John Gibson and later Desmond Archer, come at once to mind. Biggart combined all this with an ability to conjure problems out of existence, and these attributes allied to personal integrity and a strong and attractive personality enabled him to win the complete confidence, indeed often something approaching eulogy, of Queen’s, the Royal, and his colleagues alike and by the end of my period, 1949, he had attained a unique position of power and influence in the local medical scene approached only by Andrews in the 1840s on a much smaller canvas. Indeed this paper could have been, and nearly was, subtitled ‘From Andrews to Biggart’. It is pointless here to litanize his many offices: quite simply he stood at every crossword and although he had not fully entered his kingdom by 1949 he was very close to the gates. Of course the times were propitious. World War II saw the great reports on which a brave new medical world was to be built. Furthermore, the Hospitals Authority had to deal with only one medical school so that Biggart could - and did - hold strategic pluralities encompassing both bodies. Much of what came about would have come about anyhow as it did throughout Britain, but Biggart’s was the sure hand which guided the special meeting of the faculty of medicine of 18 February 1948 into accepting a blueprint for allocating medical and surgical professorial teaching beds as between the Royal and the City: the Mater was not at that time in the national health service (NHS). This was the first significant erosion of the Royal’s monopoly with respect to medicine and surgery teaching and made this meeting one of the more important in the faculty’s history. This opened the door to the joint appointment system for academic (mainly but not exclusively clinical academic) staff, which was accepted by both parties in principle on 11 May 1949, and also to professorial teaching wards with clinical instruction and lectures by professors on-site and of right and not through the hospital’s grace and favour, exactly as Drummond had proposed in 1826! Ironically the very changes to the service which greatly strengthened the Queen’s/Royal axis in the short term up to 1949 weakened it in the longer-term through the NHS corollary of uniformity of service Province-wide, and this ultimately stripped the Royal of its near exclusivity with Queen’s and it came to share resources, services, and academic units with other hospitals in Belfast and beyond, clearly evidenced to-day.

Epilogue

Finally, Chairman, ‘alliance’ or ‘special relationship’? The Oxford English Dictionary says that an alliance is a ‘combination for a common object’. The medical faculty, and the teaching hospitals in their instructional mode, clearly represent a series of co-ordinated cooperatives, and their commonality of purpose and objectives, their shared cultures, and their cross memberships though without surrender of ultimate autonomy, fulfill the definition of ‘alliance’ rather than, for example, a superior and vassal state or, as was the case of Russia and the Western Powers in World War II, ‘associated powers’ (and not ‘allies’) because they shared nothing except one thing - the defeat of Hitler. In fact I would call the faculty and the hospitals ‘a grand alliance’, borrowing the term from ‘la Grande Alliance’ of the late seventeenth century European powers against Louis XIV of France, and within this the Royal clearly is the leader on the grounds of history, of size, of range of facilities, of having the senior clinical academic units, and much more besides. It is more than primus inter pares; it is within the grand alliance a ‘special relationship’.

It is not however integration nor anything like it. Macro-structural factors inhibit this, predominantly the vertical and horizontal fault lines in medical education: vertical, in that the academic bodies are under the purview of the Department of Education for Northern Ireland, and the service and training bodies under that of the Department of Health and Social Services; and horizontal in that undergraduate medical education is conducted and very largely regulated by academic bodies and institutions, whereas graduate training is conducted largely inservice and regulated exclusively by professional bodies - with a few grey areas scattered here and there. Much ingenuity has gone into devising effective collaborative and bridging structures but as long as the basic regulatory and funding dichotomies remain it is hard to see how
closer association can take place. In fact where responsibility has been shared, as in the pre-registration year, amiable chaos has been a feature! Since 1849, ‘connexion’ has evolved into a ‘grand alliance’ with an additional ‘special relationship’ for the Royal within it; but not into ‘integration’. I personally believe that integration may be undesirable as well as impossible. At the 300th celebrations, chairman, I hope to be invited to defend this viewpoint!

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18. Froggatt, P. Thomas Ferrar, MB, LRCSI (1797-1837); the absentee professor of surgery at the Royal Belfast Academical Institution. Ulster Med J 1996; 65: 152-161.

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20. Report of Her Majesty’s Commissioners appointed to Enquire into the Progress and Conditions of the Queen’s Colleges at Belfast, Cork and Galway .... H.C. 1857-8 [2413] xxi. 53-572 (p.25)
21. Moody, TW, Beckett, C. Op. cit. (note 3 above), p.174.

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24. Fraser, Sir Ian. Father and son: a tale of two cities, 1801-1902. Ulster Med J 1968; 37: 1-37.

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26. Moody, TW, Beckett, JC. Op. cit. (note 3 above), p.119.

27. Froggatt, P. The early medical school: foundation and first crisis - the 'college hospital' affair. Ulster Med J 1987; 56 (Suppl): S5-S14.

28. Medical Charities Act, 1851. Previously the Poor Law Guardians and the medical charities authorities had a discretion in assessing the qualifications of applicants (Queen's College Commissioners. Op. cit. (note 20 above), pp.24, App. B. pp.337-8.

29. Ibid, pp.24-5.

30. Moody, TW, Beckett, JC. Op. cit. (note 3 above). pp.232-4, 257-267.

31. Ibid, pp.56-7.

32. Ibid, pp.192, 263-267, App. IIC (p.666).

33. Queen's College Belfast Calendar for 1853-4. Belfast: Alexander Mayne, 1853, pp.xxxiii et seq. These included several 'unchartered' schools in Dublin.

34. Malcolm, AG. Quoted in Allison, RS. Op. cit. (note 5 above), p.87.

35. Moody, TW, Beckett, JC. Op. cit. (note 3 above), p.126.

36. Registers of students enrolled at the Royal exist from 1866 and specify inter alia names and home addresses. They are lodged in the office of the Archivist, Royal Victoria Hospital.

37. Queen's College Commissioners. Op. cit. (note 20 above), App.B, pp.339-340. In the 1850s the clinical activity at the Royal was 'much below the required average as to render the withdrawal of recognition ... extremely likely [if] its actual condition was made known to any of the Licensing Bodies'. This was used by the College presidents to support the case for teaching at the 'Workhouse Hospitals in Belfast, Cork and Galway'.

38. Moody, TW, Beckett, JC. Op. Cit. (note 3 above), pp.228-232.

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44. Verner, JV, Morrison, AB. Islet cell tumor and a syndrome of refractory watery diarrhea and hypokalemia. Am J Med 1958; 25: 374-380.

45. Froggatt, P. Competing philosophies in the nineteenth century. The 'preparatory' medical schools of the Royal Belfast Academical Institution (1835-1849) and the Catholic University of Ireland (1855-1909). In press.

46. Medical Staff Minutes, Belfast Royal Hospital, 5 May 1882.

47. William Whitla to RUI of 10 June 1884 (cited in Allison, RS. Op. cit. (note 5 above), p.92).

48. Clarke, RSJ. Op. cit. (note 6 above), pp.69-72.

49. The Local Government Board of Ireland required that doctors who qualified after 1st May 1906 and who held a post of medical officer in a poor law dispensary district had to be in possession of a certificate of competence in vaccination (LGB (Ire.) Order of 20 December 1905). This survived until the advent of the National Health Service in 1948.

50. Medical Staff Minutes, the Mater Infirmorum Hospital, 18 Jan., 30 Jan., 19 May, 12 Oct., 1899. The approval from RUI is dated 18 Aug., 1899. (These minutes have been collated and bound by Mr Peter Gormley, FRCS, formerly consultant ophthalmologist at the Mater and to whose care and prescience historians of the hospital are forever grateful.)

51. Bishop Henry to Mater medical staff committee of 20 July 1900. (Ibid, 11 July 1900 et seq.).

52. Ibid, 25 Sept, and 13 Oct, 1908.
53. Ibid, 4 June 1915.

54. The subsequent minutes and Annual Reports are uninformative the standard wording being '... it is gratifying to report that a very large number of students are in attendance' (e.g. Annual Report Mater Hospital, 1943-4, p.12). The numbers are unlikely to have averaged more than 40 by that time.

55. Cited in Allison, RS. Op. cit. (note 5 above), p.94.

56. ‘Medical Faculty’ Minutes, Queen’s College Belfast, 6 January 1902, Sir William Whitla in the Chair (QUB library, Regalia: Folio 848).

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63. Royal Commission on University Education in London (‘The Haldane Commission’). Command Papers 5911, 6717, 6718. London: HMSO, 1913.

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66. Froggatt, P. The university academic clinical unit: an opportunity for pharmaceutical medicine? *Pharmaceut med.*, 1988; 3: 211-217.

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68. RVH Visiting Staff to Faculty of Medicine of 26 August 1909. Cited in Faculty of Medicine Minutes, 25 Oct. 1909.

69. Faculty of Medicine Minutes, 25 Oct. 1909.

70. QUB Senate Minutes, 1928, p.77 (July 11th).

71. Ibid, p.78.

72. Calwell, HG. The Life and Times of a Voluntary Hospital. The history of the Royal Belfast Hospital for Sick Children 1873 to 1948. Belfast: Brough, Cox & Dunn, 1973, p. 109.

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