Medical Dispensaries in Warwickshire: their place in local health care, 1820 –1880

by

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List of Abbreviations

BAH	Birmingham Archives and Heritage
BMA	British Medical Association
BMJ	*British Medical Journal*
BUSC	Birmingham University Special Collections
CCA	Coventry City Archives
CHC	Coventry History Centre
COS	Charity Organisation Society (of London)
EMSJ	*Edinburgh Medical and Surgical Journal*
GP	General (medical) practitioner: a term in currency from 1820s
LMG	*London Medical Gazette*
LMR	*London Medical Repository and Review*
LSA	Licentiate of the Society of Apothecaries
MB	Bachelor of Medicine
MD	Doctor of Medicine: entry by thesis
MO(H)	Medical Officer (of Health)
PMSA	Provincial Medical and Surgical Association
RCP	Royal College of Physicians:
	LRCP Licentiate (Basic)
	MRCP Member --by examination (advanced)
	FRCP Fellow, by election
RCS	Royal College of Surgeons
	LRCS Licentiate (basic: Scotland)
	MRCS Member -- by examination (basic)
	FRCS Fellow, examination or election (advanced)
SCLA	Shakespeare Centre Library and Archives
VCH	*Victoria County History*
WCRO	Warwickshire County Record Office

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Declaration

This thesis is submitted to the University of Warwick in support of my application for the degree of Doctor of Philosophy. It has been composed by myself and has not been submitted in any previous application for any degree. A small part of this thesis (from Chapter 4, pp. 194-98, 206-16) has been published by the author as:

'John Conolly: Nineteenth-Century Physician and Reformer', *University of Edinburgh Journal,*49.3 (2020), 189-93.

Abstract

This thesis offers a fresh view of the under-explored area of nineteenth- century dispensaries, outpatient medical charities that served the 'sick poor'. Most were founded by members of local elites, in varying combinations with medical practitioners. Warwickshire was selected as the study area as a varied and medium-sized county, Chapter 1 summarising its history and geography. The research was based on local case studies in different towns: Birmingham and Coventry as growing industrial centres, and Stratford-on-Avon and Southam as smaller towns covering largely semi-rural populations. Chapter 2 starts with two early foundations (c.1790) in Birmingham and Coventry but concentrates on the years of expansion during 1820-60. Chapter 3 turns to medical needs in the countryside, initially addressing Stratford-on-Avon, both its dispensary and the later infirmary. In Chapter 5, Southam is considered as the location for the first 'self-supporting' or provident dispensary in 1823. Both this and its imitators drew largely on mutual funding from regular payments by working-class users; the Chapter explores reasons for institutional success or failure. The Coventry provident dispensary was contested at its birth in 1831, but attracted many members, late in the century again provoking local professional opposition. The activities of dispensaries included the study and teaching of common diseases, and the early medical school in Birmingham relied heavily on such teaching. Some dispensary staff were active in writing and editing, and Chapter 4 analyses two individual journalistic careers. The thesis also considers wider civic and cultural activities, including reporting for public sanitary commissions in the 1840s and 1850s. The final Chapter (6) considers challenges for dispensaries late in the century, namely increased workload, renewed contestation in Coventry, and pressures from both medical officers and working people for increased recognition or influence. The study explores such tensions, together with their attempted resolution through organisational changes and representation on governing bodies.

Aims and research questions

This study of dispensaries in Warwickshire enquires, firstly, why they came into being. Chapters 1 and 2, therefore, explore factors bearing on the aims and intentions of founders (in so far as they can be inferred) from the late eighteenth century onwards. This was the era of the first midland dispensaries (in Coventry in 1789 and then Birmingham 1793-94). The focus, however, is mainly on the period following 1820, including several new foundations in different towns in the 1820s and the early 1830s (in Chapters 2, 3 and 5). The circumstances addressed as possibly relevant include economic depression and current agitation for local and national political reform. Other influences explored include industrialisation in the larger towns, local population changes, and the consequent adverse effects on the urban environment, all of which contributed to disease and evident distress and in their turn prompted medical responses.

The thesis also endeavours to explore the Individual motivations of founders. Were these simply humanitarian, or concerned with reputation, status, and social capital? While definitive answers cannot be given, background influences explored (in Chapters 1-3 and 5) include patronage networks, politics (in a wide sense), and tensions between different elements of local societies. In some cases, medical practitioners were institutional co-founders, so some attention is devoted to their alliances and wider roles, as well as the roles of dispensaries in the study of disease.

The second aim concerns the governance of dispensaries, starting with the sources of their continuing support. Relevant questions (in Chapters 2-4 and 6) extend beyond the role of elites and their role, to explore the range of support; these include subscriptions from those of varying means, donations, workplace collections, and at provident dispensaries, the contributions from working-class users. I consider their management mainly through annual reports and institutional minutes, the intention being to clarify the contributions of local elites, the medical profession, and local inhabitants more generally. In some places, notably Coventry

in the later nineteenth century, working men seemed to participate more actively in governance, so in Ch.6 their emergence and contribution are considered.

Thirdly (and of strong personal interest), what were the medical functions of dispensaries? Accounts by medical officers themselves figure largely here, whether in annual reports, pamphlets, or papers in professional journals. All these are drawn on (in Chapters 2,3,5, and 6). An important role for the study is to evaluate quantitative data, derived from institutional registers, annual reports, and articles in newspapers and periodicals. I draw inferences from these about local disease patterns, including epidemics and occupational disorders, and some indications of changing treatments provided. When practicable, the data and the conclusions from them are compared with other dispensaries, voluntary hospitals, and the Poor Law medical service. Although they play a minor role, certain 'ancillary' services are considered -- vaccination, midwifery, and other treatments such as dentistry. In Chapter 4, I address some wider activities of medical officers pursued through writing and editing.

Fourthly, what were the relationships of dispensaries with other relevant institutions and organisations? These include voluntary hospitals and the services of the Poor Law, before and after 1834 (addressed in Chapters 2-4, and 6). In Chapters 3 and 5, I explore some broader civic and cultural roles that dispensary practitioners undertook. In the later nineteenth century (Chapter 6), some towns developed a more complex medical and welfare economy, in which people received care by or through new charities, re-focused Poor Law institutions, mutual bodies (friendly societies), and private 'clubs' established by general practitioners. How far were the different forms of provision complementary, overlapping, or competing with one another?

Finally, there is a need to consider the patient's viewpoint, whether considering instances of patients' voices, or indications of their views, feelings, or experiences. Although evidence is scanty, possible clues include mentions of waiting time for attendance and other comments voiced at meetings, which are considered in most Chapters, at the point when they occur.

Introduction

In Stratford-on-Avon in July 1824, Ann Raison, a fifteen-year-old labourer's daughter, lay ill with a fever and a worrying rash. She was seen by a local medical practitioner, who diagnosed smallpox in a 'severe form'. She lived with her family in a row of small cottages in Windsor Street, a short distance from the recently founded Stratford Public Dispensary. Aware of the high mortality and contagiousness of smallpox, the dispensary's medical officers wrote to the mayor so that municipal precautions could be instigated.[1] Posters soon appeared in the town, urging vaccination on citizens, and threatening heavy fines for anyone seen on the streets with signs of smallpox infection.[2] During the following weeks, Ann seems to have improved, although her two younger sisters, Hannah and Sarah, developed smallpox themselves.

During the next two months, the dispensary dealt with two further cases in children in nearby villages (while it seems likely that other local people were also infected). By November the outbreak had evidently blown over, fortunately without any deaths. These scanty details hint at the doctors' visits and medicines that that a poor family could obtain from a dispensary. In addition, they indicate the interplay between the dispensary's purely medical function and its wider roles, including the protection of public health.

Dispensaries, like the one mentioned above, were public or charitable institutions that provided working people with medical care. They supplied medicines (a dispensary in the present-day sense) but had other functions. From the late eighteenth century, their roles included diagnosis, medical and surgical treatment, and sometimes midwifery, both on their own premises and in patients' homes. Having stated the thesis aims and research questions above, I will go on to explore relevant historiography.

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[1] Shakespeare Centre Library and Archive (SCLA) DR 253/1, Stratford Dispensary patient register, 1824.

[2] SCLA BRU15/18/133, select Vestry papers, 1 August 1824. Vaccination was the introduction into the skin of material from a cow with cowpox or Vaccinia, as described and publicised by Edward Jenner from 1796. Medical practitioners promoted it in preference to the riskier procedure of inoculation (using material from a smallpox lesion).

Some authors have addressed the rise of dispensaries as a response of urban society, and particularly of some medical and lay philanthropists, to widespread disease and distress among the poor. In a general text in 1928, Mabel Buer included a brief account of early dispensaries, their place in society and practical working.[3] A survey by Irvine Loudon provided more detail on the late eighteenth-century foundations in London and important provincial towns.[4] As Loudon explained, dispensaries were organised similarly to voluntary hospitals, and like them, founded and largely financed by prosperous urban inhabitants. Leading citizens formed their voluntary governing committees, which appointed physicians and surgeons, typically unpaid, and usually also a paid resident apothecary (later called a resident medical officer or house surgeon).

In 1992 dispensaries could be regarded as a subject 'somewhat neglected by historians' but the current picture seems somewhat different.[5] Alongside histories of individual institutions, broader accounts have considered dispensaries in their geographical context, exploring relations with other medical services. Such local and regional studies include those by Mary Fissell of eighteenth-century Bristol, by John Pickstone of Manchester and its region, and by Hilary Marland of two West Yorkshire towns. Graham Butler compared the roles of different forms of provision in Newcastle-on-Tyne (dispensary, hospital, and workhouse), while Daisy Cunynghame explored the care at three late eighteenth-century dispensaries in southeast Scotland and northeast England. Mary Chamard traced the evolution of dispensary provision in late nineteenth- and early twentieth-century London. Some histories of individual dispensaries are apparently aimed at lay rather than

[3] Mabel Buer, *Health, Wealth and Population in the Early Days of the Industrial Revolution* (London: Routledge, 1926, reissued 2006), pp. 135-6, 257-8.
[4] I. S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England'. *Bulletin of the History of Medicine*, 55.3 (Fall 1981), 322-342.
[5] Individual histories include Hilary Marland, *Doncaster Dispensary 1792–1867: Sickness, Charity and Society*, Occasional Paper 3, (Doncaster: Doncaster Library Services,1989), quote p. 2; Katherine Webb, *'One of the Most Useful Charities in the City': The York Dispensary, 1788-1988* (York: University of York, 1988).

professional audiences. This possibly also applies to Whitfield's recent overview of the institutions.[6]

The works cited mainly concentrate on the north of England, reflecting the pattern of provision there. By the turn of the nineteenth century dispensaries outnumbered hospitals in northern counties, while in the midlands and south the reverse was true.[7] Other studies informing or influencing this thesis deal with aspects of health provision in west midland counties. These are largely the work of researchers led by Jonathan Reinarz of Birmingham. Their focus, either including or overlapping with dispensaries, include Birmingham hospitals in general; Poor Law medical care; midwifery; and health care in rural midland counties. These studies explored collaboration, rivalry, and political influences in various local medical economies.[8]

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[6] Mary E Fissell, Patients, Power and the Poor in Eighteenth-century Bristol (Cambridge & New York: Cambridge University Press,1991); John V. Pickstone, Medicine and Industrial Society: A History of Hospital Development in Manchester and Its Region, 1752-1946 (Manchester: Manchester University Press, 1985); Hilary Marland, Medicine and Society in Wakefield and Huddersfield 1780-1870 (Cambridge: Cambridge University Press, 1987); Graham Alan Butler, 'Disease, medicine and the urban poor in Newcastle-upon-Tyne, c.1750-1850', (unpublished PhD thesis, Newcastle-on-Tyne, 2012); Daisy Cunynghame, 'The Roles of the Edinburgh, Kelso, and Newcastle Dispensaries in Charitable Relief, 1776-1810 '(unpublished PhD thesis, Edinburgh, 2020); Mary J. Chamard, 'Medicine and the Working Class: the Dispensary Movement in London, 1867-1911' (unpublished PhD thesis, Toronto, 1984); Michael Whitfield, *The Dispensaries: Healthcare for the Poor Before the NHS*: *Britain's Forgotten Health-care System* (Bristol: AuthorHouse, 2016).

[7] Loudon, 'Origins and Growth, p.324; 'north' and 'south' refer respectively to the areas each side of a line from the Wirral to the Wash; in 1800 there sixteen dispensaries in London and twenty-two elsewhere.

[8] Jane Adams, 'The Mixed Economy for Medical Services in Herefordshire c.1770 - c.1850' (Unpublished PhD thesis, Warwick, 2003); Frances Badger, 'Delivering Maternity Care: Midwives and Midwifery in Birmingham and its Environs, 1794-1881' (Unpublished PhD thesis, Birmingham, 2014); Richard Moore, 'Competitors for Custom: the Medical Marketplace and the Emerging Medical Profession in Nineteenth-Century Shropshire, 1835-1865' (Unpublished PhD thesis, Birmingham, 2008), Jonathan Reinarz, *Health Care in Birmingham: A History of the Birmingham Teaching Hospitals, 1779-1939* (Woodbridge: Boydell & Brewer, 2009); Jonathan Reinarz (ed), *Medicine and Society in the Midlands 1750-1950* (Birmingham: Midland History Occasional Publications, 2007); Alistair Ritch and Jonathan Reinarz, 'Exploring Medical Care in the Nineteenth-Century Provincial Workhouse: A View from Birmingham', in Jonathan Reinarz and Leonard Schwarz (eds.), *Medicine and the Workhouse* (Rochester, NY: Boydell and Brewer, 2013).

Warwickshire was chosen as a suitable area for this study for several reasons. At the start of the nineteenth century, it was approximately in the middle group of English counties in both area and population.[9] The county includes both thinly settled countryside and towns of varying size, some of which changed enormously as they became more industrialised. Birmingham became one of the country's largest cities, while Coventry remained moderate in size and population. Some of the county's market towns continued as such, while others either industrialised, like Nuneaton, or acquired functions as leisure and residential centres (as Leamington and Stratford-on-Avon did, to differing degrees). Dispensaries were established in a range of towns, and even in a few villages. The county thus offers the opportunity for case studies (or 'micronarratives') in varying local societies. I had earlier explored the history of two institutions in the medium-sized towns of Warwick and Leamington.[10] This experience suggested the potential (but also some of the challenges) of a wider county-based study.

Dispensaries as medical charities

Both dispensaries and hospitals were products of the 'associational' philanthropy that during the eighteenth century largely replaced the endowed charities of earlier epochs.[11] R. J. Morris argued that voluntary associations, including medical charities, greatly influenced the urban societies of Britain during 1780-1850, as they addressed the social strains in growing towns, or rather their consequences:

[9] The Census for 1811 placed Warwickshire (pop. 228,190) 11th of 43 counties and ridings by population; in area it was 24th of 40 counties. 'Population of the Several Counties of Great Britain', *House of Commons Hansard*, 18 January 1812, vol 21, pp. 77-83 (last accessed 13 November 2020); County areas from *Vision of Britain*, HM Census 1831, transcribed by David Gatley, Univ. of Staffordshire. https://www.visionofbritain.org.uk/census/table_page.jsp?tab_id=GB1831ABS_M%5B1%5D&u_id=10001043&show=DB&min_c=1&max_c=5 (last accessed 13 November 2020)

[10] John Wilmot '"Advice and medicine for the working classes": the Warwick and Leamington Provident Dispensaries 1869-1913' (Unpublished MSc dissertation, University of Oxford, 2013); -----, ''Advice and Medicine for the Working Classes': The Leamington and Warwick Provident Dispensaries, 1869-1913', *Warwickshire History* 16 (2014), 26-42; -----, ''Indeed a Health Resort'? Mortality at the Leamington Provident Dispensary, 1869-1913'', *Local Population Studies* 93 (2014), 54-67.

[11] David Owen, *English Philanthropy 1660-1960* (Oxford: Oxford University Press, 1965), pp. 11-12; Martin Gorsky, *Patterns of Philanthropy: Charity and Society in Nineteenth Century Bristol* (Woodbridge: Boydell & Brewer, 2011), pp. 18-19.

poverty, disease, and disorder. Their purposes could range from social welfare to culture and adult education, and their practices derived from those of joint-stock companies, nonconformist chapels and public houses. In Morris's analysis, their efforts not only drew on the classic middle-class virtues of sobriety, thrift, and self-improvement, but aimed to spread such attributes more widely. The aristocracy might lend their names as patrons of medical charities, but it was middling figures, manufacturers, merchants, and professional people, that supported them both financially and practically, staffing their committees and becoming unpaid officials.[12] Loudon sees the financial and general support of dispensaries as inspired by Enlightenment values and enabled by the rising prosperity of the middle classes.[13]

Considering motivations in more detail, donors to these and to other charities may have hoped to gain prestige, political influence, or the favour of the powerful.[14] Bronwyn Croxson considered individual impulses favouring the support of eighteenth-century dispensaries (and by implication, other medical charities). Charity sermons and fundraising literature pointed to their humanitarian benefits, to the personal satisfaction for donors, and the element of insurance (if the moneyed were themselves to fall on hard times).[15] Subscribing would reinforce the social contract of mutual obligation between rich and poor, as well as benefiting the national economy through ensuring a healthy and capable workforce. Personal bonds of generosity and gratitude would connect givers and receivers, as expressed in the letters of recommendation that patients needed from subscribers to receive treatment. With the low minimum subscriptions (for many dispensaries half a guinea annually), those of modest means could contribute to the charitable effort, and might, indeed, be helping their neighbours.

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[12] R.J. Morris, 'Voluntary Societies and British Urban Elites, 1780–1870: an analysis', T*he Historical Journal,* 24 (1982), 95–118.
[13] Loudon, 'Origins and Growth, pp. 330-1.
[14] Sandra Cavallo, 'The Motivations of Benefactors: An Overview of Approaches to the Study of Charity', in Jonathan Barry and Colin Jones, (eds.), *Charity and Medicine before the Welfare State* (London: Routledge, 1991), 47-62.
[15] Bronwyn Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', *Medical History*, 41 (1997) 127-49.

Together with the rhetoric of open-handedness, institutional rules required from beneficiaries sober, decent conduct, and compliance with medical directions. In traditional paternalistic relations, such a balancing of obligations was widely believed the necessary counterpart of benevolence.[16] Such expectations of orderly behaviour have in the past sometimes been categorised as 'social control'. While this concept doubtless has some validity, it is less favoured by current historians. In part this is through its tendency to diminish agency among poor people themselves.[17]

Roy Porter analysed critically the relations between rich and poor as they influenced eighteenth-century voluntary hospitals. He portrayed their imposing buildings as 'conspicuous monuments' to philanthropy, that expressed a 'clasping of hands' between different local groups, not only between rich and poor, but those adhering to different political and religious ideals. Through their benefits, they were intended to palliate the prevailing harsh social relations, as expressed in the Poor Laws and prevailing criminal codes. The rhetoric of funding campaigns implied that the effort of creating and maintaining hospitals would heal social divisions.[18] To explore the perhaps messier reality, Wilson examined the dates of infirmary foundations in relation to parliamentary contests. In the eighteenth century Unsurprisingly, he found a complex picture: in various instances, hospital-building initiatives did appear to have a calming effect, but in others local tensions could prevent a successful foundation. Interestingly for this study, these included

[16] Bronwyn Croxson, 'Eighteenth-Century London Dispensary Charity', p. 130; for paternalism, Harold Perkin, *Origins of Modern English Society* (London: Routledge, 1991), pp. 187-92.
[17] Alan J. Kidd, 'Philanthropy and the 'Social History Paradigm'' *Social History*, 21, 2 (1996): 180-92, esp. pp. 186, 191.
[18] Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England' In Lindsay Granshaw and Roy Porter (eds), *The Hospital in History*, 149-178. London: Routledge, 1990 (orig. 1989), pp. 152-7.

the abortive attempt in 1741 to establish a dispensary in Coventry, with its notoriously rancorous parliamentary politics.[19]

The early infirmaries were based in towns but aimed for support from surrounding hinterlands, partly though treating suitable rural inhabitants. By doing so, the institutions would attract influential contributions from regional landowners, while fostering bonds between them and leading urban professionals and businessmen.[20] This occurred in Warwickshire in the late eighteenth century, as Birmingham largely supplanted Coventry and Warwick as the social and political hub for the Warwickshire aristocracy and gentry. Such individuals provided support for the new General Hospital, while most of the funding that enabled its completion and opening in 1779, however, came from the contributions of local business figures than to rural landowners. Nevertheless, the names of regional peers and baronets continued to feature prominently in hospital publicity materials.[21]

Dispensaries and their Features

If the early hospitals were a phenomenon of the early and mid-eighteenth-century, dispensaries followed a few decades later.[22] Prominent lay or medical people launched campaigns to fund and maintain these new out- and home-patient institutions, sometimes based in purpose-built and perhaps imposing premises. Their physicians and surgeons generally gave their services gratis but might receive occasional modest honoraria, while most employed apothecaries to dispense medicines. The number grew rapidly in London in the 1770s and 1780s, and a little

[19] Adrian Wilson, 'Conflict, Consensus and Charity: Politics and the Provincial Voluntary Hospitals in the Eighteenth Century', *English Historical Review,* 111. 442 (1996), 599-619. Some of those concerned with the unsuccessful mid-century initiative in Coventry seem to have thrown their energies, two years later, into establishing the infirmary in Northampton; for Coventry, pp. 605-6; elections, pp. 606-19.

[20] Wilson, 'Conflict, Consensus and Charity'. pp. 600-1; names of institutions that reflected the rural commitment include the Northampton County Hospital and the later Coventry and Warwickshire Hospital; Pickstone, *Medicine and Industrial Society*, pp. 10-11.

[21] Adrian Wilson, 'The Birmingham General Hospital and Its Public, 1765-1779' in Steve Sturdy (ed), *Medicine, Health, and the Public Sphere in Britain, 1600-2000 (*London and New York: Routledge, 2002) 85-106, pp. 88-98; the business figures included Boulton, Watt, the Galtons and the Lloyds.

[22] Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London: Routledge, 2001). p. 90; Loudon, 'Origins and Growth'; see p. 323 for comments on the dates of dispensary foundation.

later in provincial towns, so that by 1800 there were sixteen metropolitan dispensaries and twenty-two elsewhere. They were almost exclusively urban phenomena, with some towns too small to support an infirmary establishing dispensaries instead, although both sorts of institution could become a focus for civic pride.[23]

Croxson explored the complex role of patronage and politics at the early London dispensaries. They attracted (indeed sought) the support of prominent figures who would act as presidents or patrons, and of aspiring politicians (usually in less prominent roles). They thus became part of a web of aristocratic patronage; in the 1780s, several factions became associated with different dispensaries, reflecting the shifting allegiances of late eighteenth-century high politics. This pattern of support, arising from a profusion of medical charities and on London's place as the seat of government, was evidently not echoed in provincial England.[24] However, new research on dispensaries, like this thesis, needs to explore the part played by politics, patronage, and local alliances.

In considering influences on early dispensaries, some scholars have explored the influence of dissenting religion. Adherents of such denominations, in London and elsewhere, were attracted by their practical philanthropy. In Kilpatrick's view, the convictions of Quakers particularly encouraged them to organise care of the sick at home rather than in hospital. Doing so would support family bonds, while also avoiding confinement in institutions and limiting the spread of infection. The prominence of certain Quaker physicians seems likely to have influenced Kilpatrick in emphasising their role and importance. For instance, the physician John Coaksey Lettsom was both a prolific author and the co-founder of an influential early dispensary in London.[25] Another interpretation of the social place of dissenting

[23] Pickstone, *Medicine and Industrial Society*, p. 17.
[24] Croxson, 'Eighteenth-Century London Dispensary Charity', pp.141-44.
[25] R. Kilpatrick, 'Living in the Light': Dispensaries, Philanthropy, and Medical Reform in Late Eighteenth-Century London', in Andrew Cunningham.and Roger French (eds), *The Medical Enlightenment of the Eighteenth Century* (Cambridge: Cambridge University Press, 1999), 254-80; esp. pp. 258-9, 268-9; among Lettsom's extensive writings were reports from the Aldersgate dispensary; Dr Robert Willan was another Quaker, who had a long association with the Carey Street Dispensary.

practitioners can be found in Ian Inkster's concept of the 'marginal man'. He found the medical men in Sheffield in 1780-1850 to be typically socially and geographically mobile, predominantly dissenting in religion and with radical or reformist political convictions.[26] Inkster's ideas will receive more detailed attention later in this thesis, particularly in relation to Birmingham and as regards some practitioners' careers. Those physicians who staffed London dispensaries, often with dissenting religious convictions as noted above, predominantly had qualifications gained in Scotland or in continental centres. Such a background underlined their position as 'marginal men', meaning that they were unlikely to gain appointments at the great London hospitals.

Religious differences also played a part in provincial towns, especially in relations between new and established institutions. Pickstone observed that dissenting practitioners in north-west England, faced with obstruction by their infirmary colleagues, sometimes established dispensaries as separate charities.[27] The Newcastle-on-Tyne dispensary, at its foundation in 1778, was a similar example. The physician Dr John Clark, a leading local Unitarian, needed to delay its opening by six months, reassuring his local infirmary colleagues that the new institution's work would complement the hospital's efforts rather than competing with it. [28]

Alliances of dissenters and churchmen often played a part in the support of medical charities, for instance in Wakefield and Huddersfield; this may also have been the pattern in the industrialising towns of the West Midlands, and such aspects will be explored in relevant Chapters of this thesis. [29] Beyond adherence to specific denominations, from the 1790s certain beliefs or attitudes linked with

[26] Inkster adapted the idea from the Chicago sociologist Robert Park, who studied migrants in the early twentieth century, as people familiar with two societies but at home in neither. Ian Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850', in John H Woodward and David Richards (eds.), *Health Care and Popular Medicine in Nineteenth Century England* (London: Croom Helm, 1977).
[27] Pickstone, *Medicine and Industrial Society*, p.17.
[28] Loudon, 'Origins and Growth, p. 335; Butler, 'Disease, medicine and the urban poor in Newcastle-upon-Tyne', pp. 150-1.
[29] Marland, *Medicine and Society in Wakefield and Huddersfield*, pp. 141-44.

evangelical religion increasingly influenced philanthropy and public life. Hilton argued that the distinctive 'middle-class piety' of evangelicalism fostered ideals of 'probity…frugality, professionalism, and financial rectitude'. Such convictions were found, well beyond the actively evangelical, among many established clergymen and lay people in the first half of the nineteenth century. Philanthropy became infused 'with the evangelical spirit' and especially by the belief that charity should be carefully managed.[30] This study will explore evidence for such attitudes and beliefs in the detail of dispensary administration in the case study towns.

Politics also seem likely also to have played a part in provincial medical charities. As has been seen, Wilson's study of provincial infirmary foundation offers only qualified support for the intended 'social balm' among local groups divided by wealth, politics, and religion. Initiatives in individual towns may have resulted from very localised events or circumstances, such as the Birmingham riots of 1791.[31] This alarming episode revealed social tensions inflamed by sectarian agitation. Other factors contributing were deep divisions between rich and poor and hardships resulting from economic change. Accordingly, they seem likely to have influenced Mathew Boulton and his fellow businessmen in their establishment of the Birmingham General Dispensary in 1793-4. These founders were an alliance of wealthy citizens who differed in politics and religious persuasion; several had been members of the Birmingham-based Lunar Society, active 1765 – *c.*1800. This informal dining club, numbering around a dozen, met monthly to dine and discuss new ideas in natural and experimental philosophy (or science and technology as

[30] Boyd Hilton, The Age of Atonement: The Influence of Evangelicalism on Social and Economic Thought 1795-1865 (Oxford: Clarendon Press, 1988), pp. 7, 101, 104-5.
[31] Over several days, 'Church and King' mobs attacked Dissenting chapels and the houses of wealthy Dissenters and their allies, many of which were destroyed; R. B. Rose, 'The Priestley Riots of 1791', *Past & Present*, 18 (1960), 68-88.

they would be called today). Several members were also supporters of the Birmingham General Hospital and other regional medical institutions.[32]

Self-help and Paternalism

Self-help was widely advocated in the early nineteenth century as a remedy for social ills. Studies of the phenomenon vary greatly in focus and framework, partly reflecting the varying ideologies and convictions originally at play. For evangelicals, self-help was a necessary complement to charity and to be encouraged among the poor (by implication, in individualistic forms).[33] Some scholars have interpreted the collective self-help provided by friendly societies as developing from informal links or networks connecting poor households for mutual aid. [34] At this social level, there was a porous frontier between small-scale charity and self-help. For ecclesiastical and other philanthropists, the frequent financial weaknesses of friendly societies aroused concern; in addition, their meetings in public houses were thought to encourage drunkenness and insubordinate or even seditious talk. Some voices therefore promoted the guiding role of the clergy and gentry in mutual organisations such as savings banks and 'patronised' friendly societies.[35]

Mutualism, supported and strengthened by paternalism, offered a vision that was also attractive to some medical reformers wishing to improve the health care of the poor. Importantly for this study, this included those figures championing the 'self-supporting' or 'provident' dispensaries that originated in rural

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[32] John Money, *Experience and Identity: Birmingham and the West Midlands, 1760-1800* (Manchester: Manchester University Press,1977**),** pp. 170, 263-4; Jenny Uglow, *The Lunar Men: The Friends Who Made the Future, 1730-1810* (London: Faber, 2002); Matthew Boulton and James Watt were Birmingham general hospital governors; Boulton was the main dispensary founder and Watt was a supporter; medical members of the group, William Small and William Withering, were physicians at the Birmingham General Hospital., while Erasmus Darwin was associated with the proposed Derby infirmary after he moved there in 1783.

[33] Hilton, *The Age of Atonement*, pp. 101-2.

[34] Daniel Weinbren, 'Supporting Self-help: Charity, Mutuality and Reciprocity in Nineteenth-Century Britain' in Bernard Harris and Paul Bridgen (eds.), *Charity and Mutual Aid in Europe and North America since 1800* (London: Routledge, 2008), 67-88, esp. pp. 68, 70-71.

[35] Penelope Ismay, *Trust Among Strangers: Friendly Societies in Modern Britain* (Cambridge: Cambridge University Press, 2018), esp. pp. 85-118 (Ch.3, 'The Battle between Savings Banks and Friendly Societies'); for provident dispensaries, see Lane, *Social History of Medicine*, pp. 91-93.

Warwickshire in the 1820s. These new institutions were largely supported by mutual funding, while prosperous inhabitants both contributed additional charitable sums and managed the institutions (at least in their early years). As the nineteenth century progressed, friendly societies extended their activities from aid during sickness to the provision of medical care itself.[36] They commonly appointed local practitioners as 'club doctors', while a few used provident dispensaries as agents (as in Coventry); late in the century, societies sometimes collaborated to establish combined dispensaries in larger towns. They developed complex relations, sometimes contested, with medical charities and with individual practitioners, such interactions to be explored in later parts of this thesis. One task for this study is to consider the interplay between different elements, of paternalism on one side and of collective self-help on the other; how did these alter, for instance in late nineteenth-century Coventry?

Reform Movements and Medical Charities

The 'age of reform', especially in the early nineteenth century, affected medical care together with many aspects of national life. Campaigns for reform and clashes over local and national governance had indirect effects on medical charities (as in Coventry in the 1830s). Reformers attacked political bodies for their unrepresentative nature and levelled similar attacks at the powerful London-based medical corporations. There was also widespread dissatisfaction with the Poor Laws, increasingly costly and yet seemingly incapable of meeting either national economic requirements or the needs of the poor. Some critics of the old Poor Laws drew inspiration from Thomas Malthus, whose 1798 *Essay on Population* argued that population growth would always outrun food supplies.

More immediately and practically, medical practitioners disliked the contracts at parish level that governed the medical care of paupers. In many cases these were operated in either a capricious or parsimonious manner. The new Poor Law system in 1834 can be seen as a great compromise, largely intended to reduce

[36] Martin Gorsky, 'Friendly Society Health Insurance in Nineteenth-century England', in Martin Gorsky and Sally Sheard (eds.), *Financing Medicine: The British Experience Since 1750* (Abingdon: Routledge, 2006), 147-63.

the costs of relief. However, many remained dissatisfied with new arrangements, including poor people themselves and the practitioners who served their medical needs.[37]

Utilitarianism was a particular philosophy that influenced many reformers, simply summarised as the desirability of 'the greatest happiness for the greatest number'. Jeremy Bentham's view of individual humans as being motivated by increased pleasure and the avoidance of pain was his starting point for elaborating Utilitarian principles. He argued that legislators should organise both rewards and punishments (or 'disincentives') according to the implications for the social good. Benthamite ideas, probably somewhat distorted, were used to create deterrent workhouses and the severe Victorian prison system.[38]

Many practitioners tended to favour reform, at least of the organisation of medical matters, their views often being influenced by the *Lancet* medical journal. From its first publication in 1823, this was a leading radical voice in urging the reform of both medical institutions and the wider society.[39] Thomas Wakley, the surgeon who was its editor and proprietor, was a strong personality who has continued to attract both admiration and criticism. In his articles he criticised leading surgeons at famous London hospitals for incompetence and nepotism, while dispensaries soon attracted similar accusations of jobbery and poor practice. Both hospitals and dispensaries were accused of abusing charity, for instance through the free treatment of some who could well afford to pay. In the view of the *Lancet* and many others, medicine was poorly governed, the London Royal Colleges (of physicians and surgeons) being condemned for their exclusiveness and unrepresentative nature. Physicians with Scottish or foreign degrees rarely became Fellows of their College, while the surgeons' College was unwelcoming to the numerous surgeon-apothecaries (or general practitioners, as they were increasingly

[37] Derek Fraser, The Evolution of the British Welfare State: A History of Social Policy since the Industrial Revolution (4th ed., Basingstoke, Palgrave Macmillan, 2009), esp. pp. 48-60.
[38] Fraser, Evolution of the British Welfare State, pp. 123-4
[39] Ian Burney, 'Medicine in the Age of Reform', in Arthur Burns and Joanna Innes (eds.), *Rethinking the Age of Reform: Britain 1780-1850* (Cambridge: Cambridge University Press, 2007), 163-85.

being called). Such disfranchised medical men, especially those struggling in the crowded London market, became a ready audience for Wakley's barbs and provided fresh material for his columns.

William Cobbett, Wakley's friend and mentor, greatly influenced both his robust journalistic style and his politics. Both men were influenced by French revolutionary ideas but added a strong dose of English conservatism concerning ancient customs and liberties. Such ideas carry echoes of Thomas Paine, who In the *Rights of Man* in 1791 pointed to the natural rights that the masses had lost when others gained possession of the land. Radicals in the mould of Cobbett and Wakley strenuously opposed Utilitarianism as a mechanistic, inhumane philosophy.[40]

Dispensaries and new Medical Paradigms

After a life in medical practice, both the daily work of nineteenth-century practitioners and their guiding ideas are obviously key areas of personal interest. The thinking of many contemporary medical men (men being the only practitioners in the period) was influenced by important continental concepts and practices[41]. These are often summarised as 'Paris medicine', a new way of thinking that largely altered the role of medicine in society. The main features of this form of practice included detailed observation of patients during life to determine the causative pathology, often using instruments such as the stethoscope (introduced by Rene Laennec in 1816).[42] If a patient died, autopsy was used to confirm or refute the ante-mortem diagnoses. Its third key element was the use of statistics to assess and compare the effect of different treatments. Ackerknecht regarded this new form of 'hospital medicine' as the dominant mode of medical practice throughout the first

[40] Burney, 'Medicine in the Age of Reform'; p.164, links with Cobbett; pp. 165-66, other medical journals; pp 175, 181; for 'ancient liberties' including coroners' inquests, see Fraser, *Evolution of the British Welfare State,* p. 127 for Tom Paine and the *Rights of Man.*

[41] Female medical practitioners did not exist in Britain until the late decades of the nineteenth century. Contemporaries frequently referred to 'medical men' when discussing physicians, surgeons, and apothecaries.

[42] Stephen Jacyna, 'Medicine in Transformation, 1800-1849', in W F Bynum, Anne Hardy, Stephen Jacyna, Christopher Lawrence, and E.M. Tansey(eds.), *The Western Medical Tradition, 1800-2000* (Cambridge: Cambridge University Press, 2006), 11-110, esp. pp. 25-28, 37-53; Erwin *Ackerknecht, Medicine* at the *Paris Hospital, 1794-1848* (Baltimore, MD: Johns Hopkins University Press, 1967).

half of the nineteenth century. Ivan Waddington distinguished the new style of practice as different in kind from the 'bedside medicine' of the eighteenth century. His argument was that hitherto practitioners had needed to negotiate and reach a shared understanding with their patients, especially among wealthy and prominent individuals who could offer patronage. By contrast, the early nineteenth-century doctor (particularly in hospitals) was now dealing with a 'body' rather than a 'person'.

Similar arguments, strongly influenced by medical sociology, were advanced by Nicholas Jewson and by Mary Fissell.[43] Jewson and Waddington, at least, seemed to rely on a rather idealised (or selective) view of earlier doctor-patient relations. After all, as Irvine Loudon pointed out, many practitioners dealt with patients across the social scale, only a tiny number of whom would act in any way as patrons.[44] Nevertheless, the insights of these authors include their recognition of the reductionist tendencies in nineteenth-century medicine, which tended to marginalise the identity, personality, and preferences of the patient. Foucault, in his celebrated work *the Birth of the Clinic*, referred to the practitioner's or student's 'clinical gaze' that objectified the suffering individual, leaving little room for compassion or human understanding. However (in this respect differing from the sociologists) Foucault interpreted the power inherent in clinical encounters as less oppressive (medical dominance, in other words) than being a process that implicated both parties as mutual elements of a social field. In this and in other works, Foucault observed the 'disciplinary power' or 'biopower' that controlled

[43] Ivan Waddington, *The Medical Profession in the Industrial Revolution* (Dublin: Gill & Macmillan, 1984); Ivan Waddington, 'The movement towards the professionalisation of medicine', *British Medical Journal,* 1990, 301, 688-90; N.D. Jewson, 'Medical Knowledge and the Patronage System in 18th Century England', *Sociology,* 8, No. 3 (1974), 369–85; N.D. Jewson, 'The disappearance of the sick-man from medical cosmology, 1770–1870', *International Journal of Epidemiology,* 38,3 (2009), 622–633; Mary Fissell, 'The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine', in Roger French, Andrew Wear, (eds)., *British Medicine in an Age of Reform*. London: Routledge, 1991. pp. 91–109.

[44] Loudon related this point to his wider argument that surgeon-apothecaries were, in effect, general practitioners from the mid-eighteenth century onwards, and thereby dealing with a wide social range. Irvine Loudon, *Medical Care and the General Practitioner 1750-1850* (Oxford: Clarendon, 1986), pp. 100-104.

bodies not merely in hospitals but in prisons, schools, and military barracks.[45] Jacyna, echoing Foucault, notes that many early nineteenth-century practitioners had a period of military or naval service. In Foucauldian terms, their experience predisposed them to mobilise collectives of bodies for clinical observation, then to systematise their medical care and to document key elements of the process.[46] Other scholars have commented (in simpler language) on the influential systems of hygiene promulgated by experts in military medicine and the frequent experience of service in the armed forces among early nineteenth-century practitioners.[47]

The shift in epistemology outlined above had some influence on the process of professionalisation, complex, uneven, and contested as it was. Almost all medical men, despite their differences, agreed on some key prerequisites for medical work; that those seeking to practise should undergo training that included reading and lectures, should observe the sick in hospitals, and undergo an examination for qualification.[48] Science was agreed as the necessary basis of the discipline, even if this contention might contain large elements of self-presentation for rhetorical purposes.[49] While in the giant hospitals of Paris scientific medicine reigned supreme, in Great Britain scientific observation was evident across a range of settings. These included dispensaries, which generated many accounts of the 'natural history' of common diseases. The earliest examples were the eighteenth-

[45] Michel Foucault, *The Birth of the Clinic,* trans. Alan Sheridan (London: Routledge, 1989), esp. Ch 6. (First published as *Naissance de la Clinique* (Paris: Presses Universitaires de France, 1963); Prisons and their world werew analysed by Foucault in *Discipline and Punish*, published 1975 (*Surveiller et punir: Naissance de la prison*).
[46] Jacyna, 'Medicine in Transformation', pp. 59-60, 83-86.
[47] M. W. Flinn, 'Editor's Introduction' to Edwin Chadwick*, Report on the Sanitary Condition of the Labouring Population of Great Britain*, orig. pubn. 1842, London Poor Law Commissioners (Edinburgh: Edinburgh University Press, 1965); pp. 18-20 for Edinburgh training and influence of military medicine; pp. 26- 30 for statistics.
[48] Christopher Lawrence, *Medicine in the Making of Modern Britain* (London: Routledge, 1994), pp. 38-39.
[49] Jacyna, 'Medicine in Transformation', pp. 78-9.

century dispensary physicians, who not only treated large numbers of patients with fevers but sometimes published their findings.[50]

In the next generation, British practice was linked with continental models by such men as John Forbes. In his earlier years as a dispensary physician, he translated Laennec's account of the stethoscope, then documented its application to lung disease among patients at the Penzance and Chichester dispensaries.[51] In industrial towns in the 1830s, early works on occupational health appeared from dispensary practitioners such as John Darwall of Birmingham and Charles Thackrah of Leeds.[52] Many such practitioners were active as authors, and sometimes as editors, in the medical journals that proliferated during the first half of the nineteenth century. Only a few followed the *Lancet* in adopting a radical political stance. More often they seem to have regarded their task as spreading medical news and communicating advances in knowledge and techniques, while also promoting moderate reforms of professional bodies.[53]

Professionalisation and the dispensaries

Professionalisation is the process whereby certain occupations gain greater autonomy and status as the become recognised as professions. The process has often been linked with legislative provisions, an important milestone being the Medical Act of 1858 that established the Medical Register and the General Medical Council. Jeanne Peterson regarded mid-century metropolitan medical men, especially general practitioners and before the 1858 law was enacted, as having limited autonomy and a lower status than the established clergy or much of the

[50] Ulrich Tröhler, 'The Doctor as Naturalist: The Idea and Practice of Clinical Teaching and Research in British Policlinics 1770-1850', *Clinical Teaching, Past and Present*, 21 (1989), 21-34; Loudon, 'Origins and Growth, pp. 332-3; seven dispensary authors are mentioned who published work 1770-1833, mainly on continuing fevers.

[51] Jacalyn Duffin, 'The Cardiology of R. T. H. Laennec', *Medical History,* 33 (1989), 42-71, p.45. Laennec was a Breton, so here the Breton orthography is adopted (omitting the diaeresis).

[52] Andrew Meiklejohn, 'John Darwall, M.D. (1796-1833) and Diseases of Artisans', *British Journal of Industrial Medicine*, 13 (2)1956, 142-51.

[53] Jean and Irvine Loudon, 'Medicine, Politics, and the Medical Periodical. 1800-50' in *Medical Journals and Medical Knowledge: Historical Essays* W. E. Bynum, Stephen Lock, and Roy Porter, (eds). (London: Routledge, 1992), 49-69.

legal profession.[54] In contrast to analyses (such as Peterson's) that emphasised credentials or ascribed status, Michael Brown adopted a distinctive approach to professionalisation, focusing on culture and identity. He also located the significant changes in the 1830s rather than the 1850s. In this earlier period, Brown identified the crystallising of a shared professional identity, marked by the establishment of medical societies, the rise of professional journals, and by wide participation in medico-political debates.[55]

In the middle third of the nineteenth century, medicine and its practitioners began to take part in social and governmental responses to endemic and epidemic disease. They thus became doctors to the 'social body', Mary Poovey's concept that influenced both Jacyna and Brown.[56] The hazards of some diseases were new and alarming, like Asiatic cholera on its first appearance in 1832. The boards of health co-ordinating local responses always included medical men, who could offer little in the way of effective treatment, but who, through their civic roles, encouraged hygiene and ventilation in the localities most at risk. In subsequent decades the sanitarian idea took hold; that much disease and premature death could be prevented by clean water and efficient sewage systems. The *Sanitary Report* in 1842 by Edwin Chadwick, originating from one of the chief architects of the new Poor Law, took such principles much further.[57] While Chadwick had little respect for medical men or their ideas, his report drew on a multitude of local practitioners' accounts, based on their work at dispensaries or in the Poor Law service. The 1842 Report and other enquiries into urban health conditions expressed the prevailing belief that accumulating sufficient facts or figures would almost automatically point

[54] M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Oakland, Ca: University of California Press, 1978).
[55] Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760*–1850 (Manchester: Manchester University Press, 2018); Michael Brown, 'Medicine, Reform and the 'End' of Charity in Nineteenth-Century England', *English Historical Review*, CXXIV, 511 (2009), 1353-89.
[56] The 'social body' is dealt with by Jacyna, 'Medicine in Transformation', pp. 81-97; by Brown, Performing Medicine, p.190; and is especially associated with Mary Poovey, *Making a Social Body: British Cultural Formation, 1830-1864* (Chicago: University of Chicago Press,1995).
[57] Officially the *Report on the Sanitary Condition of the Labouring Population of Great Britain*.

to solutions. In the terms used by Foucault, the governmentality implied by such statistical exercises mirrored the clinical gaze.[58]

Medical Practice and Late Nineteenth-Century Politics

In the second half of the nineteenth century, certain historians have detected a turn towards collectivism in British society, replacing earlier traditions of individualism and local voluntarism. However more recent interpretations have modified such views, suggesting, for instance, that local voluntary efforts continued to be significant.[59] In the 1860s, legislation extended the franchise to many working men, which arguably encouraged the adoption of populist policies.[60] One such policy, developing from both the national reports of the 1840s and local inquiries by sanitary engineers around mid-century, involved municipal responses to the sanitary challenges of clean water and sewage disposal. The celebrated activism of Joseph Chamberlain and his allies in Birmingham used local government to improve popular education and the urban environment, but other places followed a similar path. Also worthy of consideration, close to home, would be the contribution of Chamberlain family members and associates in the work of urban charities. [61] In the field of health care, hospitals increased in number and treated more people from the 1850s onwards; how far dispensaries shared this increased activity hitherto has been investigated relatively little.[62]

Provident dispensaries, from the 1860s, became an increasing element of urban health care, at least in some conurbations such as London and Manchester. From the 1830s in Coventry, the provident dispensary had been important and

[58] W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press,1994, pp. 77-78; Jacyna, 'Medicine in Transformation', pp. 85-86.

[59] Jose Harris, *Private Lives, Public Spirit: Britain, 1870–1914* (Oxford: Oxford University Press, 1993); this author was sceptical about the shift to collectivism identified by earlier historians like Dicey; see pp. 10-13.

[60] The relevant legislation included the Representation of the People Act ('Second Great Reform Act') in 1867 and the Municipal Franchise Act of 1869; Martin Daunton, *Wealth and Welfare: An Economic and Social History of Britain 1851-1951* (Oxford: Oxford University Press, 1993), pp. 336-360.

[61] Asa Briggs, *Victorian Cities* (Harmondsworth: Penguin, 1990).

[62] Steven Cherry, *Medical Services and the Hospital in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), pp. 45-48.

indeed increasingly dominant in daily medical care, but in Birmingham a pluralistic approach was adopted. This thesis therefore needs to address and compare the contrasting policies followed by the two large Warwickshire towns.[63] The voluntary efforts sustaining medical charities continued and grew, and included an increasing working-class contribution through workplace collections and Saturday funds.[64] The consequent pressure for a working-class voice in institutional policies offers an additional theme for exploration here.[65] At provident dispensaries an emphasis on collective self-help may, in part, have displaced the paternalism so evident earlier in the century.

The role of dispensaries as sites for clinical observation, as noted above in relation to 'Paris medicine', implies their potential for medical training and education. Their residents and honorary physicians and surgeons could hone their skills through dealing with large numbers of cases, albeit in the most unpromising social settings. Beyond such informal in-service training, the formal teaching of medical students began, initially on a small scale, at London dispensaries in their earliest days (from the 1770s).[66] A half-century later, the scale of instruction had increased at London dispensaries and their associated private medical schools, as well as in various provincial centres, several of which (including Birmingham) became nuclei for the later civic universities.[67]

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[63] Chamard, 'Medicine and the Working Class'; for rise of provident dispensaries in London, see pp. 129, 154-7, 174-6; Martin Hewitt 'Fifty years ahead of its time? The provident dispensaries movement in Manchester, 1871–85' in Alan Kidd, Melanie Tebbutt (eds.), *People, Places and Identities: Themes in British Social and Cultural History, 1700s –1980s* (Manchester: Manchester University Press, 2017), 84-108.

[64] Martin Gorsky, John Mohan, and Tim Willis, 'A "splendid spirit of cooperation": hospital contributory schemes in Birmingham before the National Health Service' in Jonathan Reinarz (ed), *Medicine and society in the Midlands 1750 - 1950* (Birmingham: Midland History Occasional Publications, 2007), 167-191.

[65] Keir Waddington, *An Introduction to the Social History of Medicine: Europe since 1500* (Basingstoke: Palgrave Macmillan, 2011), pp. 261-2.

[66] Zachary Cope, 'The Influence of the Free Dispensaries on Medical Education'. *Medical History*, 13 (1) (1969), 29-36; esp. p. 31; Drs Robert Willan and Thomas Bateman of the Public Dispensary, Carey Street, between them taught for thirty years.

[67] Cope, 'Free Dispensaries and Medical Education'; p.33; during 1831-33, 1336 candidates sat the examinations at Apothecaries' Hall (for the licentiate of the Society of Apothecaries or LSA), of whom 222 had been instructed at dispensaries.

Finally, a very partial picture of dispensaries would result if only based on the statements of doctors and governors. Writing 'history from below' using the viewpoint of the marginalised or dispossessed, has come to be regarded as a key element of social history. In 1985 Roy Porter urged the incorporation of the 'patient's view' into works of medical history.[68] While original accounts by sufferers are rare, especially among the largely illiterate recipients of aid from medical charities, Porter argued that researchers could use ingenuity to overcome many such limitations. He also argued that artistic and literary works, when judiciously employed, could be fruitful sources. The original documents of dispensaries only rarely mention the names of their patients, and do not convey their voices, but there are occasional instances where the reader can gauge their experience. Having discussed relevant areas of historiography, it seems appropriate to outline the scope, structure, and content of this study.

[68] Roy Porter, 'The Patient's View: Doing Medical History from below', *Theory and Society*, 14, No. 2 (1985), 175-198.

Structure and Content of Thesis

The chapters of the thesis are both chronological and thematic.

Chapter 1 sets out the topographical, social, and economic context of Warwickshire as a medium sized county, in part agricultural, but with intensely industrialising zones. Drawing mainly on secondary sources, the chapter reviews some relevant major social, political, and economic changes between 1790 and c.1880.

Chapter 2 mainly constitutes an institutional history of the dispensaries in Birmingham and Coventry (c.1790-1860), exploring their patronage, governance, and day-to-day functioning. In Coventry the study considers the contestation of the two institutions founded in 1831. The primary sources differ for the two towns; in Birmingham they include annual reports and minutes, (these being mostly absent for Coventry); articles in local newspapers and other periodicals were also used. The chapter will address the pattern of illnesses in both towns, using annual reports and published articles by the dispensaries' officers.

Chapter 3 is largely devoted to another institutional history, in this case of the dispensary founded in Stratford-on-Avon in 1823. Issues explored include the contrasts with more densely urban contexts, the nature of the population served, and overlaps between the country town society and the rural hinterland. The patchy sources include some minutes and meeting reports, and very usefully, a register of admissions for the first decade. Again, relevant factors include patronage, functioning and funding, together with the evolution into a small infirmary in 1838. The epidemiology will be compared with larger towns, while distinctive features include the wider roles of the medical personnel (notably their contributions to cultural and civic life).

Chapter 4 comprises a biographical study of two dispensary physicians who were prominent in the 1820s and 1830s. Other Chapters address their directly clinical work: this one will consider how their practice, authorship and

professional connexions reflected and influenced contemporary medical thought.

Chapter 5 will, firstly, outline the development of the provident dispensary movement (mainly considering Warwickshire, 1823-58), exploring reasons for the success or failure of individual institutions; then, secondly, it will consider the implications for dispensaries of some wider currents of reform, including those promoted in contemporary medical journals such as the *Lancet.*

Chapter 6 will revisit the dispensaries in Birmingham and Coventry (*c.*1860 -- *c.*1880), firstly considering changes in disease patterns and treatments. The Chapter will explore changes in demand and the consequences, together with their evolving governance and the nature and outcome of pressures from different groups for increased power and recognition, including participation in management.

Chapter 1
Nineteenth-century Warwickshire: A county of contrasts

> In these midland districts the traveller passed rapidly from one phase of English life to another: after looking down on a village dingy with coal-dust, noisy with the shaking of looms, he might skirt a parish all of fields, high hedges, and deep rutted lanes; after the coach had rattled over the pavement of a manufacturing town, the scenes of riots and trades-union meetings, it would take him in another ten minutes into a rural region, where the neighbourhood of the town was only felt in the advantages of a near market for corn, cheese, and hay.[1]

Introduction

George Eliot's passage evoking the rapidly changing world of 1831, through an imagined stagecoach ride, touches on themes relevant to this thesis and especially to this opening Chapter.[2] She draws on the north Warwickshire of her childhood to portray the impact of intensive manufacturing and the new 'shock cities' on a slowly changing, largely rural England.

The study is concerned with the nineteenth-century history of dispensaries in Warwickshire, medical charities that provided working people with outpatient and home-based medical care.[3] After early foundations in London in the 1770s and 1780s, prominent provincial towns, including Birmingham and Coventry, established their own dispensaries from c.1790. Loudon noted their common features; nearly all were funded by subscription, managed by elected governors, and were staffed mainly by unpaid medical

[1] George Eliot, *Felix Holt, the Radical* (Harmondsworth: Penguin, 1972 (orig. pubn.1866), author's introduction, p.79.
[2] This passage was also used as an epigraph by John Money, *Experience and Identity: Birmingham and the West Midlands, 1760-1800* (Manchester: Manchester University Press, 1977).
[3] This is the historic (pre-1974) county; in the period in question, both Birmingham and Coventry lay within the county.

men.[4] Their administration came to vary, partly reflecting the nature of local societies and economies, while in nineteenth-century Warwickshire differences emerged between the countryside and the larger towns (as highlighted in the opening quotation). The membership of governing bodies, as Loudon showed for early London instances, reflected local economies and especially the composition of their elites.[5] The governors of the Birmingham Dispensary in its first decade (1793-1803) were manufacturers, merchants, and bankers. For the first Coventry dispensary, founded in 1789, only four names are known; these were all medical practitioners, but with connections to the civic oligarchy.[6]

When new dispensaries were set up in the 1820s and 1830s in smaller Warwickshire towns, local gentry and medical men collaborated in founding them.[7] The pattern of foundations therefore differs from experience in north-western England. The earliest dispensaries there were late eighteenth-century foundations in smaller, peripheral towns (including Kendal, Lancaster, and Whitehaven), where, as Pickstone suggests, the contributions of leading Quakers may have been significant. In general, the Midlands institutions were closer to those in the West Riding of Yorkshire, where they started in larger towns and were supported principally by manufacturers, merchants, and professionals, of mixed political and religious convictions

[4] Irvine S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine* 55: (1981); pp. 322-42; Loudon identified sixteen dispensaries that had been founded in London by 1800 and twenty-two in the provinces; ten of the 22 provincial dispensaries were founded in the 1790s.

[5] Loudon cited the prominence of legal figures in the patronage of the Public Dispensary near the Inns of Court in London and of merchants in the Liverpool Dispensary, close to the docks; Loudon, 'Origins and Growth' p. 328.

[6] For Birmingham, Charles Pye, *A Description of Modern Birmingham* (1820), pp.144-5; for Coventry, 'the Public Dispensary', *Coventry Mercury*, 5 October 1789. Among the dispensary's founders was the surgeon Samuel Whitwell, son of the current mayor of Coventry, and in due course three times mayor himself.

[7] The towns in Warwickshire were Atherstone, Southam, Stratford-on-Avon, and Warwick. John Pickstone emphasised the importance of local studies for medical history; John Pickstone, 'Medicine in Industrial Britain: The Uses of Local Studies', *Social History of Medicine*, 2 (1989), 197-203.

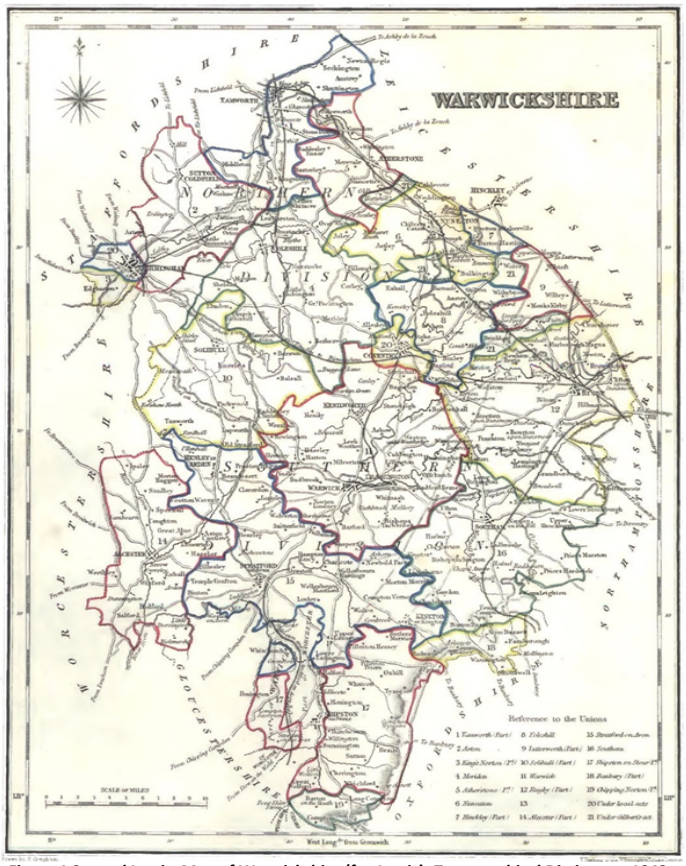

Figure 1 Samuel Lewis, Map of Warwickshire (for *Lewis's Topographical Dictionary, 1848,* accessed via *UK Genealogy Archive)* showing Poor Law Unions

In later Chapters, the detailed working of several such institutions will be explored in towns of different size and type, namely Birmingham, Coventry, and Stratford-on-Avon (with Southam also being briefly considered). The principal focus will be on the period 1820 –c.1880, but the thesis will also include relevant pre-history in late eighteenth-century Birmingham and Coventry. This Chapter will interrogate local and regional contexts in six sections, each concerning a key theme representing the chief aspects of life for working people. After a brief geographical overview, the first theme concerns local

industries and their working conditions (whose health effects were studied by some dispensary practitioners).

The second explores urban growth, addressing the crowded and often squalid housing conditions that developed in expanding industrialising towns, and the consequent adverse effects on health. Medical practitioners, particularly those connected with dispensaries, became familiar with such conditions through professional visits to poor people in their homes. They contributed to the urban health reports of the 1840s and 1850s, which in turn helped to stimulate sanitary improvements by national and local government. As these detailed accounts of local health circumstances are themselves rich research sources, they will receive close attention in this and later Chapters.

The next theme to be explored here concerns local 'mixed economies of welfare', embracing the patchy safety net offered by the Poor Law, general philanthropic provision, and the collective self-help of clubs and friendly societies. In the 1820s and 30s, a fresh wave of dispensary foundations also utilised, for most running expenses, the mutual funding model of benefit or friendly societies. These were the 'self-supporting' or provident dispensaries.[8] The fourth theme to be developed is that of voluntary societies, which mainly served affluent or middling social groups. As well as providing opportunities for associative life, these were important in supporting and financing medical and other charities. The fifth theme considers religious practice in Warwickshire towns, while the final theme focuses on local political processes, including tensions between traditional establishments and rising social groups, battles over reform, and the slow adjustment of civic government to new challenges.

[8] The first 'self-supporting' or 'provident' dispensary anywhere was set up in Southam, Warwickshire, in 1823, and soon copied, e.g. in Coventry in 1831 (which institution established close links with friendly societies). The Stratford Dispensary in 1823 was purely charitable. Chapters in this thesis are devoted to case studies of Coventry (Chapters. 2 and 6), of Stratford (Ch 3), and of Southam and its imitators (Ch 5). Also see Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950*, (London: Routledge, 2001) pp. 89-92.

'The heart of England': Nineteenth-century Warwickshire and its urban network [9]

The changes in populations of different towns were linked to their varying nineteenth-century fortunes (see table 1 for population and figure 1 for a county map).[10] Warwick, at the county's centre, remained its official capital but had been overtaken by Coventry and later by Birmingham, both in size and economic importance.[11] Warwick was largely rebuilt in the eighteenth century following a disastrous fire in 1694. Its neoclassical central streets provided a backdrop for polite associative life, encouraging the county gentry to congregate socially and sometimes to build houses there.[12] After gaining canal connexions and some short-lived textile mills around 1800, its subsequent growth was steady rather than spectacular.[13] Three miles away Leamington started the nineteenth century as a village with some interesting springs, expanded during the next half-century into a fashionable watering place, and from c.1850 became increasingly a residential and retirement centre. The fast-growing town provided social and cultural resources akin to those in Warwick but increasingly serving a middle-class rather than wealthy clientele. Coventry, ten miles to the north of Warwick, had been one of England's leading cities in

[9] Michael Drayton, 'Warwickshire ... the heart of England.' *Poly-Olbion* (1612–22) Song 13, l. 2, https://www.oxfordreference.com/view/10.1093/, last accessed 2 October 2021.

[10] William Field, *An Historical and Descriptive Account of the Town & Castle of Warwick*, (Warwick: H. Sharpe, 1815); William Page, 'HM Census: Population Tables', in *Victoria History of the County of Warwick,* (London: Constable, 1908), pp. 184-92.

[11] Birmingham was incorporated as a borough in 1838 and was designated both a county borough and a city in 1889; Coventry had been regarded as a city from mediaeval times. Alan Dyer, 'The Midlands', in Peter Clark, ed., *The Cambridge Urban History of Britain 1540-1840* (Cambridge: Cambridge University Press, 2000), 95-110, p.101.

[12] Peter Borsay, *The English Urban Renaissance: Culture and Society in the Provincial Town 1660-1770 (*Oxford: Oxford University Press, 1991), pp. 1-38, 203-4, 319-20; 28; Dyer, 'Midlands', p.101

[13] Field, Town and Castle of Warwick, pp. 48, 89; William West, The History, Topography and Directory of Warwickshire (Birmingham: Wrightson, 1830), p. 602.

the high Middle Ages, before a decline in the sixteenth century and a subsequent partial recovery.[14]

The county's larger centres were surrounded by various smaller market towns, with populations in 1801 mostly between one and two thousand, including Southam and Rugby.[15] North of Coventry, the exploitation of the northeast Warwickshire coalfield around the turn of the nineteenth century stimulated the growth of Nuneaton, Bedworth, and nearby villages. These places also gained secondary employment in ribbon weaving as a spin-off from Coventry's industry.[16] Early nineteenth-century Stratford-on-Avon continued as a market centre serving both the agrarian Felden district to its south and the more varied Arden localities of central Warwickshire. By the century's second decade, waterborne trade had recommenced locally, extending into Gloucestershire and beyond. Later in the nineteenth century, the town developed a new role as a hub for culture and tourism. [17] Among the smallest towns, Rugby's population increased five-fold during 1801-81 (from 1485 to 8891), while Southam (which lacked direct canal or rail connections) grew only slightly.

[14] Charles Phythian-Adams, *Desolation of a City : Coventry and the Urban Crisis of the Late Middle Ages* (Cambridge: Cambridge University Press, 1979); Dyer, 'Midlands', pp.101, 107.
[15] Peter Clark, 'Small Towns 1700-1840', in Peter Clark (ed), *Cambridge Urban History of Britain* (Cambridge: Cambridge University Press, 2000), 733-74, pp. 740, 760-3; Marie Rowlands, *The West Midlands from AD 1000*, (London: Longmans, 1987), p. 255;
[16] Rowlands, *West Midlands*, pp. 236-41; Clark, 'Small Towns', pp. 740, 760, 765-6.
[17] Dyer, 'Midlands', pp. 95-7.

Table 1: Population of Warwickshire towns and of county, 1821-81

Census year	1821	1841	1861	1881
Town. Etc. --				
Birmingham	73,678	106,722	221,020	366,624	532,435
Increase %		45	107	66	45
Coventry	16,049	21,239	30,881	40,936	44,313
Increase %		32	46	33	8
Leamington Priors	315	2,183	12,864	17,402	22,979
Increase %		493	489	35	32
Southam	935	1,161	1,670	1,674	1,738
Increase %		24	44	0.2	3.7
Stratford-on-Avon	2,982	5,171	6,022	68,23	8,395
Increase %		73	14	13	23
Warwick	5,592	8,233	9,775	10,570	11,784
Increase %		21	18	8	11
Warwickshire	206,798	2744,82	401,703	561,848	737,343
Increase %		33	46	39	31

Notes: the 'increase' is the additional population over the last 20 years, expressed as a percentage of the population two decades previously. **Areas covered:** the Birmingham conurbation includes Aston, Edgbaston, and from 1841 Deritend and Duddeston hamlets; Coventry excludes the former county of the city; Stratford-on-Avon includes the borough and the parish of Old Stratford. Other instances relate to the civil parish.

Adapted from HM Census and Population Tables in William Page (ed.), *Victoria History of the County of Warwick*, 2 (London: Constable, 1908) pp. 184-92.

Birmingham expanded rapidly from the mid-eighteenth century as new canals and turnpike roads helped it overcome the disadvantages of landlocked geography.[18] Manufacturers used new links with both the Severn and Trent waterways for transport to and from seaports, and thereby to the capital and overseas.[19] Communications were most dense between Birmingham and the rapidly growing towns of the 'Midland hardware district' including Dudley, Stourbridge, Walsall and Wolverhampton: all these were in Staffordshire and Worcestershire, although Warwickshire towns also gained from the new roads and canals.[20]

Birmingham's considerable growth was stimulated by such improved transport links, but also by various topographical, economic, and cultural factors. These included nearby deposits of coal and iron ore, abundant clean water from its aquifers for increasing industrial and domestic use, and space for expansion.[21] Later boundary changes contributed to population increase, as the nineteenth-century borough absorbed adjacent urbanised areas. An open society, without barriers for religious minorities, were widely claimed to contribute to Birmingham's success. Such claims have provoked much enquiry and debate, which will be discussed further below. [22]

The investors in the new transport schemes included regional landowners, both aristocrats and those gentry with larger landholdings. Their seats in both parliamentary houses enabled them to smooth the passage of the

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[18] Lynn Hollen Lees, 'Urban Networks', in Martin Daunton (ed), *The Cambridge Urban History of Britain,* (Cambridge: Cambridge University Press, 2000), 57–94, pp. 63-4; Peter M. Jones, *Industrial Enlightenment,* p. 25.

[19] Dyer, 'Midlands', pp. 93-4.

[20] The modern term the 'Black Country' was not used until the 1840s. Peter M. Jones, *Industrial Enlightenment: Science, Technology, and Culture in Birmingham and the West Midlands, 1760–1820* (Manchester: Manchester University Press, 2008), pp. 31-6; Field, *Town and Castle of Warwick,* p.322.

[21] G. C Allen, *The Industrial Development of Birmingham and the Black Country, 1860-1927* (London: Frank Cass, 1966 (orig. pbn. 1928)), pp. 7-9; the estimated 23,688 inhabitants in 1750 grew to 73,670 in 1801; see Eric Hopkins, *The Rise of the Manufacturing Town: Birmingham and the Industrial Revolution,* (2nd ed, Stroud: Sutton, 1998), p. 31.

[22] Asa Briggs was among those who supported this view; Asa Briggs, *Victorian Cities*, (London: Odhams, 1963), pp. 186-88.

necessary legislation, and their collaboration with business interests may have fostered a regional identity.[23] In later decades this regional spirit was also expressed through patronage of different institutions, notably the Birmingham General Hospital. This institution was first mooted in 1765, had a funding campaign that flagged before a revival in the 1770s, and eventually opened in 1779 (aspects to be explored more closely later in the Chapter).[24] During the nineteenth century, Birmingham increasingly developed as a regional capital in relation to communications, manufacturing, and trade networks, largely displacing Coventry from its earlier leading role. It also developed a leading position in certain aspects of medicine and health care.[25]

Most dispensaries served local urban populations (in contrast with general hospitals, which covered wider catchment areas). Therefore, regional relationships were less relevant to them. However, this did change somewhat in the 1820s with the rise of provident dispensaries, chiefly through their support by landowners. Their originator, the Southam surgeon Henry Lilley Smith, joined with medical and lay allies to establish a 'Warwick committee' and a London-based society to promote his ideas and encourage their spread. In the years around 1870 the Coventry Provident Dispensary inspired imitators in a similar way (these aspects will be addressed in Chapters 5 and 6 respectively).

The industrial experience of Birmingham and Coventry

This section focuses on industrial development, especially the wages and working conditions that governed the lives of ordinary people; later Chapters

[23] Lords Aylesford, Craven, Hertford, and Warwick dominated eighteenth-century Warwickshire politics. In addition, the Staffordshire landowners, the earls of Dartmouth and Dudley, were influential in Birmingham. Members of Parliament came from the substantial gentry, including the Holte, Dugdale, Newdigate, Mordaunt and Skipwith families. Money, *Experience and Identity,* pp. 9-10, 17-18.

[24] The funding campaign will be explored more closely later in the Chapter; Jonathan Reinarz, *The Birth of a Provincial Hospital: The Early Years of the General Hospital, Birmingham, 1765-1790*, (Stratford-on-Avon: Dugdale Society with Shakespeare Birthplace Trust, 2003), pp. 1-10.

[25] Birmingham developed a regional medical role through its General Hospital, its Medical School, and later the BMA structures. Coventry's trading connections were largely with the capital and it did not develop a similar sub-regional role.

will consider some of the direct effects on health. Few of those attending local dispensaries would be employed in large factories until around the mid-nineteenth century. Most Birmingham workpeople worked in small and medium-sized workshops, and those in Coventry at looms or workbenches in their houses. Birmingham's workshops relied on craft skills, with extensive division of labour, to work metal and other materials. Their simple technology, comprising hand presses, stamps and lathes, was only slowly adapted to steam power and further mechanisation.[26] The Georgian town was best known for its manufacture of 'toys', then meaning small decorative objects that supplied a growing middle-class luxury market; but also it made practical items like leather goods, hand tools and guns.[27] The smallest establishments were those of the 'garret masters', employing a handful of workers in an actual attic or another tiny space. Everywhere artisan labour, piecework payment, and flexible working hours persisted. [28] Birmingham wages were relatively high, those in button manufacture, for instance, being 25-30s weekly for adult males, for women 7s, and for children between 2s 6d and 3s 6d. Skilled male wages in different trades often reached 30-40s weekly.[29] The small workshops attracted criticism from the Children's Employment Commission in 1843: 'In general…the buildings were very old…often dilapidated…dark and narrow… suffocatingly hot in summer and very cold in winter.' The child workers labouring alongside their parents or other adults 'were hardly used… seldom had enough to eat… many

[26] Hopkins, Birmingham and Industrial Revolution, pp. 7-8.
[27] Maxine Berg, *The Age of Manufactures, 1700-1820 : Industry, Innovation and Work in Britain*, 2nd ed (London: Routledge, 1994), pp. 23, 29, 264-9; Hopkins, *Birmingham and Industrial Revolution*, pp. 40-5, 52-3; W. B. Stephens, 'City of Birmingham: Economic and Social History: Social History since 1815', in *A History of the County of Warwick,* 6 (London: Victoria County History, 1964), pp. 223-45.
[28] As one instance of stubborn artisan habit, 'Saint Monday', the custom of a day with little or no work, was widely observed in both Birmingham and Coventry well into the nineteenth century. Douglas A. Reid, 'The Decline of Saint Monday 1766-1876', *Past & Present,* 71 (1976), 76-101.
[29] Hopkins, *Birmingham and Industrial Revolution*, pp.102-8, 152; Berg, Age of Manufactures, pp. 274-7.

were in rags.'[30] Hopkins commented that, despite such testimony, conditions for children were preferable to those in contemporary textile mills.[31]

In contrast with Birmingham's dozens of trades, Coventry produced just two main products for external consumption; silk ribbons and watches and clocks.[32] By the early nineteenth century its weavers were producing the brightly coloured silk ribbons used in women's dresses. Relatively well-paid self-employed outworkers formed the largest group of weavers. The males using more advanced looms would generally earn 10s-15s weekly; the 'second-hand' journeymen employed by other weavers typically earned about half these amounts, and the 'country' weavers in villages north of the city slightly less still.[33] The latter two groups were generally in work only when demand was high, and therefore, according to the Hand-Loom Weavers' Commission, lived in the 'greatest want and misery'.[34] The different sorts of weavers and watchmakers in Coventry were from 1831 using the two local dispensaries.

Weaving in Coventry was often a family affair, the journeyman's wife using a plain loom and children winding the silk. Until the late 1850s, both national protectionist policies and the locally agreed list of piecework prices fostered modest prosperity. In his 'topshop' the weaver could largely control his work, commonly taking a break on Mondays and on other holidays, while working longer and more intensely late in the working week. The use of more productive looms enabled family earnings to increase until the 1850s, often

[30] The inspector attributed such treatment to the eagerness of some parents to use their children's wages for drink; children directly employed by manufacturers were better treated. H.M. Commissioners, *Children's Employment Commission*, (London: HMSO, 1843); appendix by Mr Grainger. Quotes pp. 790-1 (PDF), also original pp. 32-33, 43, 50, 79, 100, appendix F17-24.
[31] Hopkins, Birmingham and Industrial Revolution, pp. 102-8.
[32] Prest, *Industrial Revolution in Coventry*; the young barrister, Joseph Fletcher, was Assistant Commissioner to the Handloom Weavers' Commission, and visited Coventry in 1838; Joseph Fletcher, *Royal Commission on Hand-Loom Weavers. Reports from Assistant Commissioners*. Part IV, on the Midland Districts of England, (London: House of Commons Parliamentary Papers, 1840).
[33] Prest, *Industrial Revolution in Coventry*, pp. 52-3, quoting Fletcher, Assistant Commissioners' Reports, 1840, pp. 55-65, 273.
[34] Prest, *Industrial Revolution in Coventry*, pp. 70-71; Fletcher, Assistant Commissioners' Reports, 1840, p. 302.

comfortably exceeding a pound weekly.[35] As a result the 'better' weavers often possessed clocks, rugs, and bedsteads. [36] However, the dependence on fashion made for insecure employment for all, the wintertime slack periods driving many towards charitable or parochial aid. Dispensary practitioners observed the long hours, and noted how these, combined with anxiety arising from insecure work, had adverse effects on weavers' health.[37] Craftsmen in Coventry's second key industry of watchmaking were more prosperous, with typical earnings of 25s weekly; they were unaffected by seasonal unemployment and less prone to slumps.[38] A few watchmakers were masters, who used part of their homes as workshops, where journeymen and apprentices would work.[39]

During the middle third of the nineteenth century, both Birmingham and Coventry developed some larger factories that changed both working conditions and employer-worker relations. Although the full detail is beyond the scope of this thesis, it is worth noting that difficult market conditions stimulated a search for reduced costs in Birmingham industry, encouraging consequent economies of scale, often in larger units. Small masters increasingly became sub-contractors to larger companies, relying on their credit and marketing facilities.[40] Complex patterns of subcontracting grew up within manufactories, with artisans typically receiving gross payments for a given output and then paying wages to other workers. Harriet Martineau observed this practice in a nail factory, where each skilled man supervised and paid four boys operating

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[35] 'Topshop'; upper-floor weaving space with large windows. Prest, *Industrial Revolution in Coventry*, pp. 65-7; imports were prohibited until 1826, because of tariff protection, Stephens, *VCH Warwickshire* 8, p. 169.
[36] Fletcher, Assistant Commissioners' Reports, 1840, p.301.
[37] Fletcher, *Assistant Commissioners' Reports*, 1840, p.300-01; Fletcher quoted the dispensary practitioner C.B. Nankivell on such health effects.
[38] The numbers of watchmakers were increasing around mid-century; in 1851, of all local apprentices, 54% were learning watchmaking and only 20% weaving. Prest, *Industrial Revolution in Coventry*, pp. 81-7.
[39] Prest, *Industrial Revolution in Coventry*, p. 82; these watchmakers used long extensions to the rear of the masters' houses, a few such instances still existing in the western suburb of Chapelfields.
[40] Behagg, *Politics and Production*, pp. 6-7, 44.

steam-powered machines.[41] Increasingly fierce competition encouraged the takeover of small firms by large manufacturers. As such conditions also drove down both prices and quality, some garret masters came to use sweated labour to produce the cheap, showy, but substandard articles popularly known as 'Brummagem' ware.[42] Working conditions in the emerging large factories were physically more comfortable but subject to a stricter employer-led discipline. Joseph Gillott, for instance, was a former garret master who produced steel pens in his 'palatial' factory. He directly employed 500 workers, mostly female, without any sub-contracting. Gillott's employees were required to work in silence; but they gained access to a works-based sickness fund and summertime annual outings or 'gipsy parties' to the countryside.[43]

Birmingham Society: enterprise and invention?

The predominance of small and medium enterprises in Birmingham industry was widely considered a strong influence on the local culture. A view of local artisans as ingenious and inventive was supported by statistics for patent applications.[44] Innovation may have been fostered at elite level by the Lunar Society, an influential group that met regularly in Birmingham from 1765 to c.1800. This was less a formal society than a loose, amicable association of about a dozen prominent entrepreneurs, scientists, and physicians.

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[41] Harriet Martineau, 'The Wonder of Nails and Screws', *Household Words*, 4 (1852), 138-42, p.139.

[42] 'Brummagem - cheap, showy, or counterfeit', *Oxford Dictionaries*, https://en.oxforddictionaries.com/definition/us/Brummagem (last accessed 1 July 2021). This report was one of the commissioned articles by the journalist Charles Mackay based on Birmingham in 1850-1851; Charles Mackay , 'Birmingham XII: Workers in Brass'*, in The Victorian Working Class: Selections from Letters to the Morning Chronicle* ed. by P.E. Razzell and R.W. Wainwright (London: Frank Cass, 1973 (orig. pubn.1851)), pp. 300-01

[43] Mackay, 'Birmingham IX: Manufacture of Steel Pens', *Letters to Morning Chronicle*, pp. 297-99.

[44] For this view, see, e.g., Hopkins, *Birmingham and Industrial Revolution*, pp. 34-36, 55-57. The total of Birmingham patent applications for 1760-1850 amounted to three times those from any other town; Jones, *Industrial Enlightenment,* pp. 19, 40.

The group was led by Joseph Priestley, the chemist and Unitarian divine, until 1791, when the destructive Birmingham riots forced his departure.[45] Thereafter the manufacturer Mathew Boulton continued to host the group's convivial meetings.[46] Members combined ideas from experimental science with the 'useful knowledge' applied in industry. Their ideas and interactions formed a major component of the broad-ranging movement that has come to be called the 'Midlands Enlightenment', which was widely diffused both geographically and in terms of field or discipline. As well as the scientists and industrialists, the group had connections, mainly by correspondence, with creative individuals like the painter Joseph Wright of Derby, the Wyatt family of architects, originally from Staffordshire, and the poet Anna Seward of Lichfield.[47] Following the dissolution of the Lunar Society (*c*.1800), early nineteenth-century Birmingham may have fallen behind other large towns intellectually, as judged by the formation of learned societies and mechanics' institutes.[48]

At more modest economic levels, small masters could readily start up and expand. William Hutton, the town's first historian, pointed to the consequent opportunities for social mobility. Hutton argued that inhabitants were less trammelled by craft restrictions than corporate towns, while local

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[45] R. B. Rose, 'The Priestley Riots of 1791', *Past and Present,* 18 (1960), 68-88; during three days in July, large crowds, inflamed by 'church and king' agitation, attacked the homes, businesses and chapels of prominent Dissenters and their allies. Among these was Joseph Priestley, whose home, library and laboratory were destroyed by fire.

[46] Jennifer Tann, 'Boulton, Matthew (1728–1809), manufacturer and entrepreneur.' *Oxford Dictionary of National Biography,* (Oxford: OUP, 2004, Online edn. 2013). Accessed 16 Oct 2020. https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-2983. Robert E. Schofield, *The Lunar Society of Birmingham: A Social History of Provincial Science and Industry in Eighteenth-Century England* (Oxford: Clarendon Press, 1963), pp. 410-11, 440.

[47] Jones and Budge are particularly associated with the study of the Midlands enlightenment; see Jones, *Industrial Enlightenment,* pp. 83-4, 89-92, 228-32; Gavin Budge, 'Science and Soul in the Midlands Enlightenment', *Journal for Eighteenth-Century Studies,* 30(2) (2007), 157–160; Roy Porter, *Enlightenment: Britain and the Creation of the Modern World* (London: Penguin, 2000), esp. pp. 44-46, 154, 329, 353-59, 410-15, 428.

[48] Boyd Hilton, *A Mad, Bad, and Dangerous People? England, 1783 –1846* (Oxford: Oxford University Press, 2006*),* p. 169.

religious tolerance enabled dissenters to thrive. Asa Briggs and others adopted key elements of this account to suggest an open and cohesive local culture, a view challenged by Clive Behagg and Harry Smith.[49] In their revisionist interpretations, they claim that Hutton promulgated comfortable civic 'myths', and argue that in reality local class tensions were greater and social mobility much less than Hutton and others claimed.[50] Ward, however, cites well-informed contemporary observers such as Richard Cobden and John Stuart Mill, asserting (in this author's view convincingly) that mid-nineteenth century Birmingham was indeed more open, with greater social mobility, than other large industrial towns.[51] What might be the relevance of a more open, socially mobile city to the foundation or support of dispensaries? That is difficult to answer, but some of the many small masters appear to have supported the General Dispensary with subscriptions (see Chapter 2).

Coventry society: conflict or harmony?

Coventry has stimulated historical debate, like Birmingham, concerning the relative degree of concord or conflict. Prest and Searby considered that industrial relations up to the 1830s were mostly harmonious but became much more tense during the 1840s and 1850s.[52] They saw the earlier masters as being influenced by a benign paternalism, which was mirrored by a degree of deference among workers, relationships favoured by face-to-face encounters in a compact town. Many local inhabitants understood decent wages as a key

[49] William Hutton*, An History of Birmingham* (Birmingham: W. Hutton, 1783), pp. 49-50, 61-3, 81, 111; Briggs, *Victorian Cities*); W. B. Stephens, 'City of Birmingham', *VCH Warwickshire* 6, pp. 223-45; Harry Smith, 'William Hutton and the Myths of Birmingham', *Midland History,* 40 (2015), 53-73, esp. pp. 53-4; Clive Behagg, 'Myths of Cohesion: Capital and Compromise in the Historiography of Nineteenth-Century Birmingham', *Social History,* 11 (1986), 375-84; Clive Behagg, *Politics and Production in the Early Nineteenth Century* (London & New York: Routledge, 1990).

[50] Smith, 'Myths of Birmingham', pp 68-72; Hopkins, *Birmingham and Industrial Revolution*, pp. 85-9.

[51] Roger Ward, 'Birmingham: A Political Profile 1700-1940' in Carl Chinn, Malcolm Dick, (eds)., *Birmingham: The Workshop of the World* (Liverpool: Liverpool University Press, 2016), pp. 165-66.

[52] In 1831, both a charitable and a 'self-supporting' or provident dispensary began operation in Coventry.

component of local prosperity; in other words, there was wider support for the 'moral economy'.[53] Revisionist interpretations include persuasive analyses by Beaven and Powell, who identified clashes and instances of intimidation linked both with political campaigns and industrial disputes. Some of the weavers meted out humiliating sanctions to transgressors, both workers and employers, sometimes analysed as part of the 'moral economy'. The best-known instance was the 'donkeying' of Josiah Beck in 1831, who during a period of wider unrest had opened the first steam-powered factory. As a riot destroyed the building, he was seated backwards on a donkey and driven through the streets. [54]

Tiratsoo noted how by the middle of the nineteenth century the policies of employers were increasingly moulded by an exacting version of political economy (in other words, economic liberalism).[55] In the harsher conditions of the 1840s, masters were much less favourable towards the list of agreed piecework prices. The latter also appeared poorly suited to the much more productive steam-powered factories then proliferating.[56] In 1852 Harriet Martineau found thirty factories in Coventry, some impressive in scale, and together employing 3000 people (of a total 10,500 weavers).[57] However the 'robust and coherent subculture' of the weavers resisted various facets of the

[53] E.P. Thompson, 'The Moral Economy of the English Crowd in the Eighteenth Century', *Past & Present,* 50 (1971), 76-136. This term only gained wide currency several years after Thompson's 1971 essay.

[54] Bradley Beaven, 'Custom, Culture and Conflict: A Study of the Coventry Ribbon Trade in the First Half of the Nineteenth Century', *Midland History*, 15 (1990), 83-99, esp. p. 91; Sarah Boote Powell 'Coventry Corporation and the Myth of Paternalism: Electoral Politics in Coventry, 1826–1835',*Midland History*, 34(2009), 77-97; this incident was also discussed by E.P. Thompson, 'Rough Music', in E.P. Thompson, ed., *Customs in Common*, (London: Merlin, 1991), 467-538, esp. pp. 467, 520, 478-9; Searby also analyses this riot in terms of the moral economy; Peter Searby, 'Paternalism, Disturbance and Parliamentary Reform: Society and Politics in Coventry, 1819-32', *International Review of Social History*, 22 (1977), 198-225, esp. pp. 215-21.

[55] Beaven, 'Custom, Culture and Conflict'; Powell, 'Coventry Corporation and the Myth of Paternalism', pp. 77-97
Nicholas Tiratsoo, 'Coventry's Ribbon Trade in the mid-Victorian Period: some Social and Economic Responses to Industrial Development' (Unpublished PhD Thesis, London, 1980).

[56] Prest, Industrial Revolution in Coventry, pp. 45-65.

[57] Harriet Martineau, 'Rainbow Making', in *Household Words* (London, 1852), 485-9, p. 489.

new market economy.[58] Weavers expressed their solidarity and loyalty to informal norms through involvement in mutual organisations (which included the city's provident dispensary), and also through the practice of unofficial sanctions as noted above.

Coventry: crisis and recovery

During the 1850s the industry was affected by frequent disputes between manufacturers and weavers, until Coventry's climactic conflict in 1858-59.[59] In August 1858 a lengthy strike began, supported by almost all the weavers; after 15 months they appeared to gain a victory.[60] However, the Cobden-Chevalier treaty in early 1860 ended protectionism and was followed by a flood of French imports. [61] By May two-thirds of the 10,000 Coventry weavers were out of work, with widespread distress that overwhelmed poor law resources. Subsequent special relief efforts included a national appeal and organised overseas emigration. [62] Weavers were described as visiting the fields for: 'raids on… turnips and potatoes… to save their children from utter starvation', while other observers observed the 'hungry men, sauntering aimlessly… [and the] pinched faces of the women'.[63] During the early 1860s many masters went

[58] Tiratsoo, 'Coventry's Ribbon Trade', p. 85.
[59] Peter Searby, *Coventry in Crisis, 1858-1863 : Ribbon Factory, Free Trade, and Strike*, (Coventry: University of Warwick for Historical Association 1977).
[60] Nearly all the masters eventually agreed to pay according to the list (of piecework prices); Searby, *Coventry in crisis* pp. 3-5.
[61] The French ribbons were cheaper and considered more fashionable. Searby, *Coventry in crisis,* pp. 5-7.
[62] Searby, *Coventry in Crisis,* pp. 7-10, 11-12. Lord Leigh of Stoneleigh (Lord Lieutenant of Warwickshire) launched the national appeal.
[63] Joseph Gutteridge, 1816-99, published his autobiography in 1893; 'Lights and Shadows in the Life of an Artisan: The Autobiography of Joseph Gutteridge', in *Master and Artisan in Victorian England: The Diary of William Andrews and the Autobiography of Joseph Gutteridge,* ed. by Valerie E. Chancellor (London: Evelyn, Adams & Mackay, 1969), pp.121-4; Searby, *Coventry in crisis,* p. 11, quoting E.W. Cooper, 'Sixty Years of Reminiscences: an Autobiography of a Cycle Trade Pioneer' (CHC Typescript, 1928), p.3.

bankrupt and the area lost population, although some firms survived as specialist manufacturers of medal ribbons and other small-volume items.[64]

Tiratsoo and Bailey documented the slow decline of traditional trades from c.1860 until the early twentieth century, first in weaving and then watchmaking.[65] After the collapse of 1860-61, only a small number of handloom weavers continued, working long hours for small amounts.[66] Watch manufacture continued, partly in one large factory but mostly in artisans' homes and small workshops. The trade seemed to prosper until early in the twentieth century, when foreign competition caused it to decline in its turn. [67] New light engineering industries emerged to replace ribbon weaving, often in newly redundant silk mills, employing former weavers and (later) watchmakers, bicycles being built locally from 1869, followed by motorcycles and cars. [68] The relationship between the local economy and the fortunes of the city's provident dispensary was complex, given the requirement for paid-up membership before treatment was given. The total membership (which depended on regular payments being made) declined briefly in the crisis years of 1860-61 but increased greatly thereafter.

By the late nineteenth century, Birmingham was becoming a recognisably modern industrial city. Its economy was dominated by some large and powerful concerns, whose proprietors and workers supported dispensaries and other medical charities. Coventry was recovering from its crisis by developing a more diversified economy, whose workers (and some employers) supported the city's large dispensary. Stratford-on-Avon continued as a market town, with contributions from culture and tourism. In addition to the local

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[64] Prest, *Industrial Revolution in Coventry*, pp. 127, 129-30; between the censuses of 1861 and 1871 the city's inhabitants declined by 1,555, and the surrounding North Warwickshire districts by 4818; by 1865, more than half the eighty masters identified in 1858 were no longer trading; Searby, *Coventry in crisis,* p. 13.
[65] Tiratsoo, 'Coventry's Ribbon Trade', pp. 211-19.
[66] Tiratsoo, 'Coventry's Ribbon Trade', pp. 287-317.
[67] Peter Searby, 'Watchmaking in Coventry', *Warwickshire History,* 3 (1976), 106-14, p.111.
[68] Stephens, *VCH Warwickshire,* 8*,* pp. 172-3; Frances Diana Warr, *Industry and Social Change in Nineteenth Century Coventry* (Coventry: F.D. Warr, 2018), pp. 197-214.

infirmary (formerly the dispensary) local people were also served by newer medical charities and mutual organisations.

Changes in the urban environment

This section explores urban expansion and the resulting living and housing conditions in the relevant Warwickshire communities, and the consequences for health. The ill-health that became common amongst their poor inhabitants seems likely to have encouraged the foundation of dispensaries and stimulated the attendance there of needy patients, aspects explored in detail later in the thesis (Chapters 2-4 and 6). Practitioners serving at all the county's dispensaries became familiar with such housing conditions and contributed to the health reports from the 1840s onwards. The population of the conurbation of Birmingham, including Aston and other contiguous built-up areas, had by the early nineteenth century reached one hundred thousand (table 1). While there were some handsome churches and squares as well as the severely classical Town Hall, most observers found it a grimy, noisy, smoky town.[69] New building had by this date spread well beyond the original settlement clustered around St Martin's Church, the Bull Ring and the River Rea (figure 2). New Street, with its theatre and banks, climbed from this old centre to the western hilly locality (the New Hall and Colmore estates), transformed by eighteenth-century residential development.

69 The squares included St Paul's and St Philip's (the latter now the cathedral); the Town Hall opened for concerts and assemblies in 1832; prominent commentators included Thomas Carlyle and de Tocqueville; W Showell, 'T. Carlyle, Letter to His Brother', quoted in *Dictionary of Birmingham,* (Birmingham: Cornish, 1885), p.30; Alexis de Tocqueville, *Journeys to England and Ireland* trans. George Lawrence and K. P. Mayer (London: Faber and Faber, 1968).

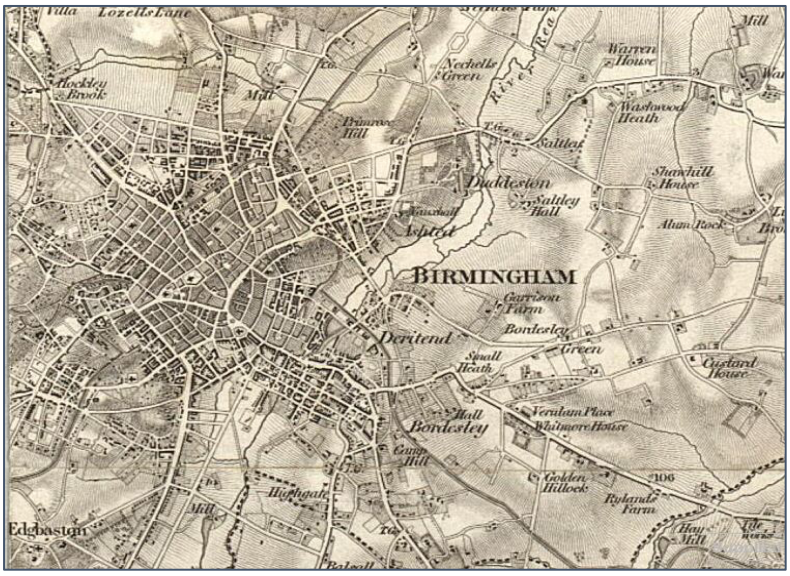

Figure 2: Ordnance Survey Map of Birmingham, 1834
1:63,300 (Public Domain: Ordnance Survey, https://www.ordnancesurvey.co.uk/getoutside/local/birmingham-west-midlands); last accessed 1 July 2021

These wealthier streets formed a loose arc, enfolding an industrial district where small dwellings were closely intermingled with workshops (extending towards Deritend – see fig. 2). But by the mid-nineteenth century, substantial houses in many localities had been changed through piecemeal industrial use: 'The small master … has used his house as a workshop, has annexed another [and] has built on the garden or the yard'.[70] Some examples of such micro-level changes can be seen in the jewellery quarter.[71] The consequent deterioration in the crowded urban environment was by the 1840s encouraging the prosperous middle classes to move to greener outlying areas, especially to

[70] Samuel Timmins, 'The Industrial History of Birmingham', in *The Resources, Products, and Industrial History of Birmingham and the Midlands Hardware District* (London: Frank Cass, 1967 (orig. pubn.1866)), 207-24, p. 223.
[71] A few of these survive; see John Cattell and Bob Hawkins, *The Birmingham Jewellery Quarter: An Introduction and Guide* (London: English Heritage, 2000); aerial photographs on pp. 8, 11.

new villas on Lord Calthorpe's Edgbaston estate southwest of the centre.[72] The new living conditions encouraged changes in social patterns, as some families developed new interests focused on their house and garden. The well-known study of a few such families by Davidoff and Hall can be seen as emphasising the 'separate spheres' analysis, with women's lives becoming more limited to the domestic sphere (while spending time and energies on the wider family, religion, and philanthropy).[73] Vickery, however, argues that these authors may have overstated the case for 'separate spheres' of male and female life. Nevertheless, the home lives of the middle classes tended in this period to become separated from those of manual workers, most of whom continued to occupy back-to-back dwellings in the crowded centre

[72] Hopkins, *Birmingham and Industrial Revolution*, pp. 120-1; David Cannadine, 'Victorian Cities: How Different?' *Social History,* 2 (1977), 427-84.
[73] Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class 1780-1850* (London: Routledge, 1992), pp. 357-97, 416-449 (Ch. 8 & 10); Vickery argues her qualifying case in Amanda Vickery, 'Golden Age to Separate Spheres? A Review of the Categories and Chronology of English Women's History', *Historical Journal* 36, 2 (1993), 383-414.

Coventry

Figure 3: Map of Coventry, c1838: adapted from John Prest, *The Industrial Revolution in Coventry*, (Oxford: OUP, 1960), p. 22

Coventry's population expanded from the late eighteenth century, stimulated by growth in the city's two staple industries.[74] Several striking monuments recalled its mediaeval prominence, notably St Mary's guildhall and the two central parish churches of Holy Trinity and St Michael.[75] Apart from a few larger houses and public buildings, Coventry in the late eighteenth-century had benefited little from the 'urban renaissance' that changed other Midland towns.[76] By 1800, travellers were noting a town that seemed stuck in the past; it

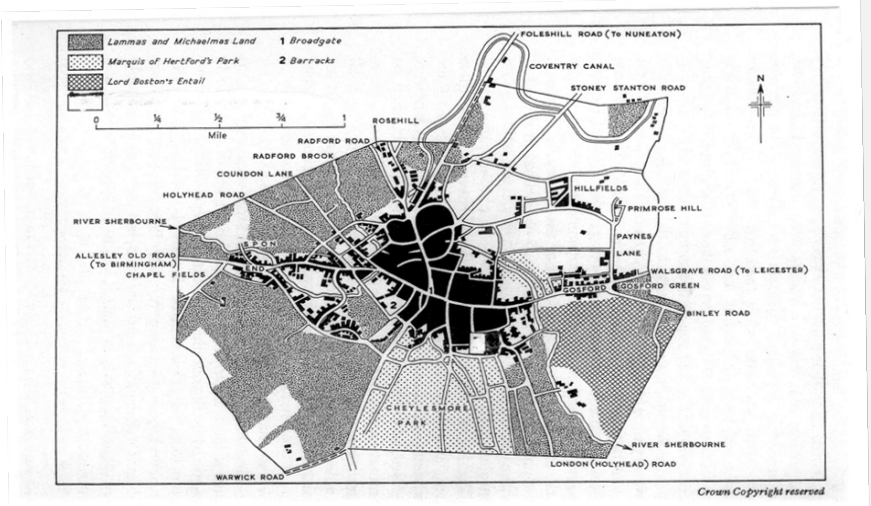

Figure 3: Map of Coventry, c1838: adapted from John Prest, *The Industrial Revolution in Coventry*, (Oxford: OUP, 1960), p. 22

seemed 'old-fashioned… [its] streets narrow [and] dirty'. It mostly retained its mediaeval ground plan, its expansion constrained by the surrounding commons

[74] The population grew from an estimated 12,000 in 1750 to 16,000 in 1801, contrasting with a contemporary trebling in Birmingham's population. Stephens, *VCH Warwickshire* 8, p. 5; Hopkins, *Birmingham and Industrial Revolution*, p. 31.
[75] Frederick Morton Eden, 'Coventry', in *The State of the Poor,* (Cambridge: Cambridge University Press, 1797 (online edn. 2012)), 44-73, p.793
[76] Borsay, *The English Urban Renaissance,* pp. 1-38, 203-4, 319-20; this work cites, *inter alia*, central Warwick and St Philip's Square in Birmingham.

and parkland (these are the lightly shaded areas on the map --figure 3).[77] In the old mediaeval centre, densities steadily increased following infilling behind the timbered merchants' houses. Dwellings here housed the poorer weavers, while their more prosperous peers increasingly moved to the city's first suburb, developed from the early 1830s northeast of the old city at Harnall (later Hillfields). The two- and three-storey houses here incorporated 'topshops'.[78] However even here houses lacked sewers and surface drainage, carts sinking up to their axles in the muddy ground.[79]

Smaller towns: Stratford-on-Avon

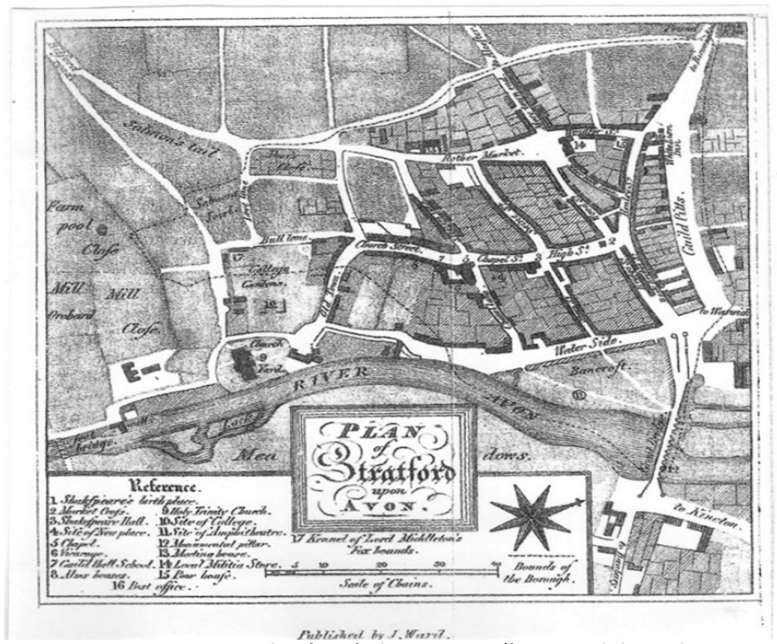

Figure 2 Figure 4: Street Plan of Stratford-on-Avon, 1814 (from R. B. Wheler, Guide to Stratford-on-Avon (Stratford-on-Avon: J. Ward, 1814)

[77] Stephens, *VCH Warwickshire* 8, p. 222; John Prest, *The Industrial Revolution in Coventry* (Oxford: Oxford University Press, 1960), p. 21. Prest, a former Fellow of Balliol College, is chiefly known as a nineteenth-century political biographer.
[78] Prest, *Industrial Revolution,* Figure 4: in Coventry, pp. 23, 38, 73-8.
[79] Stephens, *VCH Warwickshire*. 8, p. 73.

Stratford-on-Avon, as a town based largely on trade rather than manufacture, also experienced nineteenth–century expansion.[80] Its commercial heart was concentrated in a few mediaeval streets extending west and south (downstream) from the fifteenth-century Clopton Bridge (figure 4).
The most important of these, leading south towards Holy Trinity church, contained the principal public buildings and the houses of wealthier inhabitants. During the Georgian era some older timbered buildings in the centre were adapted to current tastes through rendered or brick-built classical frontages. [81] Early nineteenth-century changes stimulated by the new canal link with Birmingham (opening in 1816) included new housing and riverside 'wharves…and warehouses' and the nearby terminus of the horse-drawn railway to Moreton and Shipston (Figure 4; these features are not shown on this earlier map, but the canal runs at the right, i.e., north of the town).[82]

Stratford-on-Avon was thus changing from its established role as a pure market town, having both increased trade through improved canal and river links, and developed some small-scale manufacture.[83] After several decades of relative inactivity, from about 1823 the borough council is said to have become more energetic in managing its urban responsibilities.[84] During the nineteenth century local prosperity increased, due to the success of concerns devoted to brewing, milling and timber processing (conducted, respectively, by the Flowers, Lucy and Cox families).

From the later 1820s, Stratford's citizens also increasingly celebrated Shakespeare through local associations and festivals, thereby raising the

[80] Philip Styles, ed.,'The Borough of Stratford-Upon-Avon: Historical Account', in *A History of the County of Warwick*, 3 (London: Victoria County History, 1945), 234-44; p. 236.
[81] Nicholas Fogg, *Stratford-upon-Avon: The Biography* (Stroud: Amberley, 2014), p.54.
[82] Pigot's *Warwickshire*, 1828-9, p. 835; West's *Warwickshire*, 1830, pp. 532-3; the warehouses adjoined the canal basin on the Bancroft (now Bancroft gardens, in front of the Royal Shakespeare Theatre); Styles, *VCH Warwickshire,* 3: 243.
[83] The population of the Stratford parish in 1831, including outlying areas, was 5171, with 3433 living in the borough; all population figures are taken from H.M. Census figures, collated by Page, in *VCH Warwickshire*, 2, pp. 182-92.
[84] Styles, *VCH Warwickshire*, 3: 234-44, pp. 238-9, 254-8.

cultural profile of the town.[85] Of Stratford's five thousand inhabitants in 1831, 69 per cent lived in the borough and the remainder in the large surrounding semi-rural parish of Old Stratford. One-fifth of all households worked in agriculture (in 1831, 44 per cent in Old Stratford as against 7.5 per cent in the borough, while the equivalent figures were 8.6 per cent in Warwick and 3.9 per cent in Birmingham and Coventry). Of the borough population, 49 per cent were engaged in trade and (small-scale) manufacture. Local directories of 1828-30 list 43 trades, being carried on by 108 individuals and firms.[86] These included 15 maltsters, a few craftsmen producing luxury items (two silversmiths, one clockmaker), and the building- and transport-related trades typical of a market town. There were five professions or semi-professions (17 individuals and firms -- attorneys, auctioneers, bankers, insurance agents, surgeons and one physician). Therefore Stratford, like other market towns, had a range of occupations providing goods and services for both the town and its hinterland.[87] When founded in 1823, the local dispensary would be supported by local business and professional people, in its turn serving many of the poorest among both townspeople and surrounding rural inhabitants, both labourers and small tradespeople (see Chapter 3).

[85] Philip Styles, 'Shakespearean Festivals and Theatres' in *VCH Warwickshire*,3, pp. 244-5.
[86] Pigot's *Warwickshir*e 1828-9, and West's *Warwickshire*, 1830.
[87] Penelope Corfield, *Power and the Professions in Britain 1700-1850* (London: Routledge, 1995), pp. 137-74.

Southam: a significant small town

Southam deserves attention here, as the place that became the cradle of the 'self-supporting' or 'provident dispensaries' in the 1820s. This was a market town of just over one thousand people (1256 in 1831), located at the junction of the Coventry-Oxford and the Warwick-London turnpikes. The town possessed many inns serving travellers; it was also a staging post on the Welsh drovers' route leading to the south Midlands and the capital. According to a county directory in 1830, there were 223 houses; ninety-four individuals followed different professions and trades. While it had a sleepy air, a local directory stated that the town had 'rather improved of late'.[88]

Urban change: consequences and responses

The congested environment in different towns created adverse consequences for the health of poorer people, as will be explored further in this section. From the 1820s, dispensary medical officers produced various accounts of local diseases: in annual institutional reports, published articles, and submissions to mid-century urban sanitary commissions. As well as reflecting urban conditions, they illustrate the work of the dispensaries themselves.

By the 1840s various epidemics, most alarmingly of cholera (in 1832 and 1848-49) were concentrating public attention on growing urban overcrowding and the consequent squalor. Humanitarian responses to contagious diseases among the poor were coupled with fear (because even the wealthy were potentially at risk).[89] Overall mortality rates, as shown in Table 2, were used as the main measure of contemporary population health when comparing towns and districts.[90] The table suggests that Birmingham was healthier than Liverpool

[88] Southam was thirteen miles south of Coventry and eight miles east of Leamington West's *Warwickshire*, 1830), p. 745-7, quotations p. 745; see also John H. Drew, 'The Welsh Road and the Drovers'*, Transactions & Proceedings, Birmingham Archaeological Society* 82: 38–43

[89] Dorothy Porter, Health, Civilization and the State: A History of Public Health from Ancient to Modern Times (London and New York: Routledge, 1999), pp. 113-4,118-20.

[90] This measure had limitations that were slowly recognised, e.g. by William Farr, through its inability to differentiate between deaths in adulthood, in childhood or in infancy, with their different causes. Margaret Pelling, *Cholera, Fever and English Medicine: 1825-1865*, (Oxford: Oxford University Press, 1978), pp. 39-40, 83-4.

and Manchester, and in 1840 a Parliamentary Select Committee recognised its differences vis-à-vis other large industrial towns. This apparent salubrity was attributed to the occupancy by most families of separate houses, with cellar dwellings being almost unknown.[91] While there was much debate concerning the role of contagion *per se*, all agreed that crowded living conditions and tainted air fostered illness. These circumstances were worst in the cellar dwellings common in Liverpool and Manchester, damp, unventilated and commonly contaminated by nearby cesspits.[92] Dispensary practitioners, together with their Poor Law counterparts, documented the health effects of living and working conditions in Warwickshire's towns, Dr John Darwall of the Birmingham General Dispensary being an early example.[93] In 1840-41, the Birmingham 'Committee of Physicians and Surgeons', most of whose members had direct experience of dispensary or poor law practice, was among many groups reporting to national enquiries.[94]

The best-known national commission was that led by Edwin Chadwick in 1839-42. Chadwick developed the 'sanitary idea' largely from the testimony in many local reports, supplied by those with direct experience of working-class living conditions. His argument was that fresh water supplies and efficient sewerage would reduce disease among the urban poor, and his 1842 Report used the observations of local practitioners to cite Birmingham conditions in

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[91] Hopkins, *Birmingham and Industrial Revolution*, pp. 120-4; Select Committee on the Health of Towns, *Report*, (London: HMSO, 1840), 384 (XI), p. xii; the much worse figures for Liverpool and Manchester are shown in Table 2.

[92] Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: England 1800-1854* (Cambridge: Cambridge University Press, 1998), pp. 10, 23.

[93] John Darwall, 'Observations on the Medical Topography of Birmingham and the Health of the Inhabitants', *Midland Medical and Surgical Journal,* 1 (1828), 106-12, 40-53, pp.106-7.

[94] Committee of Physicians and Surgeons, *Report on Public Health in Birmingham* (Shannon: Irish Universities Press, 1971 (orig. pubn. 1841)). The chairman was Joseph Hodgson, the General Hospital surgeon (who was formerly a surgeon at the General Dispensary); the seven other members were: J.M. Baynham, Dr. P. Blakiston, and Dr. J.R. Corrie, of the General Dispensary; J. Russell and F. Ryland (ex-dispensary surgeons); Dr. S. Palmer and J. Wickenden. Several members had also served at the Town (Poor Law) Infirmary. The committee reported to the Select Committee on the Health of Towns in 1840 and to Edwin Chadwick's inquiry in 1841.

some detail.[95] The Public Health Act of 1848 also expressed Chadwickian thinking, as it equipped local authorities with new powers and enabled the appointment of engineers to plan new urban sanitary systems. Christopher Hamlin argued that the concentration on hygiene distracted attention from poverty, poor wages, or faulty diet as causes of disease and misery. He accuses Chadwick of ignoring or even suppressing much evidence that pointed in other directions. He argues, persuasively enough, that Chadwick was motivated by a harsh utilitarianism and a form of political economy opposed to improvements in wages or work conditions. Nevertheless, improved sanitation had generally beneficial effects on working-class health. [96]

To focus more closely on the Birmingham committee's reports, in 1840 and 1841 its members discussed Birmingham's very prevalent back-to back housing, mainly arranged around courtyards. Two thousand courts in the borough housed 50,000 'of the poorer classes' (36 per cent of the population).[97] Their lack of surface drainage called for 'immediate attention'. In addition, the older instances had narrow entry passages, typically only 3-4 feet wide, which impeded both ventilation and efficient clearance of waste. The shared privies were therefore often overflowing and 'in a most filthy condition'. Those in nearby manufactories, however, appeared 'equally disgusting.' Conditions were worst close to the river Rea, the 'cloaca or great sewer' of the town.[98] Heavy

[95] Edwin Chadwick, *The Sanitary Condition of the Labouring Classes of Great Britain* (Report to Her Majesty's Principal Secretary of State for the Home Department), (London: House of Commons, 1842); MW Flinn, 'Editor's Introduction', *in The Sanitary Condition of the Labouring Population of Great Britain*,(Edinburgh: Edinburgh University Press, 1965), pp. 51-58; Both sanitarian thinking and fear of the approaching cholera epidemic appear to have influenced Parliament in passing the legislation; Hamlin*, Public Health and Social Justice*, pp. 245-75 (Ch. 8)

[96] Hamlin, *Public Health and Social Justice,* pp. 53-8, 121-4, 156-62.

[97] Committee of Physicians and Surgeons, *Report on Public Health in Birmingham*, pp. 186, 194, 196, quote p. 186; the courts were those located in the Borough of Birmingham alone (population 138,000), although conditions in Aston were very similar. The report included plans and elevations of newer courts (on pp. 187-92), some of them reproduced by Chadwick in his national report.

[98] These comments are from the report produced in 1840; they were toned down for the later version quoted by Chadwick; Committee of Physicians and Surgeons*, Public Health in Birmingham,* 1840, p.199.

rain led to malodorous flooding nearby, while sewage and industrial processes contaminated local wells.[99] The numerous slaughterhouses and manure heaps attracted 'great swarms of flies', not only unpleasant but also believed to give rise to pathogenic 'miasmas.'[100]

By the 1840s a few highly paid artisans were using building society finance to build terraced housing on the town's outskirts for both rental and owner-occupation. While larger and better ventilated than the back-to-backs, they still lacked sewerage connections.[101] Even in wealthy suburbs like Edgbaston, the contents of water closets were discharged into undrained roadside ditches.[102] At the other social extreme, moralising medical opinion identified overcrowded lodging houses in central streets as foci of both disease and immoral or criminal behaviour. They were 'generally in a very filthy condition…the resorts of the most abandoned characters…[and] sources of extreme misery and vice'. Many Irish immigrants lived in or close to such lodgings. Mostly labourers, such people were in Darwall's earlier words, 'poorly fed, miserably clothed, and miserably lodged'; unsurprisingly they were particularly prone to fever.[103]

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[99] Darwall, 'Medical Topography of Birmingham', pp. 106-7.

[100] Rawlinson, *the Sanitary State of Birmingham*, Appendix by J. Hodgson, pp. 85, 87; the surgeons Joseph Hodgson and James Russell were close friends from apprentice days; they had become unpaid Medical Sanitary Inspectors under the 1848 Public Health Act; see Rachel Franklin, 'Medical Education and the Rise of the General Practitioner, 1760-1860' (Unpublished PhD thesis, Birmingham, 1950), pp. 64-69; for current views on contagion and miasmas, see Margaret Pelling, 'Contagion/Germ Theory/Specificity', in W F Bynum and Roy Porter, eds., *Companion Encyclopaedia to the History of Medicine*, (London: Routledge, 1997 (orig. publ. 1993)), 309-34.

[101] S.D. Chapman, J. N. Bartlett, 'The Contribution of Building Clubs and Freehold Land Societies to Working-Class Housing in Birmingham', in Stanley D. Chapman, ed*., The History of Working-Class Housing: a Symposium*, (Newton Abbott: David & Charles, 1971), 223-46.

[102] The absence of underground sewers affected the major arteries, the Hagley and Bristol Roads, and smaller suburban roads, whose disgruntled residents made strong representations. Rawlinson, *the Sanitary State of Birmingham*, pp. 26, 29-31; Appendix by J. Hodgson, pp. 82-3.

[103] Committee of Physicians and Surgeons, *Public Health in Birmingham*, pp.195-7; Darwall, 'Medical Topography of Birmingham', pp. 109-11, quote p.110; Darwall's observations on local Irish immigrants (written in 1828) seem compassionate, in comparison with some of his peers, who blamed them for spreading fever.

Despite the environmental problems, typhus was uncommon locally, especially in the epidemic or 'malignant' form found in other large towns.[104] By the end of the decade such 'low fevers' were mainly limited to poorly drained localities. About half the cases of continuing fever from the 1820s onwards are believed to have arisen from typhoid, a water-borne infection; most of the remainder were typhus, spread by close bodily contact. [105] Early childhood mortality was, however, higher than in other towns, its contribution to total mortality in 1841 exceeding the figures for many other districts (50% of the total, with over half of these dying in the first year). The doctors attributed this to 'want of proper care… [due to] absence of the mothers in the workshops.' [106]

In Coventry, the Health of Towns Commission was very critical of conditions in central localities and especially of housing standards for the poor.[107] The Commissioner visiting in 1843 noted the ramshackle modern structures bordering ancient buildings. The offensive-smelling streets, mostly unpaved and poorly drained, were 'narrow, ill-arranged… giving a sombre appearance… lanes, courts, and alleys abound in every direction'. Dwellings had recently been built on some central sites, but in a particularly cramped and crowded manner. Typically measuring 12 by 18 feet and with thin walls, these housed poor weavers, often 'three or four families' to each house.[108] Mills obstructing the river Sherbourne resulted in accumulations of 'animal and vegetable matter'. Local practitioners observed that fever was commonest among those living close to the river. Here outbreaks of influenza, measles, and

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[104] Committee of Physicians and Surgeons, *Public Health in Birmingham,* pp. 202-3, 205.
[105] Rawlinson, *the Sanitary State of Birmingham*; Appendix by J. Russell, pp. 88-91; about half the cases of continuing fever (or 'low fever') from the 1820s onwards are believed to have arisen from typhoid, a water-borne infection; most of the rothers were typhus, spread by close bodily contact, see Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon, 1986) pp. 59-60.
[106] Committee of Physicians and Surgeons, *Public Health in Birmingham,* p. 207.
[107] J. R Martin, 'Part II: Apppendix: Coventry: Report on Its Sanatory Condition', in *Royal Commission on the State of Large Towns and Populous Districts,* ed. by Duke of Buccleuch and HM Commissioners (London: W.Clowes & Co for HMSO, 1844), 258-66, pp. 259-60; also see N. W. Alcock, 'Housing the Urban Poor in 1800: Courts in Atherstone and Coventry, Warwickshire', *Vernacular Architecture,* 36 (2005), 49-60.
[108] Martin, *Report on Coventry*, pp. 261-62.

scarlet fever had a high mortality, the most striking instance being the fifty workhouse deaths in January 1838 (out of 330 inmates). All the city's dead, including victims of contagious illnesses, were buried in two overcrowded central churchyards. The lack of space for fresh burials, resulting in premature disinterments and 'distressing scenes', may also have contributed to the spread of disease, until a handsome-park-like cemetery was opened in 1847.[109]

By the 1840s civic leaders in Coventry were ready to improve the city's lamentable sanitary state, if they could do so without undue expense.[110] Designated as a Local Board of Health from 1849, the council was empowered to commission plans for sewerage and water supply.[111] The inspecting engineer, William Ranger reiterated earlier observations, quoting local practitioners (all either dispensary or Poor Law medical officers) who described several central streets as 'the seats of epidemic, endemic, and other contagious diseases'.[112] These contributed to an overall mortality of 26 per thousand, against 22 nationally. Ranger pointed to the numerous dependent widows and orphans, with the consequent additional costs for ratepayers arising from the 'excess' premature mortality.[113] By 1858 the city possessed an arterial system of sewers, but these were only slowly connected to inner-city streets and courts.[114]

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[109] Martin, *Report on Coventry*, pp. 259-60; deaths from fever, p. 263; he quoted Dr R. Arrowsmith, the physician to the Hospital and the Provident Dispensary, who attributed the workhouse deaths to 'cholera'; this should be understood as 'English cholera', namely severe diarrhoea rather than Asiatic cholera. Joseph Paxton, the prominent engineer and gardener, designed the new cemetery.

[110] Peter Searby, *Coventry Politics in the Age of the Chartists, 1836-1848* (Coventry: Historical Association, Coventry Branch, 1964), pp. 31-2.

[111] The city council was constituted as a local Board of Health in 1849 under the 1848 Public Health Act; Stephens, *VCH Warwickshire,* 8, p. 278.

[112] William Ranger, Report to the General Board of Health on a Preliminary Enquiry into the Sewerage, Drainage, and Supply of Water, and the Sanitary Condition of the Inhabitants of the City of Coventry (London: W Clowes & Co for HMSO, 1849). The three Poor Law doctors quoted (pp. 5-6) included Edward Bicknell, who was also a dispensary surgeon. During the previous 12 months, the Provident Dispensary had attended 251 cases of fevers and diarrhoea (13.9% of total cases; Dispensary Annual Report 1848-9, quoted by Ranger).

[113] Ranger, Sanitary Report on Coventry, p.5.

[114] Stephens, *VCH Warwickshire* 8, pp. 278-9.

Stratford-on-Avon shared the defects of larger towns, as an ancient borough described by the inspecting engineer as having grown up 'without any attention to drainage or cleanliness'. Its mid-century mortality figures (23.5 per thousand in 1848) were surprisingly high for a small market town. These arose from higher levels of illness in the northern 'New Town' built near the canal after 1818.[115] Dr John Conolly had noted, from his time as a dispensary practitioner in the 1820s, that fevers frequently occurred in recently built cottages; by the 1840s a quarter of the inhabitants of two streets in the New Town were affected by 'zymotic' disorders.[116] The houses in question stood on undrained clay soil, unlike the gravel elsewhere in the town, and experienced seepage from the nearby canal.[117]

The comments of dispensary medical officers figured prominently in the urban health reports. This reflects their important role, alongside the Poor Law medical service, in dealing with the fevers and other diseases believed to result from poor sanitary conditions. Such conditions are discussed in more detail in the Chapters dealing with specific dispensaries in Birmingham, Coventry, and Stratford on-Avon (Ch. 2, Ch. 3, and Ch. 6). The public in different towns, and their council representatives, varied in their attitudes to sanitary improvement.

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[115] George T. Clark, Report to the General Board of Health on a Preliminary Enquiry into the Sewerage, Drainage and Supply of Water, and the Sanitary Conditions of the Inhabitants of the Town of Stratford-on-Avon (London: W Clowes for HMSO, 1849); quote p. 5; in December 1848 the borough population was calculated as 3269 and the rest of Old Stratford parish as 2363 (total 5632). Mortality rates were 21 per thousand in the borough and 26 in Old Stratford (including the New Town). Dr Thomson, physician to the Stratford Infirmary and Dispensary, supplied the mortality figures for 1841-47, p. 6.

[116] Conolly's role at the dispensary during 1823-8 is considered in Ch.3 and his writing career is explored in Ch. 4. He remarked on the prevalence of fever in new cottages in a paper delivered in 1832; John Conolly, 'A Proposal to Establish County Natiural History Societies', *Trans PMSA,* 1 (1833), pp. 188-9; the term 'zymotic', from the Greek word for 'ferment', was currently applied to fevers and contagious diseases, including typhus and typhoid fevers, smallpox, scarlet fever, measles, erysipelas, cholera, whooping-cough, diphtheria, &c; 27 per cent of the inhabitants in these streets were affected, compared with an average incidence for the town of 9.3 per cent; Clark, *Sanitary Report on Stratford-on-Avon,* p.11. Dr Thomas Thomson became mayor that year; Stratford's nineteenth-century mayors included eight medical practitioners, five serving repeated terms.

[117] Clark, Sanitary Report on Stratford-on-Avon, pp. 7-8.

Birmingham gained an effective council in 1842 but its early priority was to displace earlier oligarchies, and the strong belief of most councillors in laissez-faire probably reflected their electors' priorities.[118]

The eight overlapping local bodies also impeded coordinated action and the 1851 Improvement Act passed only after a bitter struggle between them. The Street Commissioners (an active authority but regarded as oligarchic) had commenced sewer construction in the 1840s. Under the borough council in the 1850s, implementation slowed down, being, hindered by lawsuits and the period of 'economy' in corporation expenditure.[119] In Coventry by the 1840s the reform-minded council favoured sanitary improvement, provided costs were not too great. In succeeding decades, water supplies improved, and sewers were laid, although it was many years before all inner-city courts were connected.

Stratford-on-Avon exhibited in miniature the problems of much larger towns and the struggles to remedy them. A Local Board of Health was formed in September 1850 but gained only muted support. Wealthier inhabitants supported the proposals for improved drainage and water supply, their leaders on the council being Dr Thomson, the surgeon David Rice, and the brewer Edward Flower (who himself experienced flooding from the canal into his adjoining house and brewery).[120] Some small tradesmen gained election to the Board as 'economisers' to oppose the costly plans. After a lengthy disagreement the plans were implemented in 1853, but the town's streets were not paved until 1868.[121] Mid-century local authorities can seem muddle-headed and reactionary, but Hamlin has argued that some of their scepticism towards

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[118] Conrad Gill, *History of Birmingham,* 1: *Manor & Borough to 1865* (Oxford: Oxford University Press, 1952), pp. 273-4.
Stephens*, VCH Warwickshire*, 7, p. 340.
[119] Stephens, *VCH Warwickshire*, 7, p.341.
[120] Clark, *Sanitary Report on Stratford-on-Avon,* pp. 8-9; RI Penny, 'The Board of Health in Victorian Stratford-Upon-Avon: Aspects of Environmental Control', *Warwickshire History,* 1 (1971), 1-19, pp. 9-10. There were no local cases in the 1848-49 cholera epidemic, and this may have diminished support for the Board.
[121] Penny, 'Board of Health in Victorian Stratford', pp.10-11.

costly and unproven sanitary 'improvements' was reasonable. This was especially in the light of flaws in some technical solutions that Chadwick dogmatically promoted.[122]

Table 2: Crude Death Rates for Selected Boroughs, and for England and Wales, 1820-80

Town, etc.	England & Wales	Birmingham	Coventry	Stratford-on-Avon	London	Liverpool	Manchester
1822-7		28.2					
1830-39	21.5	27.2			26.7		35.6
1841-50	22.3	27	27	24	25	36	35
1851-60	22.2	27	25	19	24	32	31
1861-70	22.5	26.5	21				
1871-80	21.3	25.8		21.9 (Reg. Sub-District)			

Birmingham (conurbation, including Aston and Edgbaston) 1822-7, J. Darwall, 'Observations on the Medical Topography of Birmingham and the health of the inhabitants', *Midland Medical and Surgical Reporter,* 1 (1828), 106-12, p.109; later data from Registrar-General's *Annual Reports* (4th, 25th, 36th) and relate to the relevant boroughs in 1841, 1851, 1861, 1871 and 1881 (but for Stratford in the 1870s, used the registration sub-district).

Nevertheless, the fall in urban mortality in the study towns from the 1860s (table 2) would seem to reflect the effects of the sanitary improvements

[122] These included small-bore sewage pipes and the use of untreated sewage as manure on farmland. Hamlin, *Public Health and Social Justice,* pp. 274-334; Christopher Hamlin, 'Muddling in Bumbledom: On the Enormity of Large Sanitary Improvements in Four British Towns, 1855-1885', *Victorian Studies,* 32 (1988), 55-77.

even while incomplete.[123] Coventry shows impressive changes, the annual death rates falling from 27 per thousand people in the 1840s to 25 and then 21 during the next two decades; in Stratford-on-Avon the corresponding rates were 24, 19, and 21.9.[124] The rates in Birmingham fell only slightly, from 27 in the 1840s to 25.8 in the 1870s. An analysis by Woods indicates that Birmingham's sluggish mortality decline may have reflected the persistence of poor housing (and the associated poverty) in the city's central wards.[125] The improvements in municipal hygiene were thus important, but far from the only factor underlying improvements in health and mortality. The implementation of improved sanitation was an undoubted public health achievement, but its completion was a lengthy medical and municipal task. As Woods suggests, other changes, such as improved housing, reductions in poverty, and enhanced hospital provision are likely to have contributed to the mortality decline.[126]

Mixed economies of welfare: mutual aid, philanthropy, and poor relief

This section will consider, firstly, the collective self-help networks established by those living and working in the larger towns. In Coventry, such organisations were closely intertwined with the provident dispensary (partly because reduced membership rates were available at the dispensary to friendly society members). In Birmingham the general dispensary was large and busy, developed late-century links with organised workplace collections, but remained separate from friendly societies. Provident dispensaries there never gained strong support (possibly due to more individualistic attitudes in Birmingham's small-master economy).

[123] In this study and elsewhere. The question of whether dispensary treatment contributed to these changes will be discussed in later Chapters.
[124] The figures for Stratford in the 1870s were based on the larger registration district rather than the borough, therefore including some areas with poorer housing and drainage.
[125] Woods' study was for a later, although overlapping, period; Robert Woods, 'Mortality and sanitary conditions in the "best governed city in the world"--Birmingham, 1870-1910' *Journal of Historical Geography,* 4(1) (1978), 35-56.
[126] Woods, 'Birmingham mortality and sanitary conditions', pp. 52-55.

In 1851 the journalist William Mackay portrayed the Birmingham scene. Originally writing for the *Morning Chronicle*, he noted the enthusiasm of the inhabitants for 'association for mutual benefit, real or supposed'. Birmingham public houses were the base for many 'clubs', including benefit societies, informal savings and loan banks, and building societies; the Pearl-button Makers' Union was one among several large trade-based large associations.[127] By the 1830s the 'more scientifically conducted societies' were said to be meeting 'in the vestries or schoolrooms of chapels and churches' (rather than in taverns).[128] Estimates of numbers include 40,000 members in 400 friendly societies in 1835, and a probably more realistic 30,000 members in 213 clubs in 1849.[129] Middle-class observers, of course (like the journalist Mackay), tended to disapprove of the spending on drink during club nights and on occasional feasts and 'showy' processions.[130]

In Coventry the associational life of nineteenth-century artisans was also largely centred on public houses, including 'club nights' (generally Monday evenings). Their mutual aid associations, many of them sickness clubs, were mostly located in taverns. [131] In 1838 the benefit clubs were 'exceedingly numerous', with 'not fewer than twenty … in contract with the Provident Dispensary'. [132]At mid-century, 32 of the 202 pubs in the city organised 56 clubs

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[127] Mackay, 'Birmingham XXI: Clubs of Working Men and their Families', *Letters to the Morning Chronicle,* pp. 320-23, quote p. 320; ---- 'Birmingham IV: The Pearl and Fancy Button and Stud Manufacture, *Letters to the Morning Chronicle,* pp. 289-93; this association covered almost all adult males in that trade (1150 out of a total 2000 workers).

[128] William Hawkes Smith, *Birmingham and Its Vicinity, as a Manufacturing and Commercial District*, (London and Birmingham: Tilt & Co: Radclyffe and Co, 1836) p.35.

[129] Wiiliam Hutton and James Guest, *The History of Birmingham: With Considerable Additions*, 6th edn (Birmingham: James Guest, 1835 (orig. edn. 1783)) p. 294.; Stephens, *VCH Warwickshire*, 7, pp. 225-6.

[130] e.g., Mackay, 'Birmingham Clubs of Working Men', p. 321.

[131] These remarks are derived partly from Prest, and partly from the reminiscences of W. H.Stringer (a local publican's son); Prest, *Industrial Revolution in Coventry*, p. 73; WH Stringer, 'Tavern Life in Coventry in the 1850s' *c.*1914, ' in *Coventry Newspaper Cuttings,* compiled by O Heap (Coventry History Centre, c.1914).

[132] Peter T Weller, 'Self Help and Provident Friendly Societies in Coventry in the Nineteenth Century' (Unpublished MPhil Thesis, Warwick, 1990), p. 26.

or provident societies, 50 being sickness clubs. [133] The provident dispensary (itself being largely mutually funded) provided medical care at favourable rates to friendly society members, although a few societies employed their own medical officers. [134] The Coventry Provident Dispensary, linked as it was with friendly societies, gained a dominant position in the local health care economy, which was consolidated during the last three decades of the nineteenth century. [135] Despite local economic disruption and hardship, the dispensary endured and even grew. Its membership was 4,500 in 1857, 5,000 in 1870 and 15,000 in 1882. [136]

Networks of poor relief varied considerably between the study towns, and some of the differences will be identified below. The urban welfare economies combined in varying proportions the statutory system, traditional dole charities, and some highly specific, sometimes temporary provisions.[137] Dispensaries were principally intended to serve those in work, rather than those receiving poor relief, but rules for eligibility sometimes became blurred. Areas of overlap also existed between dispensaries, other charities, and the Poor Law (especially the old Poor Law). A prominent instance was the first 'self-supporting' dispensary in Southam. On its formation in 1823, it served both paupers and the working poor. This was also the case with slightly later institutions inspired by Southam, at least until the years following implementation of the new Poor Law from 1834, when statutory provision became increasingly distinct. Some dispensaries offered direct assistance with

[133] Fletcher, Assistant Commissioners' Reports, 1840, p.74.
[134] Prest, *Industrial Revolution* in Coventry, p. 73, quoting *Coventry Herald,* 1 August 1851
[135] Charles H. Bracebridge, 'Notes on Self-Supporting Dispensaries, with Some Statistics of the Coventry Provident Dispensary', *Journal of the Royal Statistical Society*, 21 (1858), 460-63, p. 460; C. B. Nankivell, 'The Provision of Medical Attendance on the Independent Poor by Provident Dispensaries', *British Medical Journal,* 2 (1871), 318-20, p. 319; Charles Bray, *Phases of Opinion and Experience During a Long Life: An Autobiography*, (London: Longmans Green, 1884), p. 87.
[136] Weller, 'Coventry Friendly Societies', p. 159.
[137] The last comprising civic or congregational collections or special relief funds.

food and other needs (varying greatly by time and place).[138] The Poor Law provisions in different areas will be summarised, given the areas of overlap as noted above.

Poor relief provision in both Birmingham and Coventry was governed by local Acts of Parliament, enacted in 1783 and 1801 respectively. The ratepayers in several Birmingham parishes jointly elected 108 Guardians (see Table 3). Paupers needing medical care attended the workhouse infirmary, established in 1766 and separated into a new building in 1797. In size and staffing this resembled a general hospital, with six surgeons attending in- and out-patients in rotation, also paying home visits when required.[139] As in Coventry, staffing overlapped with the local dispensary, some surgeons serving both institutions, a few simultaneously, but more often in sequence. Medical officers acting on behalf of the Poor Law dealt with large numbers of individuals, mostly as outpatients at the Town Infirmary (in 1834, 9783 people, with another 4477 being treated at home).[140]

Birmingham's varied industrial scene meant that a downturn in a particular business might be followed by new job opportunities in the 'town of a thousand trades'; but in generalised slumps any employment became scarce. In 1837 some so-called 'economisers', a group comprising mainly smaller tradesmen, became Guardians of the Poor. They were keen to reduce the burden on ratepayers by bearing down on out-relief, for instance in the severe winter of 1839.[141]

Table 3: Institutions founded under the Old and New Poor Law (excluding Lunatic Asylums) in Birmingham, Coventry, and Stratford-on-Avon, 1766--1880.

[138] The dispensaries at Birmingham, Coventry and Stratford on Avon had such arrangements, in the latter two cases provided through 'Ladies' Committees' in the 1820s and 1830s; to be further discussed in later Chapters.
[139] The staff included two members of the well-connected Cox family; different medical officers also published accounts of their practice in medical journals.
[140] Between 1829 and 1843, the medical officers attended fluctuating numbers, but they included at least 4600 outpatients and 2400 home patients; Alistair Ritch, 'New Poor Law Medical Care in the Local Health Economy', *Local Population Studies*, 2017, 99, 2017, 42-55; Table 4, p.50
[141] Behagg, *Politics and Production*, pp. 106-7.

Local authority	Location	Date	Name	Beds/places
Birmingham United Parishes	Lichfield Street	1734	Workhouse	600 1848: 645
		1766	Infirmary Wing	270
	Asylum Road/ Summer Lane	1797	Asylum for Infant Poor	200
Birmingham United Parishes	Birmingham Heath (Dudley Road)	1852	Workhouse	700 adults 600 children
	Dudley Road	1852	Infirmary	600
Coventry Incorporation (of 3 parishes)	Whitefriars/ Gulson Road	1801	House of Industry	1843: 450
Union -- from 1874		1870 1889	Fever Hospital Infirmary	
Stratford-on-Avon	Borough (Henley Street)	1777	Workhouse	50
	Old Stratford	1777	Workhouse	40
Stratford Union (36 parishes)	Arden Street	1837	Union Workhouse	200
Sources: Alistair Ritch, 'Medical care in the workhouses in Birmingham and Wolverhampton, 1834-191' (PhD thesis, Birmingham, 2015), pp. 63-5; Stuart Wildman, *'He's only a Poor Pauper whom Nobody Owns': Caring for the Sick in the Warwickshire Poor Law Unions, 1834-1914*. *Occasional Paper* 53, (Stratford-on-Avon: The Dugdale Society, 2016), p. 9; Peter Heginbotham, 'The Workhouse' pages for Birmingham/Coventry/Stratford-on-Avon, http://www.workhouses.org.uk/ (see also map of Unions -- fig.1 above)				

Thus by about mid-century the poor feared the system's harshness, while those of middling standing resented the demands made on them; different sections of Birmingham society thus had different reasons for hostility to the Poor Law.[142]

[142] Hopkins, Birmingham and Industrial Revolution, pp. 152-6.

In the 1830s outdoor relief in Birmingham amounted to between £5818 and £10,222, the reasons including 'sickness [and] want of work'.[143]

In Coventry, the authorities aimed to mitigate the widespread distress arising from the frequent slumps in the silk ribbon trade. The fifteen 'Directors of the Poor' used their relative freedom from parsimonious national policies to provide outdoor statutory relief, together with aid from the well-endowed local charities.[144] Until the 1830s the corporation tended to channel such charitable aid only to those freemen who voted for the Corporation-approved (usually Tory) candidates. This partisanship was among the many abuses affecting local parliamentary elections, criticised by both the Charity Commissioners and the commissioners for municipal corporations. From 1835, however, members of the reformed council and other charity trustees seem to have performed their duties diligently and without undue favour.[145] Local Poor Law arrangements are considered here, as those attending the dispensary might need such assistance at some time in their lives (e.g., during periods of unemployment or in old age). Early in the century, local poor law relief was relatively generous, being supplied in 1830 to 1395 outdoor pauper families. A funding deficit that year of over £4500 forced sharp economies, including stricter criteria for support.[146] After 1844 local poor relief was firmly under the control of the Poor Law Board, leading in a few years to a halving of the numbers on out-relief and of the

[143] Committee of Physicians and Surgeons, *Public Health in Birmingham,* p. 210; very similar figures were cited in 1849; Rawlinson, *the Sanitary State of Birmingham*, p. 44.
[144] In Birmingham, Coventry, and Stratford respectively in 1816-21, annual Poor Law relief amounted to £6.40, £16.45 and £7.34 per head (of poor); charitable disbursements to £0.11, £0.99 and £0.05 per head. Both statutory and non-statutory relief were thus more generous in Coventry; Sylvia Pinches, 'Charities in Warwickshire in the Eighteenth and Nineteenth Centuries' (Unpublished PhD Thesis, Leicester, 2000), p. 264.
[145] Peter Searby, 'The Relief of the Poor in Coventry, 1830–1863', *The Historical Journal,* 20 (1977), 345-61, pp. 356-7; Powell, 'Coventry Corporation and the Myth of Paternalism', pp. 85-87.
[146] That year £20,636 was spent on relief, as against only £16,089 raised in rates; Searby, 'the Poor in Coventry', p. 355.

amount spent.[147] During slumps the mayor launched special collections at public meetings; in 1841 such private distress funds amounted to £1352 and in 1847 to £1002.[148]

In Stratford-on-Avon, the parish authorities managed poor relief up to 1834, whereupon the town became the head of a union of 36 parishes (Fig 1.). By mid-century high rates of sickness, as discussed above in relation to local housing, were driving up the amount of out-relief (from £876 in 1845-6 to £1592 in 1847-8), such costs reinforcing the arguments used by Chadwick and others, in different places, to argue in favour of spending on sanitary improvement.[149] In this respect, self-interest reinforced humane concern and sanitary spending could be presented as cost-effective.

While the role of dispensaries evolved over time, their purpose was to help large swathes of the working population, while the Poor Law continued as a rather frayed (and increasingly separate) safety net for those in the worst circumstances. However, old age, continued sickness or other ill-fortune could propel the dispensary patient towards reliance on Poor Law services. The governors of dispensaries therefore used the prospect of averting such an unwanted outcome as an argument in favour of supporting their institutions.

[147] In 1841 there had been 531 out-poor, receiving a total of £3700; in another slump year, 1847, numbers had fallen to 260 and total payments had halved to £1700; Searby, 'the Poor in Coventry', p. 355.
[148] Searby, 'the Poor in Coventry', p. 358.
[149] See, e.g., Clark, Sanitary Report on Stratford-on-Avon, p. 6.

Voluntary Societies: purposeful associational life

The fourth theme concerns the voluntary societies that from the later eighteenth century channelled social energies, mainly among the middle classes, towards individual and collective improvement. As analysed by Morris, they derived their organisation from the joint-stock companies formed for business, self-governing nonconformist chapels, and the various clubs meeting in public houses.[150] Some were concerned with medical (and other) charity, such aspects receiving close attention in later Chapters of this thesis. The basis of most societies was a 'subscriber democracy', albeit steered by smaller oligarchies of the leading members (generally the prominent and wealthy). Morris argues that local elites used their role in such societies to spread their values, of thrift, sobriety, and cleanliness, thereby increasing their urban hegemony.[151] Several local instances are advanced below which partly support and partly qualify this view.

Birmingham business figures played a leading role in establishing two late eighteenth-century medical charities. The first of these was the General Hospital, whose funding campaign was initiated with some enthusiasm in 1765, but lost momentum a few years later. Jonathan Reinarz has explored its faltering progress, its rekindling in the later 1770s, and the eventual opening in 1779. Adrian Wilson attributed the revived campaign to the participation of prominent businessmen. The entrepreneur Mathew Boulton encouraged contributions from James Watt, members of the Galton and Lloyd families, and others. Publicity materials gave prominence to landed proprietors, but their financial contribution now came second to those from bankers, merchants, and manufacturers. A music festival, adopted as a key element of the later fundraising drive, would continue to figure largely in local cultural life.[152]

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[150] R.J. Morris, 'Voluntary Societies and British Urban Elites, 1780–1850: an Analysis', *The Historical Journal*, 26 (1983), 95-118.

[151] Morris, 'Voluntary Societies', pp. 101, 110-12.

[152] Reinarz, *The Early Years of the General Hospital, Birmingham*, pp. 4-9; Adrian Wilson, 'The Birmingham General Hospital and Its Public, 1765-1779' In *Medicine, Health and the Public Sphere in Britain, 1600-2000*, ed. Steve Sturdy (London and New York: Routledge, 2002). 85-106, pp. 88-98.

In 1793, prominent Birmingham citizens deliberated the foundation of a local dispensary, initially in a desultory way. Matthew Boulton again took a lead and continued his close involvement in the management of the Birmingham General Dispensary after its opening in 1794.[153] This later funding campaign (for the dispensary) developed against a background of local dissension, demonstrated by the destructive riots of July 1791.[154] These disturbances pointed to deep social, political, and economic divisions, including sectarian tensions and resentment of the wealth of some Dissenters. The intentions of the founding committee may have included dispensing the 'social balm' of medical charity, aiming both to benefit the sick poor and to heal political and social divisions among elites and the general population.[155] Thus the founders of the institution were businessmen rather than the gentry or members of the medical profession (although the committee recruited medical officers when the plans were well advanced). Landowners never played a large part in the conduct of the Birmingham Dispensary, in contrast to institutions founded in smaller towns.

In Coventry, two new dispensaries were vying for support during the stormy year of 1831, with all its political tensions. Against a background of agitation for parliamentary reform, the silk industry was in a deep slump, and industrial changes were provoking local disturbances. A new 'self-supporting' institution, later known as the Coventry Provident Dispensary, gained the support of clergymen, manufacturers, and others. Its rival (purely charitable) General Dispensary was championed by nearly all local medical practitioners

[153] Charles Pye, *Description of Modern Birmingham* (Birmingham: J. Lowe, 1820), p. 12.
[154] Rose, 'The Priestley Riots'; Priestley and others lost their homes; Boulton was among those who managed to keep any attack at bay, by arming certain workmen and barricading the Soho works. .
[155] Roy Porter, *Bodies Politic: Disease, Death and Doctors in Britain 1650-1900*, (London: Reaktion, 1995); 'social balm', p.25; Money implies that concerns about social tensions contributed to Boulton and others establishing the dispensary; Money, *Experience and Identity*, p. 266.

but appeared to have a narrower base of general support. In 1840 the latter was absorbed into the new Coventry and Warwickshire Hospital.[156]

Some voluntary societies had educational or cultural aims. The 'Brotherly Society' was established in 1796 by a group of Birmingham Unitarians, building on earlier initiatives by Joseph Priestley.[157] In its provision of adult education to artisans, this anticipated the mechanics' institutes of the 1820s. The Society evidently nurtured reformist thinking during the decades of political repression during the wartime years and its aftermath. Its leading member Thomas Clark became a prominent supporter of the General Dispensary (and for a time, chairman of its committee).[158]

In suburban Birmingham by about 1830, the Birmingham Botanical and Horticultural Society reflected concerns with science and rational recreation. The founders, who included the dispensary physician and botanist John Darwall, established a joint stock company in 1829, and in 1832 opened the botanical gardens in Edgbaston. These served a middle-class membership, many fired with new enthusiasm for tending the gardens of their suburban villas, often influenced by gardening writers like John and Jane Loudon.[159] However, partly through financial pressures, in 1845 the gardens were opened to the working classes at a penny a head; by 1853 annual numbers of these 'decorous and well-dressed' visitors had reached 45,000 each year.[160]

In nineteenth-century Stratford-on-Avon, culturally focused groups arose to celebrate the town's most famous son. In 1824, twenty younger individuals, mainly tradesmen, established the Shakespeare Club to honour the

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[156] These events will be discussed in Ch. 2; Stephens, *VCH Warwickshire,* 8, pp. 282, 284.
[157] Established in 1796, this was associated with the earlier Book Society, and in turn a Benefit Society was formed for its members; Money, *Experience and Identity,* p.143; Gill, *History of Birmingham,* 1, p.134.
[158] For mechanics' institutes in Warwickshire, see Stephens, *VCH Warwickshire* 7, pp. 209, 227-8 (Birmingham); Stephens, *VCH Warwickshire* 8, p. 223 (Coventry).
[159] Edgbaston inhabitants were avid consumers of new manuals on gardening by, e.g., John Claudius Loudon, and his wife Jane Webb Loudon. J.C. Loudon designed the Birmingham botanical gardens' layout; Davidoff and Hall, *Family Fortunes,* p. 206.
[160] Davidoff and Hall, *Family Fortunes*, pp. 423-4; Reid, 'The Decline of Saint Monday, p. 83.

dramatist with dinners and convivial evenings. During the following decade (from c.1831), it developed a more serious tone, establishing lectures and a library, also campaigning for the repair of Shakespeare's tomb. Dr John Conolly, co-founder of the Stratford Dispensary, became one of its leading members.[161]

The launch of medical charities was often a complex and contested affair, aspects which will be explored in later Chapters (2, 3, 5 and 6). Some founders and governors of dispensaries had wider roles, including contributing to cultural initiatives. Matthew Boulton, for instance, supported the establishment of Birmingham's theatre and the music festival that was used to generate hospital funds; a few years later, the dispensary governor Thomas Clark supported activities in Birmingham popular education.[162] Some dispensary medical practitioners were also active in voluntary societies with a cultural focus. Examples include Darwall at the Botanical Gardens, and Conolly (followed by his local successors) in support of the schemes celebrating Shakespeare in Stratford-on-Avon.[163] Some of the above initiatives originated among elites, but others arose among people of middling position, thereby tending to nuance the arguments of Morris regarding the hegemony of dominant groups.[164] The contribution of dispensary medical officers and other practitioners to cultural

[161] Philip Styles, ed., 'The Borough of Stratford-upon-Avon: Shakespearean Festivals and Theatres', in *VCH Warwickshire* 3, pp. 244-247; Susan Brock, Sylvia Morris, *The Story of the Shakespeare Club of Stratford-Upon-Avon 1824-2016* (Stratford-on-Avon: Shakespeare Club, 2016), pp. 16-18, 56-60. Conolly, always a Shakespeare enthusiast, was by then living in Warwick.

[162] Tann, 'Matthew Boulton', *ODNB*; for Clark, see Money, *Experience and Identity*, p.143.

[163] For Darwall and the Botanical Gardens, see Davidoff and Hall, *Family Fortunes,* p. 206; for Shakespeare, Brock and Morris, *The Shakespeare Club of Stratford-Upon-Avon,* pp. 16-18, 56-60, 71.

[164] While Boulton was clearly an elite figure, Clark, Darwall, and the tradesmen who founded the Shakespeare Club appear middling. Morris, 'Voluntary Societies', pp. 101, 110-12.

movements will be discussed in Ch.5 in relation to Inkster's adaptation of the 'marginal man' idea.[165]

Religion in Warwickshire Towns

In an overview of organised religion, Obelkevich argued that its social relevance increased during the first century of industrialisation (1750-1850). He saw the churches, especially in industrialising towns, as responding to 'social and economic change with considerable success'.[166] During most of the nineteenth-century in smaller towns and the countryside, the Church of England continued to occupy its central role, in Warwickshire as elsewhere. In industrial districts, the various congregations of Protestant Dissenters had become more prominent. This was in part related to their social make-up, comprising as they did predominantly tradesmen and artisans, together with a few wealthy businessmen.[167]

In both Birmingham and Coventry, the denominations of old Dissent, namely Baptists, Independents, Presbyterians, Quakers, and Unitarians, generally survived and sometimes thrived; some groups gained new adherents, while others were notable for influence beyond their actual numbers. John Wesley inspired both the evangelical movement in the established church and stimulated the Methodist or Wesleyan groupings categorised as 'New Dissent', which in Warwickshire had mixed experiences.[168] As urban populations grew, most churches found it difficult to provide space for all those who might wish to worship, particularly in larger towns and in industrialising districts. The Church of England thus failed to keep pace with population increases: most

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[165] Ian Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850', in J. H. Woodward, J.H. and David Richards, (eds)., *Health Care and Popular Medicine in Nineteenth Century England*, (London: Croom Helm, 1977), 128-63.

[166] James Obelkevich, 'Religion' in F. M. L. Thompson, ed., *The Cambridge Social History of Britain, 1750-1950* (Cambridge: Cambridge University Press, 1990), 311-356, quotes p.311.

[167] Obelkevich, 'Religion', social make-up, p.316; wealthy businessmen, p. 333.

[168] Keith Geary, ed., 'Introduction', in *the 1851 Census of Religious Worship: Church, Chapel and Meeting Place in Mid Nineteenth-Century Warwickshire* (Stratford-on-Avon: Dugdale Society/Shakespeare Birthplace Trust, 2014), 1-84.

denominations of 'Old Dissent' did manage to do so, while the response of Wesleyan groups was more complex.[169]

On 30 March 1851, the day of the Religious Census, places of worship in different sorts of Warwickshire town had very distinct experiences. In traditional country towns like Southam, Stratford, and Warwick, between 65 and 70 per cent of the population attended services, nearly three-quarters of them in the established church. In Birmingham and Coventry, attendance was lower (38.1 and 43.7 per cent respectively), with slightly less than half of these attending Anglican services.[170] As was widely expected, the survey confirmed a falling away of industrial workers had from organised religion. In the Warwickshire context, however, many recent migrants to large towns had moved from rural parishes where attendance had been weak for generations.[171]

Some of the main places of worship will be outlined, together with the numbers recorded as attending in March 1851. In Birmingham, St Martin's was the original parish church, while newer foundations from the town's eighteenth-century enlargement included St Philp's and St Paul's in their squares, and St Mary's in a poorer central locality. At Carr's Lane Independent chapel, the minister from 1805 to 1859 was the noted preacher John Angell James. Mid-century Unitarians attended both the New and the Old Meeting House, while some also visited the church of the Saviour to hear sermons of George Dawson. With Irish immigration, Roman Catholic congregations had swelled, notably at St Chad's (built 1841 and a cathedral from 1852). Older Catholic chapels included St Peter's, near Broad Street, dating from 1786.[172] The

[169] Geary, 'Editor's Introduction', *1851 Census of Religious Worship*, pp. 26-27.
[170] In the Southam, Stratford, and Warwick Registration Districts, the percentage at Anglican services was respectively 67.8, 75.0, and 74.9; in Birmingham and Coventry the relevant figures were 44.6% and 47.9%; Geary, *1851 Census of Religious Worship,* pp. 37-39.
[171] Geary, *1851 Census of Religious Worship,* pp. 34-35, Obelkevich, 'Religion', p.337-38.
[172] On 30 March 1851, Roman Catholic attendances included 640 at St Peters Chapel; at St Chad's, 4300 attended the three Sunday morning masses (an average of 1433); Geary, *1851 Census of Religious Worship*, pp. 100, 121.

Quakers used a Meeting House in Bull Street (as they still do).[173] In central Coventry, St Michael's and Holy Trinity were the two mediaeval parish churches. The main Dissenting chapels were in Cow Lane (Baptists), and Vicar Lane (Calvinists, Independents, and the Friends Meeting House). Stratford-on-Avon possessed the large parish church of Holy Trinity, while Dissenters attended chapels in Payton Street (Particular Baptists), Rother Market (Independents), and Birmingham Road (Wesleyans).

Religious convictions may, at least in part, have motivated both the supporters and the medical staff of dispensaries and other medical charities. The philanthropic impulses of such individuals have been attributed to a general Enlightenment humanitarianism, but also linked to Dissenting or Evangelical beliefs (as will be further discussed in Ch.2).[174] The dispensary medical staff at the Birmingham General Dispensary included both staunch Anglicans and Dissenters, while certain dispensary policies suggest 'ideals of economy, frugality…and financial rectitude', that Hilton has linked with evangelical beliefs.[175]

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[173] The Anglican attendances on 30 March 1851 (excluding Sunday scholars) in Birmingham included 1700 at St Martins, 784 at St Philip's, 600 at St Paul's, 100 at St Mary's; for Nonconformists,1240 Independents attended Carr's Lane; 320 Unitarians the New and 202 the Old Meeting; 950 at the Saviour's church; 272 the Friends' Meeting House, and 1433 at St Chad's (R.C.). In Coventry, Anglican attendances were -- St Michaels 750, Holy Trinity 493; for Nonconformists, Independents 46, Calvinists 1028, Baptists 334, Friends 321. In Stratford, 800 attended the parish church, and the chapels; Baptist 100, Independents 126, and Wesleyans 50; Geary (ed), *1851 Census of Religious Worship;* entries for Birmingham, pp. 107, 110-111, 116-117, 120-21; Coventry, pp. 193, 195-98; Stratford, pp. 262, 264.

[174] Loudon, 'Origins and Growth' pp 330-1; Boyd Hilton, The Age of Atonement: The Influence of Evangelicalism on Social and Economic Thought, 1785-1865 (Oxford: Clarendon, 1988) pp. 6-7, 100-01; Pickstone, Medicine and Industrial Society, pp.16-17; Robert Kilpatrick, 'Living in the Light': Dispensaries, Philanthropy, and Medical Reform in late Eighteenth-century London', in Andrew Cunningham, and Roger French, (eds)., *The Medical Enlightenment of the Eighteenth Century*, (Cambridge: Cambridge University Press, 1999), 254-80.

[175] Such practitioners wrote articles or reports on public health and social conditions, explored in ch.2; see Ian Cawood and Chris Upton, '"Divine Providence': Birmingham and the Cholera Pandemic of 1832', *Journal of Urban History* 39 (2013), 1106-24, esp. pp.113-14; Hilton, *Age of Atonement*, p.7.

The two dispensaries in Coventry show evidence of divergent religious influences. The governors of the (purely charitable) General Dispensary were evidently predominantly wealthy and probably also Anglican. [176] The rival 'self-supporting dispensary' had a governing committee covering a broader social range, and which included both Anglicans and Dissenters. The institution espoused a strong philosophy of self-help, an attitude typically associated with evangelical attitudes to philanthropy, even if some committee members were of a different religious persuasion.[177]

Local and Regional politics: Reform, Radicalism, and Reaction

It would be tempting to regard dispensaries as being responses to troubled times, but only in a few cases is there clear evidence that this is so. In the unsettled conditions in Birmingham during the early 1790s, the founders of the General Dispensary could be seen as intending to dispense the 'social balm' of medical charity.[178] Then in Coventry in 1831 at the height of reform agitation, two new dispensaries were established, but one of these had been two years in the making, while the second institution can be seen as being a reaction to the first. They should be understood, therefore, as responses to a general climate rather than to the specific events of 1831.

Politics in Warwickshire towns were from the first phase of dispensary foundation (c.1790) occasionally of national significance. That applied to the period (1820s-1830s) when various new dispensaries came into being, although the linkages are often unclear between politics and medical charities. Politics as the exercise of power (rather than electoral or party differences), was often expressed through traditional philanthropy. In the case-study towns these include the long-established grammar schools and alms-houses, under either

[176] The 114 subscribers included four Anglican clergymen and eleven members of the aristocracy and gentry, 'Subscriptions to Coventry General Dispensary', *Coventry Herald*, 8 July 1831.

[177] For instance, this group's leader, the Reverend Walter Hook, was a High Churchman; Hilton, *The Age of Atonement*, pp. 101-04.

178 Porter, *Bodies Politic,* 'social balm', p.25; Money seems to imply a calming intention for the dispensary foundation. Money, *Experience and Identity*, p. 266.

corporation or ecclesiastical control. In Birmingham, the King Edward VI Foundation was the town's wealthiest charity, and in the 1830s and 1840s was dominated by an Anglican-Tory establishment from the town and the vicinity. This was the argument of Dennis Smith, who also identified a similar group (or in some views a 'clique') which had a strong presence on the boards of some medical charities, notably the General Hospital (but also at the Medical School and Queen's Hospital in the 1840s, to be discussed in Ch.2 and Ch.6).[179]

During the 1830s and 1840s political campaigns in the Midlands that had a national impact included the Birmingham Political Union (BPU) and its movement for political and currency reform. This claimed a wide social base, as a 'union of the classes.'[180] Other towns, such as Leamington, Stratford, and Warwick, also formed unions, generally affiliated to Birmingham. In the elections of 1831 and 1832 radicals and reformist Whigs won all the parliamentary seats in Coventry and Warwickshire.[181] Following the 1832 Reform Act, many supporters of the earlier Birmingham Union instead pressed for the town's incorporation, achieved in 1838, when still dissatisfied Birmingham radicals became active in the Chartist movement.[182] After some orderly mass meetings, a riot in the Birmingham Bull Ring in July 1839, together with unrest elsewhere, alienated middle-class and moderate opinion.[183]

Coventry had its own Political Union founded in 1830, which later became a Chartist campaign attracting support from silk workers, other radicals, and some sympathetic manufacturers.[184] From 1848 support for the Coventry Union declined, local energies being deflected into provident and other mutual

179 Dennis Smith, *Conflict and Compromise: Class Formation in English Society 1830-1914* (London: Routledge & Kegan Paul, 1982), pp. 92-3 (school), pp. 144-6 (hospital)
180 Asa Briggs, 'IV. Thomas Attwood and the Economic Background of the Birmingham Political Union', *Cambridge Historical Journal,* 9 (1948), 190-216, pp. 192-3, 212
181Margaret Escott, 'Constituencies: Warwickshire 1820-32', in D.R. Fisher (ed), *The History of Parliament: The House of Commons 1820-1832*, 2009 https://www.historyofparliamentonline.org/volume/1820-1832/constituencies/warwickshire, last accessed 8 October 2020.
182 Hilton, A Mad, Bad, and Dangerous People? pp. 617-9.
183 Behagg, *Politics and Production*, pp. 202-20.
184 Nancy Lopatin-Lummis, 'Popular Politics in the Midlands: The Coventry Political Union and the Great Reform Act', *Midland History*, 20 (1995), 103-18.

institutions.[185] In Warwickshire more widely, electors in 1831 and 1832 returned to parliament those who supported the Whig government's reform programme. Following the reforming period of the early and mid-1830s the Tories regained local parliamentary seats. Thus, by the end of the decade, traditional landowning elites seemed to be back in political control of the more rural areas [186] Thus in the 1820s and 30s, when new groupings were challenging a traditional Tory establishment, they had successes in in the larger towns, but not lastingly in the countryside. Some of the figures active in parliamentary reform campaigns were also prominent supporters of dispensaries, especially of the self-supporting type, an aspect to be explored more closely in local case studies (especially Ch.2 and Ch.5).[187]

Some supporters of dispensaries (and other charities) were interested in both local and wider affairs. Charles Bray was active in Coventry during the middle third of the nineteenth century. While never holding office, he was the long-standing Liberal editor-proprietor of the *Coventry Herald.* As an author and philosopher, he became an important mentor for Mary Anne Evans (George Eliot) in the 1840s. Bray drew ideas on social reform from a wide range of reformist and radical thinkers, many visiting him and his wife Cara in Coventry. His influences ranged from Robert Owen, the cooperative pioneer and utopian socialist, to Herbert Spencer, the populariser of Darwin (and originator of 'social Darwinism') and to George Combe, the phrenologist. He became known as a paternalist silk manufacturer and a leading supporter of the Provident

185 Peter Searby, 'Chartists and Freemen in Coventry, 1838-1860', *Social History*, 2 (1977), 761-84.

186 Fogg, N., '"Tracts and Bills Galore"': Political Processes in Victorian Stratford-on-Avon', in Robert Bearman, ed, *The History of an English Borough: Stratford-upon-Avon*, 1196-1996 (Stroud: Sutton/Shakespeare Birthplace Trust, 1997), 139-59; pp. 141-43.

[187] For instance, two dispensary governors, Sir Gray Skipwith, Bart, at the Southam and Stratford Dispensaries (and who was president of both institutions), and John Tomes at Southam and Warwick, were MPs during the 1830s for Warwickshire and Warwick Borough respectively.

Dispensary, for which he acted as honorary secretary 1837-c.1840.[188] However, he probably needs to be regarded as more significant as a cultural rather than political figure.

Chamberlain and his influence in Birmingham

In Birmingham politics, the borough council in the 1850s came to be dominated by a group of 'economisers', mainly tradesmen and small manufacturers. Their parsimonious policies first affected poor law support, later slowing sanitary improvement and other areas of policy. Few have found much to admire in the group that Hunt has described as a 'reactionary shopocracy'.[189] By contrast, the politics of later nineteenth-century Birmingham are often linked with the striking figure of Joseph Chamberlain, who with relatives and other allies introduced a distinctive brand of Liberal politics; his associates were active in medical charities, as will be explained.

Following an upbringing in prosperous London Unitarian circumstances, Chamberlain started work in 1854 in the family-owned screw manufacturing concern recently established in Birmingham. Over the next fifteen years this company, Nettlefold & Chamberlain, exploited new technology and canny financing to become dominant not only in Birmingham but in several international markets.[190] Chamberlain's cousin, Joseph Nettlefold, son of the

[188] The *Coventry Herald*, founded in 1808, was edited by Bray 1846-67; Stephens, *VCH Warwickshire*. 8, pp. 223-4 (editorship and provident dispensary); Matthew Lee, 'Bray, Charles (1811–1884), freethinker and social reformer.' *Oxford Dictionary of National Biography.*23 Sep. 2004, last accessed 14 Sep. 2021. https://0-wwwoxforddnb.com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-3292

[189] Tristram Hunt, *Building Jerusalem: The Rise and Fall of the Victorian City*, (London: Weidenfeld & Nicholson, 2004), See pp. 31, 36, 322; Briggs, *Victorian Cities*, pp. 206-13.

[190] Peter T. Marsh 'Chamberlain, Joseph [Joe] (1836–1914), industrialist and politician.' *Oxford Dictionary of National Biography*, 23 Sep. 2004; Accessed 14 Sep. 2021,https://0-www.oxforddnb.com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-32350.

founder, drew on his engineering training in supervising production in a large purpose-built factory just over the boundary in Smethwick.[191]

Influences on Chamberlain and his circle included local preachers. Well-to-do Unitarians (such as the Kenricks, Martineaus and Nettlefolds) attended the non-denominational Church of the Saviour. Many, including Chamberlain, were deeply affected by the brilliant oratory of the minister there, George Dawson. Dawson urged the modern city and its leaders to adopt a higher purpose, in other words, to work towards the good life for all citizens. Richard Dale was another charismatic preacher who influenced the Birmingham Unitarians, inspiring ambitious programmes of social improvement.[192] This 'civic gospel' could not be more different from the economisers' philosophy; it heralded a new, more expansive Liberalism, with a greater role for national and local government.[193] They perceived that beyond the palliative work of charities, local government had the potential to achieve more radical change. The Chamberlain faction therefore campaigned in elections to the new school boards in 1867 and later to the borough council. Its candidates won the votes of newly enfranchised workingmen, partly through the support of J.T. Bunce, the editor of the *Birmingham Post*.[194] Over several years, Chamberlain led the newly energised Liberal group on the council in instituting a school building programme and grand designs for slum clearance and redevelopment. Chamberlain's bold moves included convincing the council to mount a takeover

[191] In early years the elder Joseph Chamberlain also worked in the firm with his brother-in-law, son, and nephew; see *Peter Marsh, Joseph Chamberlain: Entrepreneur in Politics* (New Haven & London: Yale University Press, 1994), pp.10-17, 21-23; also Peter T. Marsh, 'Chamberlain, Joseph [Joe] (1836–1914), industrialist and politician.' Oxford Dictionary of National Biography. 23 Sep. 2004; last accessed 12 July 2021. https://0-www-oxforddnb.com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-32350

[192] Briggs, *Victorian Cities,* pp. 230-36; Hunt, *Building Jerusalem*, pp. 240-49; Marsh, *Joseph Chamberlain*, pp. 31-41.

[193] Hunt, *Building Jerusalem*, pp. 326-8.

[194] Hunt, *Building Jerusalem*, pp. 332-4; many had gained the vote through the Representation of the People ('Second Great Reform') Act of 1867 and the Municipal Franchise Act of 1869.

of local utility companies, whose profits ('gas and water socialism') were to be applied to the great task of improving the urban fabric.

Joseph Chamberlain, admittedly a compelling figure, continues to receive much more attention than his relatives and political allies. His leading supporters were his brothers and the Kenrick and the Martineau families, all of them closely connected, often by marriage.[195] Seed has described the typically close networks that Unitarians formed through kinship, intermarriage, and business partnership.[196] The ambitious municipal policies were pursued alongside the traditional philanthropy that Dissenters understood as a Christian duty. Birmingham Unitarians had an established pattern of supporting medical charities, notably the General Dispensary. Significant figures during *c*.1860-80 include Joseph Nettlefold, who became chairman; Joseph Chamberlain as a dispensary subscriber; and his younger brother Richard Chamberlain (1840-1899, committee member in the 1870s and president (when mayor) in 1880).[197] Arthur Chamberlain, the middle brother, was closely involved with the Women's Hospital from its foundation in 1871.[198]

Chamberlain's early political activity was in campaigns for universal basic education through the nonconformist-led National Education League. In 1869 he and like-minded modernisers were voted on to the Town Council, a body

[195] Lesley Rosenthal, 'Joseph Chamberlain and the Birmingham Town Council, 1865-80', *Midland History*, 41, 1 (2016), 71-95, pp. 74, 78

[196] John Seed, 'Theologies of Power: Unitarianism and the Social Relations of Religious Discourse, 1800–50', in R. J Morris(ed) *Class, Power and Social Structure in Nineteenth-century British Towns* (Leicester: Leicester University Press, 1986), pp. 130-31.

[197] Joseph Nettlefold (1827-81) was chairman of the dispensary 1868-81; Richard Chamberlain (1840-1899) was a committee member in the 1870s and president (when mayor) in 1880. In 1885 he followed his brother into Parliament as a Liberal, later also becoming a Liberal Unionist.

[198] Arthur and Richard Chamberlain, Joseph's younger brothers, had joined the brass-founding firm of Smith and Chamberlain. Arthur Chamberlain (1842-1913) was a major supporter of the Women's Hospital from its beginnings in 1871; see Judith Lockhart, 'Women, health and hospitals in Birmingham: the Birmingham and Midland Hospital for Women, 1871-1948' (Unpublished PhD Thesis, Warwick, 2008), pp 84-85.

that he led as mayor during 1873-76.[199] Mortality rates from disease in the overcrowded central localities had remained stubbornly high. Accordingly, the 'Birmingham Improvement Scheme', launched in 1875, aimed (as Glasgow had done previously) to clear the worst central slums and to replace them with modern shops and houses. In Corporation Street, Birmingham gained an impressive central boulevard, but the great cost of the scheme strained the borough's resources, and improvements in working-class housing were much slower to be realised.[200] Indeed the poorest inhabitants were not rehoused so much as decanted to a different set of crowded dwellings in nearby locations.

Late in the nineteenth century, imposing public buildings expressed the new civic pride; in the 1870s and 80s the Council House and an adjoining Museum and Art Gallery were erected close to the Town Hall that was built in 1840.[201] The new medical institutions can be seen in a similar light, as embodying a Victorian confidence and a zeal for improvement in aspects of the social fabric.

Conclusions

This Chapter presents an overview of various developments in the case study towns studied in this thesis, while later Chapters will concentrate on the functioning of the dispensaries themselves. The contexts explored reveal the expected contrasts between places, but also some surprising points of similarity. At the start of the nineteenth century Birmingham was larger and more vigorous economically than Coventry, such differences, if anything, increasing over the decades. Birmingham gained strength from its very varied industrial trades, while Coventry was limited by its marked industrial specialisation until its late-century diversification. The early economic

[199] In 1876 Joseph Chamberlain was elected as a member of Parliament for Birmingham. While retaining a home in Birmingham and maintaining an interest in civic affairs, his attention came to be much more focused on national politics.
[200] Glasgow's improvement plan received parliamentary approval in 1866, having been inspired, like Birmingham, by Baron Haussman's changes in Paris; Hunt, *Building Jerusalem,* pp. 337-49.
[201] Hunt, *Building Jerusalem*, pp. 357-9.

relationships, with their complex patterns of subcontracting (in Birmingham particularly) were shifting around mid-century towards local economies increasingly dominated by large factories. The local culture in both large towns gained a particular flavour from the predominance of artisans, although Birmingham, especially, developed a prosperous and politically active middle class. The ordinary inhabitants of both Birmingham and Coventry shared similar associative worlds, revolving round pub or chapel and benefit clubs. Both large towns had numerous and active friendly societies, in Coventry closely linked with the leading dispensary, in contrast with Birmingham (where the many small masters may have encouraged a more individualistic climate). Towns of varying size developed voluntary societies devoted to medical and other charities and to scientific and cultural matters (so including Stratford and possibly Southam). Birmingham played a central role in the eighteenth-century English Enlightenment, but this faded somewhat in the nineteenth century The early dispensaries tended to be straightforward medical charities resembling voluntary hospitals. In the second quarter of the nineteenth century, different places in Warwickshire acted as a test bed for the new hybrid type of institution, first established in Southam, with its blend of charitable and mutual elements.

As regards the towns themselves, all (except the smallest) developed increasingly dense poor areas. Their crowded housing, insufficient clean water, and deficient sewerage created the diseases that became the task of the dispensaries. This was so even in little Stratford where the unhealthy conditions were on a smaller and localised scale. Local government in different places had the daunting task of formulating responses, sanitary and otherwise, to these massive urban challenges. Dispensary medical practitioners played a major part in facilitating such policies, not least by documenting living conditions (and to some extent, work environments), together with the adverse effects that both had on health. Their detailed reports, together with those of Poor Law practitioners, informed not only local responses but also national policies, for instance through Chadwick's sanitary commission of 1842. In one town

(Stratford-on-Avon), medical men were accustomed to serve on the old close corporation. Some sought election to the reformed (post-1835) town council; having been elected, they collaborated with others to implement changes in water supply and sewerage. Such municipal activism was, however, uncommon among medical men more generally.

This introductory chapter has identified some important features of Warwickshire towns in the nineteenth century. Including the pre-history from c. 1790, nearly a century is covered, in which England evolved from a country connected by stagecoaches, with most people working on the land, to the era of railways, steamships and the telegraph. For the poorest during this period, life had not become much easier or more comfortable, but there were some clear advances. Young people had a greater prospect of surviving until old age, working hours in industry had reduced, and some working men possessed the vote. The shape of social institutions was beginning to resemble those in the present day; in particular, medical care that was accessible and safe was coming to be seen as an everyday expectation. Later chapters will explore the part that dispensaries played in this developing landscape of health and welfare.

Chapter 2

Caring for the Urban Poor: The Dispensaries in Birmingham and Coventry until c.1860

> It is probable that a greater mass of beneficial effect is produced by this [the Birmingham General] Dispensary, in proportion to its means, than by any other institution whose object is the relief of human suffering from sickness.[1]
>
> The [Coventry Provident Dispensary] scheme had been eminently successful, for it had provided medical care of the very best kind for the working man.[2]

Introduction

The first Chapter addressed the history of Warwickshire, and especially of its towns, from the late eighteenth century onwards. As Birmingham and Coventry became increasingly industrialised, their population expanded, and they developed progressively more crowded central districts. Their poorer inhabitants experienced much ill health, which prompted action from wealthier citizens, including the formation of medical charities, which will be explored in this Chapter. Such measures extended provision for the 'sick poor' beyond the Poor Law system, initially (in many places) through the founding of voluntary hospitals.[3] These were followed by the dispensaries, serving outpatients and those confined to home through illness.[4] These form the focus of the Chapter,

[1] William Hawkes Smith, *The Picture of Birmingham* (2nd ed, London: Longman, 1837) p. 86.
[2] A B Herbert, Mayor of Coventry; 'Report of meeting regarding the Provident Dispensary', *Coventry Herald,* 29 October 1858.
[3] In 1800, the only voluntary hospital in Warwickshire was the General Hospital in Birmingham.
[4] Irvine S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine,* 55 (1981), 322-42.

and indeed of the thesis as a whole, starting with their late eighteenth-century origins, first in London, and then in provincial towns.[5] As discussed in Chapter 1, Birmingham and Coventry were both growing industrial towns but differed in size, economic base, and civic governance. Their medical charities also followed distinctive paths, but each town shared the pattern of a large and enduring dispensary alongside others that were smaller and shorter-lived. The principal themes of the chapter will include the context of dispensary foundation, their place within local society, and their relationship to the evolution of medical thinking and practice. This will require exploring locally prevalent diseases, the treatments dispensaries offered and the wider roles of the institutions and their personnel. This chapter aims to demonstrate the significance of dispensaries in these local societies and urban medical economies.

The founders of dispensaries and other medical charities were undoubtedly moved by the plight of the sick poor, especially in times of increased distress. Their philanthropic impulses have been linked with Enlightenment humanitarianism and often also to Evangelical beliefs.[6] However, beyond such general ideas, their motivations seem likely to be complex. Local communities may have gained indirect benefits from philanthropic collaborations, including enhanced social cohesion, what Porter has termed 'social balm'.[7] However the historians of the eighteenth century, Roy Porter and Adrian Wilson, have shown that efforts to establish infirmaries did not always calm and unite groups divided by politics, religion, or other

[5] By 1800 sixteen dispensaries existed in London and twenty-two in the provinces; Loudon, 'Origins and Growth', pp. 324-26.
[6] Loudon, 'Origins and Growth', pp 330-1; Boyd Hilton, *The Age of Atonement: The Influence of Evangelicalism on Social and Economic Thought, 1785-1865* (Oxford: Clarendon, 1988) pp. 6-7, 100-01.
[7] For the relationship between social conditions and new (or reoriented) medical charities, see John V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and Its Region, 1752-1946* (Manchester: Manchester University Press, 1985), pp.17-18; for 'social balm' see Roy Porter, *Bodies Politic: Disease, Death and Doctors in Britain 1650-1900* (London: Reaktion, 1995), p. 25.

factors.[8] In some places, any tendency to social harmony was countered by plans that advanced sectional concerns and interests. For instance, in the early 1790s, radical dissenting physicians and their lay allies promoted new services at Manchester Infirmary, whereby the hospital developed a home visiting service, a feature much more typical of dispensaries (and which survived many years).[9] As already discussed, in London in the 1770s and 1780s, several dispensaries became part of the patronage networks of wealthy noblemen seeking to increase their political influence.[10]

Thereafter, during the great political tension of the 1790s, the association of dispensaries in the capital with Dissenters and their service of the poor may have made them seem politically risky, with only two new metropolitan dispensaries starting during the decade. Provincial towns differed, ten of them establishing such institutions during the period.[11] The difference between the capital and the provinces may lie, in part, in the responses of regional elites to widespread hardship among working people, arising from the experience in the decade of wartime economic dislocation, poor harvests, and costly staple food items. Comments on Birmingham by Sir Frederick Eden provide some supporting evidence. He noted in 1796 that the number of poor people receiving outdoor relief had doubled since 1790, attributed by him to

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[8] Similar considerations would seem to apply to both dispensaries and infirmaries: Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in Lindsay Granshaw and Roy Porter, eds., *The Hospital in History,* (London: Routledge, 1990), 149-78; Adrian Wilson, 'Conflict, Consensus, and Charity: Politics and the Provincial Voluntary Hospitals in the Eighteenth Century', *English Historical Review* 111 (1996), 599-619.

[9] J.V. Pickstone, and S.V.F. Butler, 'The Politics of Medicine in Manchester, 1788–1792: Hospital Reform and Public Health Services in the Early Industrial City', *Medical History,* 28 (1984), 227–49.

10 Bronwyn Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', Medical History 41 (1997), 127 - 49.

[11] Donna T. Andrew, *Philanthropy and Police: London Charity in the Eighteenth Century* (Princeton, NJ: Princeton University Press, 1989) p.325; Susan C. Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge: Cambridge University Press, 1996), pp. 41-2; Loudon, 'Origins and Growth', pp. 324-25.

the fact that 'the trade of this toy-shop of Europe…has suffered considerably during the war.'[12]

Themes of Chapter

There are five main themes explored in this chapter. Firstly, the circumstances leading to the setting up of dispensaries are considered, together with the sources and nature of their support. How far did their inception and growth reflect the concerns and interests of local elites, middling groups, or the working classes who were the intended beneficiaries? 'Support' embraced financial contributions, and for some, the time and energies involved in membership of a managing committee. Secondly, the chapter will address the day-to-day functioning of dispensaries, including regulations, daily routines, and the individual roles of their officers. Thirdly, the chapter explores the medical aspects of dispensary work, including the diseases identified by the medical staff, the treatments provided, and how these evolved over time. The fourth theme extends consideration to wider roles, of the dispensaries and of individual staff members. These include contributions to research and medical education, various initiatives in local public health, and the significance of dispensary service in medical careers. Finally, the experiences of dispensary users, the patients, will receive attention, albeit limited by the lack of direct evidence in original documents.

The available sources are patchy overall but differ in the two towns. In Birmingham, the general dispensary was a significant urban institution and a major teaching site in the early days of the local medical school (in the 1830s). Perhaps as a result, local archives, both civic and academic, hold many of its primary documents, offering possibilities for 'triangulation' with medical and general periodicals.[13] This contrasts with the situation in Coventry, where hardly

[12] The figures for out-poor were 2292 in 1790 and 4660 in 1796; Sir Frederick Morton Eden, *The State of the Poor, or the History of the Labouring Classes in England*, 1 (London: B & J. White, 1797), p. 737 for statistics, p. 739 for quotation.

[13] They are now divided between the Wolfson Archives at the Library of Birmingham (Birmingham Archives and Heritage – BAH) and Birmingham University's Special Collections (BUSC), housed in the Cadbury Research Library on the university campus.

any of the original dispensary documents survive. The Coventry Provident Dispensary formed a major element of the local welfare economy from 1831, but its gestation and birth were bitterly contested. Late in the century almost all local medical practitioners again opposed the provident dispensary, and such tensions may have contributed to the lack of surviving records in local archives. However, its growth and apparent success in early decades (1831 -- c.1860) resulted in local press articles and analysis by various commentators. Some scholars point to the limitations of annual reports and newspaper articles based on such reports, with their optimistic rhetoric of benevolence and public benefit. Reinarz, for instance, commends minutes and registers for their glimpses of debates, dissension, and practices varying from official policy. However, common experience suggests that minutes can also be cryptic or disingenuous, and therefore require careful interpretation.[14] Indeed, almost all sources reproduce the carefully crafted accounts of those who founded or supported dispensaries, both lay and medical. Their limitations include the absence of a view 'from below', with only rare glimpses of the institutions' working-class users and especially of their voices.

The first Midlands dispensary: early medical charity in Coventry

Late eighteenth-century Coventry suffered from an old-fashioned and insalubrious physical fabric (described in Ch.1), with many inhabitants suffering poverty and poor living conditions. The journeymen silk weavers were said in 1775 to be 'wretchedly poor', and in the 1780s a deep slump was causing hardship for Coventry weaving families.[15] Despite such conditions the city lacked medical provision for the working poor.[16] It thus lagged the other

[14] Jonathan Reinarz, 'Investigating the 'Deserving' Poor: Charity and the Voluntary Hospitals in Nineteenth-Century Birmingham'. In Ann Borsay and Peter Shapely ((eds)), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, C.1550–1950* (Aldershot: Ashgate, 2007),.111-134, pp.111-12.

[15] W.B. Stephens, 'The City of Coventry: Social History from 1700', in *Victoria History of the County of Warwick* (London: OUP, for Institute of Historical Research, 1969), 222-31; p.222. The quote is from the diary of John Whittingham; Ruth Barbour, 'John Whittingham: Coventry Nurseryman, Diarist, Catholic Apologist and Political Activist', *Warwickshire History*, XVI (2014), 8 - 25.

[16] Eden, 'Coventry', in *The State of the Poor*, p. 44.

Midland towns that had gained voluntary hospitals, including Northampton in 1743, Worcester in 1746, and Birmingham in 1779.[17]

In 1789 four medical practitioners announced a new 'public dispensary' intended to help meet this deficiency (fig 5). This was to operate from a house in the central Bayley Lane, suitably equipped, and possessing stocks of the 'most genuine chemical and Galenical medicines…from the first druggists of London' (figures 9 & 10 for location).[18] The city's wealthier inhabitants, who had evidently urged such a foundation, were now pressed for subscriptions to help fund the appreciable costs. The new institution was unusual in several ways. Significantly, the co-founders of dispensaries often included medical practitioners, but it was less common for them to take the lead, as in this case, and apparently not in concert with other leading citizens.

In York in 1788, the 'faculty' of all local medical men collaborated with other citizens in forming a dispensary.[19] In the Coventry case, by contrast, all the founding practitioners were partners in the four-man group practice (itself rare) established by the leading Coventry surgeon Bradford Wilmer. They had themselves covered the significant initial expenses otherwise funded through a public appeal.[20] This seems a fresh instance of the varied origin and funding of early dispensaries, ranging from the family charitable trust at Bamburgh Northumberland to John Wesley's religious congregations in Bristol and London.[21]

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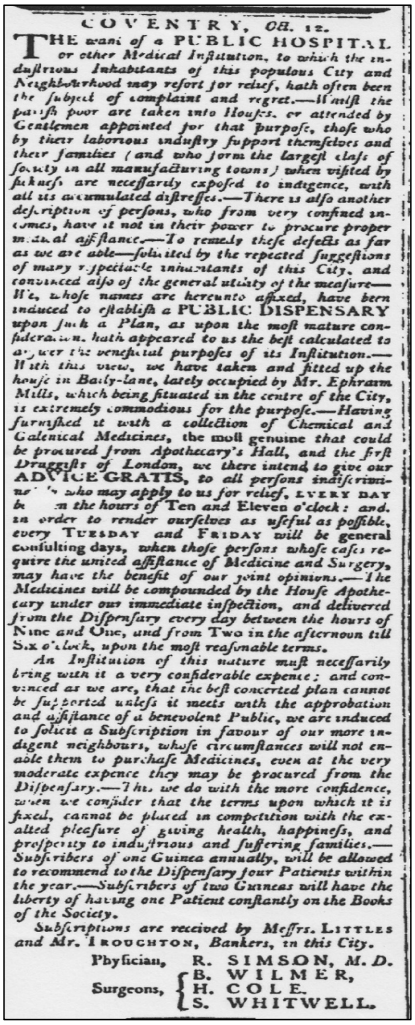
[17] Wilson, 'Conflict, Consensus and Charity', p. 602

[18] Advertisement, *Coventry Mercury*, 5 October 1789; 'Galenicals' were plant-based medicines.

[19] Katherine Webb, *'One of the Most Useful Charities in the City': The York Dispensary, 1788-1988* (York: University of York, 1988), pp.1-4.

[20] Joan Lane, 'Eighteenth-Century Medical Practice: A Case Study of Bradford Wilmer, Surgeon of Coventry, 1737–1813', *Social History of Medicine* 3 (1990), 369-86 pp. 370-2.

[21] Alun Withey, 'Medicine and Charity in Eighteenth-Century Northumberland: The Early Years of the Bamburgh Castle Dispensary and Surgery, C. 1772–1802', *Social History of Medicine,* 29 (2016), 467-89; Deborah Madden, 'Wesley as Adviser on Health and Healing', in Randy L. Maddox and Jason E. Vickers, eds., *The Cambridge Companion to John Wesley* (Cambridge: Cambridge University Press, 2010), pp. 176-89, pp. 179-80.



COVENTRY, *Oct.* 12.

THE want of a PUBLIC HOSPITAL or other Medical Inſtitution, to which the induſtrious Inhabitants of this populous City and Neighbourhood may reſort for relief, hath often been the ſubject of complaint and regret.—Whilſt the pariſh poor are taken into Houſes, or attended by Gentlemen appointed for that purpoſe, thoſe who by their laborious induſtry ſupport themſelves and their families (and who form the largeſt claſs of ſociety in all manufacturing towns) when viſited by ſickneſs are neceſſarily expoſed to indigence, with all its accumulated diſtreſſes.—There is alſo another deſcription of perſons, who from very confined incomes, have it not in their power to procure proper medical aſſiſtance.—To remedy theſe defects as far as we are able—ſolicited by the repeated ſuggeſtions of many reſpectable inhabitants of this City, and convinced alſo of the general utility of the meaſure—We, whoſe names are hereunto affixed, have been induced to eſtabliſh a PUBLIC DISPENSARY upon ſuch a Plan, as upon the moſt mature conſideration, hath appeared to us the beſt calculated to anſwer the beneficial purpoſes of its Inſtitution.—With this view, we have taken and fitted up the houſe in Baily-lane, lately occupied by Mr. Ephraim Mills, which being ſituated in the centre of the City, is extremely commodious for the purpoſe.—Having furniſhed it with a collection of Chemical and Galenical Medicines, the moſt genuine that could be procured from Apothecary's Hall, and the firſt Druggiſts of London, we there intend to give our ADVICE GRATIS, to all perſons indiſcriminately who may apply to us for relief, EVERY DAY between the hours of Ten and Eleven o'clock: and, in order to render ourſelves as uſeful as poſſible, every TUESDAY and FRIDAY will be general conſulting days, when thoſe perſons whoſe caſes require the united aſſiſtance of Medicine and Surgery, may have the benefit of our joint opinions.—The Medicines will be compounded by the Houſe Apothecary under our immediate inſpection, and delivered from the Diſpenſary every day between the hours of Nine and One, and from Two in the afternoon till Six o'clock, upon the moſt reaſonable terms.

An Inſtitution of this nature muſt neceſſarily bring with it a very conſiderable expence; and convinced as we are, that the beſt concerted plan cannot be ſupported unleſs it meets with the approbation and aſſiſtance of a benevolent Public, we are induced to ſolicit a Subſcription in favour of our more indigent neighbours, whoſe circumſtances will not enable them to purchaſe Medicines, even at the very moderate expence they may be procured from the Diſpenſary.—This we do with the more confidence, when we conſider that the terms upon which it is fixed, cannot be placed in competition with the exalted pleaſure of giving health, happineſs, and proſperity to induſtrious and ſuffering families.—Subſcribers of one Guinea annually, will be allowed to recommend to the Diſpenſary four Patients within the year.—Subſcribers of two Guineas will have the liberty of having one Patient conſtantly on the Books of the Society.

Subſcriptions are received by Meſſrs. LITTLES and Mr. TROUGHTON, Bankers, in this City.

Phyſician, R. SIMSON, *M. D.*

Surgeons, B. WILMER, H. COLE, S. WHITWELL.

Figure 5: Notice in *Coventry Mercury*, 5 October 1789 (Coventry City Archives)

Medical charity, however, was typically mobilised through voluntary societies, embedded as they were in local power structures, governed by leading citizens, and sometimes patronised by aristocrats.[22] These features, coupled with well-publicised annual meetings, generally helped to ensure

[22] Loudon, 'Origins and Growth', pp. 328-9; Morris, 'Voluntary Societies and British Urban Elites', pp. 101-3, 112-6.

recognition, longevity, and a continuing flow of donations and subscriptions. The medical founders in Coventry did have some connections to the civic elite, as the junior partner was the son of the mayor and was later mayor three times himself.[23] While this eighteenth-century dispensary was the city's original medical institution, it has left few historical traces. Its later progress is thus unclear; references in 1793 and 1799 indicate its survival for a decade but possibly not much longer.[24]

Wilson's study, referred to above, pointed to the difficulties of establishing medical charity in eighteenth-century Coventry, citing the abortive attempt in 1741 to establish a dispensary in the town 'during the epidemic fever then raging'. This, however, was an election year, and the accompanying dissension prevented success at that point, and indeed when a renewed attempt was made three years later.[25] Elections in Coventry were notoriously rancorous and unruly, and it may well be that such discord associated with the Coventry election of 1790 influenced the early dispensary's funding.

As regards the position of the medical dispensary founders, Michael Brown has located their counterparts in York within a context of a culture of 'medico-gentility', marked by 'politeness, sociability and civic engagement',

[23] John Whitwell (an auctioneer) was a second-term mayor, while his son Samuel was elected to the post in 1800, 1829 and 1830; see 'List of Mayors of Coventry', https://www.historiccoventry.co.uk/history/mayors.php#y1700 (last accessed 4/3/2021).

[24] The city council decided to subscribe to the dispensary to provide medical care to pupils of the grammar school (Bablake Hospital); Coventry Archives, Order Book BA/H/3/17/10, October 1793; Thomas Beddoes, *A Collection of Testimonies Respecting the Treatment of the Venereal Disease by Nitrous Acid* (London: J. Johnson, 1799), pp.129-30 (this included two case reports forwarded by Wilmer, one from the dispensary). Coventry's first dispensary was later said to have failed through the lack of charitable support; Rev J Sibree, letter to editor, *Coventry Herald,* 18 Dec 1829.

[25] Wilson, 'Conflict, Consensus and Charity', pp. 601, 605.

some of which may apply also to Coventry.[26] Joan Lane portrays Bradford Wilmer as an influential figure who developed a successful practice, corresponding widely and writing several textbooks. He and his colleagues probably shared the desire of the York worthies (and of practitioners in eighteenth-century Bath) to do good and to be seen to do so, gaining social capital by doing so. They resemble Bath's medical men, as Ann Borsay has suggested, in using their involvement in local medical charities to negotiate and advance their status. [27] From the fragmentary evidence, it does not appear that the first Coventry dispensary left any legacy after its apparently short existence.

[26] Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, C.1760 – 1850* (Manchester: Manchester University Press, 2011), pp.1-3; Elliott has shown how until 1850 literary and scientific societies flourished in the old county and cathedral towns (such as York and Worcester) rather than in industrial towns; Paul Elliott, 'Towards the Creation of a Geography of Scientific Culture: Provincial Identity and Literary and Philosophical Culture in the English County Town, 1750–1850', *Urban History,* 32 (2005), 391-412.

[27] Ann Borsay analysed the involvement of medical practitioners in Bath's medical charities, suggesting that they used this work to negotiate and advance their status; Anne Borsay, 'A Middle Class in the Making: The Negotiation of Power and Status at Bath's early Georgian General Infirmary, c. 1739–65', *Social History,* 24 (1999), 269-86.

The Birmingham General Dispensary 1793 -- 1860

In contrast to Coventry, the principal founders of Birmingham's first dispensary in the 1790s were wealthy businessmen, with medical professionals playing a supporting role. In 1792 a group of prominent inhabitants started to discuss a new institution for the 'sick poor' of the town. The discussions followed Birmingham's disastrous riots the previous July, when over three days large crowds attacked and largely destroyed Nonconformist chapels, as well as the homes of both prominent Dissenters and their associates.[28] The pseudonymous anti-Jacobin pamphleteer, 'Job Nott', praised the planned institution among others:

> 'And many other blessed charities there are…a Dispensary, as they call it, I see is a-going to be established.'[29]

Then in 1793, Matthew Boulton 'took it under his patronage'. As donations were slow in arriving, Boulton offered to act as treasurer, also making it known that he would underwrite any deficit in the institutional funds.[30] A public meeting in November elected a provisional committee that included Boulton, the ironmaster Samuel Garbett and the gunmaker Samuel Galton. They were soon joined by other prominent business figures, including the banker Sampson Lloyd and the silversmith Thomas Ryland.[31] The body thus embraced both moderate Tory Anglicans (Boulton and Garbett) and dissenting liberal Whigs; the Quakers, Galton and Lloyd, and the Unitarian Ryland. The founders may have hoped to foster harmony, in response to the discord evident in the riots

[28] There was a loyalist, 'church and king' element to the riots, so sectarian, social, and economic factors all appear to have played a part; see R.B. Rose, 'The Priestley Riots of 1791', *Past and Present* 18 (1960), 68-88.

[29] 'Job Nott', *Job Nott's Humble Advice, with a Suitable Postscript* (2nd ed, Birmingham, 1792) p.4; the author ventriloquised a working man's voice in these pamphlets, which were vehicles for anti-Jacobin propaganda; see John Money, *Experience and identity : Birmingham and the West Midlands, 1760-1800* (Manchester: Manchester University Press, 1977), p. 267.

[30] Charles Pye, *A Description of Modern Birmingham* (Birmingham: J. Lowe, 1820)

[31] Birmingham Archives & Heritage (BAH), Birmingham General Dispensary (BGD), General Meetings, MS 1759/1/1/1, 27 December 1793; 17 November 1794.

two years previously.[32] Matthew Boulton also knew the value of paternalism, as shown by his welfare schemes for his workforce, which included a sickness insurance scheme (organised as a friendly society) and the provision of housing and medical care for particularly valued artisans. Other industrialists probably offered similar (but less well documented) schemes.[33] Boulton guided the institution closely in its first decade, chairing most committee meetings until 1803 (while remaining, officially, treasurer; he left the committee in 1805).[34] The provisional committee is said to have included a Dr Milne, but medical men seem to have played a minor role in the creation of the dispensary; this corresponds with John Pickstone's view of their status vis-à-vis manufacturers in contemporary Manchester (as useful people, like engineers or factory managers, but of lower standing).[35]

The governors appointed a paid apothecary and honorary physicians and surgeons, who in early months treated patients 'in their own habitations'. The patronage of leading citizens seemed to encourage wider support, the dispensary acquiring 200 guineas in donations and subscriptions by November

[32] The alliance of Tory Anglicans with Whig or Radical Dissenters also echoed the links established by the Lunar Society in earlier decades. Roy Porter, *Disease, Medicine and Society in England, 1550-1860,* 2nd edn (Cambridge: Cambridge University Press, 1995), p.30; John Money implied a calming intention for the new foundation; Money, *Experience and Identity*, p. 266.

[33] Sue Tungate, 'Workers at the Soho Mint (1788 — 1809)', in Kenneth Quickenden, Malcolm Dick, and Sally Baggott (eds.), *Matthew Boulton: Enterprising Industrialist of the Enlightenment,* (London: Routledge, 2013), pp. 194-6; Eric Hopkins, *Birmingham: The First Manufacturing Town in the World 1760-1840* (London: Weidenfeld & Nicolson, 1989), pp. 194-97.

[34] By the time of his departure, he was afflicted with painful kidney stones; Jennifer Tann, 'Boulton, Matthew (1728–1809), manufacturer and entrepreneur', Oxford Dictionary of National Biography, 23 Sep. 2004; last accessed 24 Aug. 2021. https://0-wwwoxforddnbcom.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-29

[35] John V. Pickstone, 'The Professionalisation of Medicine in England and Europe: The State, the Market and Industrial Society', in Teizo Ogawa (ed), *History of the Professionalisation of Medicine: Proceedings of the 3rd International Symposium on the Comparative History of Medicine, East and West, Japan 1979* (Osaka, Japan: Taniguchi Foundation, 1987), p. 44.

1794.[36] In June 1794 the institution settled in rented premises in Temple Row, overlooking St Philip's Church (now the Cathedral; see figure 6, and for location fig. 8).[37] As a favourite location for medical and other professional men, this was convenient for honorary staff, if less so for patients. Numbers of patients increased, 252 being treated in 1794, 1250 in 1801, and 2926 in 1821 (see Table 5).

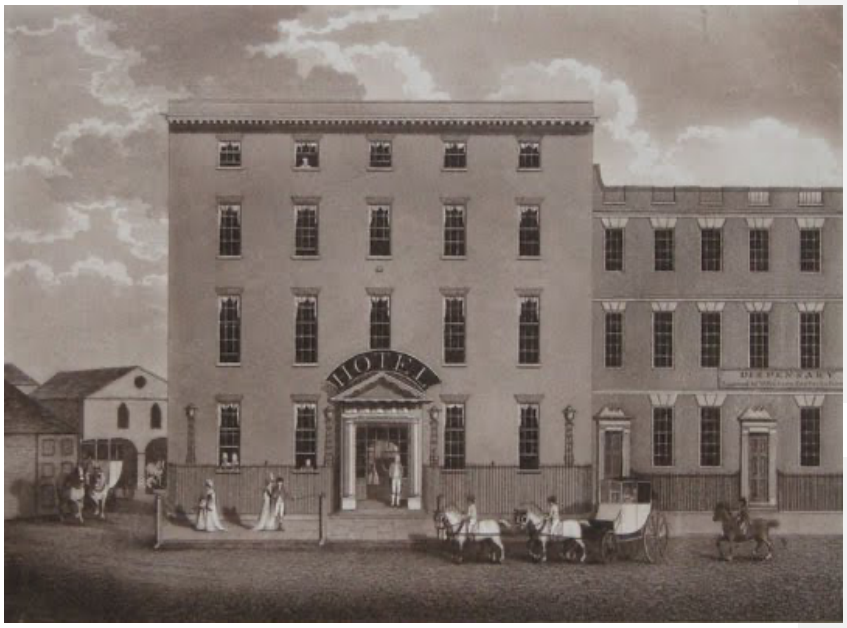


Figure 6: Temple Row, showing Royal Hotel and Dispensary, (at right; its sign can be seen above the door), c.1800 (*Mapping Birmingham:* http://mappingbirmingham.blogspot.co.uk/2012/10/the-dispensary-temple-row.html)

[36] For simplicity, those who supported the charity with regular payments will be referred to in this thesis as 'subscribers', and as 'governors' those who were elected to a committee that managed the institution.

[37] MS 1759/1/1/1, Annual General Meeting, 7 November 1794; Temple Row formed part of a neo-classical square, as discussed by Peter Borsay, *The English Urban Renaissance: Culture and Society in the Provincial Town 1660-1770* (Oxford: Clarendon, 1989), pp. 76-7.

These numbers represent not individuals but 'cases' or episodes of illness; Loudon suggests that each case probably resulted in three or four attendances, about one-third of them being home visits.[38] The total cases amount, in 1801 and 1821, respectively to 1.6 and 2.7 per cent of the borough population, a lower figure than in contemporary Northern towns.[39] Numbers attending increased in later years, but apparently only in proportion to the population, being 2.1 per cent in 1860 (see table 5).[40]

As activity increased, staffing and organisation altered, if sometimes rather sluggishly. Some tensions resulted from the institution's commitment to midwifery, a service that many dispensaries did not provide.[41] In this period, poor women could obtain assistance in childbirth from (some) dispensaries and from lying–in charities. By 1820 lying-in charities had been set up in Birmingham, Coventry, and several smaller Midlands towns.[42] In September 1795 the dispensary' s honorary surgeons complained that the time-consuming and unpredictable needs of midwifery patients were harming their private practice. The dispensary therefore employed midwives *ad hoc* from November 1795, and two months later appointed a 'skillful woman' [sic] as a full-time midwife.[43] In 1800, alongside a second (short-lived) visiting apothecary, the first

[38] Loudon, 'Origins and Growth', pp. 328-9.
[39] The proportion was about 10% in several towns, albeit all rather smaller than Birmingham (Chorley, Preston, Huddersfield, and Wakefield); Pickstone, *Medicine and Industrial Society,* pp. 70, 73-5; Hilary Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge: Cambridge University Press, 1987), pp. 103-5.
[40] In 1860, 4456 cases were dealt with; the borough population in 1861 was 212,621.
[41] A recent study has explored the dispensary's midwifery service, so this will not be addressed in detail here. See Frances Jane Badger, 'Delivering Maternity Care: Midwives and Midwifery in Birmingham and Its Environs, 1794-1881' (Unpublished PhD Thesis, University of Birmingham, 2014); while general hospitals usually excluded pregnant women, the policy of dispensaries evidently varied.
[42] Lying-in charities were founded in Coleshill in 1789, in Coventry in 1801 and 1810, in Warwick in 1812, and in Birmingham in 1813 and 1842; Badger, 'Delivering Maternity Care', pp. 111-13.
[43] BAH, MS 1759 1/2/1, BGD Committee Minutes, 7 September 1795; MS 1759 1/2/1, Committee Minutes, 11 November 1795, 4 January 1796.

dispenser (a 'druggist' or pharmacist) was appointed as 'Assistant Apothecary'.[44]

The dispensary was administered similarly to its counterparts elsewhere. At each annual meeting the subscribers heard reports on the year's activities and elected a new committee of governors. The latter met monthly, the honorary medical officers attending *ex officio* (while also meeting regularly in a separate medical committee). Special general meetings were also held, usually to appoint honorary staff. The apothecary (from the 1820s called the resident surgeon) performed much day-to-day administration, was secretary to the general and medical committees, and evidently treated most of the patients.[45] Subscribers to the institution, as elsewhere, had the useful privilege of recommending individuals for treatment but with important qualifications.[46] They were enjoined to enquire 'with minuteness' to ensure that patients were genuinely needy, and were reminded that treatment could not continue beyond six weeks without a fresh subscriber's letter 'to prevent the excessive expence [sic]…from … obstinate and incurable complaints.' Evidently a second letter might be provided but never more than this. [47]

The rules of voluntary hospitals (although actual practice might differ) commonly excluded chronic or incurable conditions as well as (actual or potentially) infectious cases.[48] Dispensaries were generally less restrictive, although the Westminster dispensary had a rule very similar to Birmingham's.[49]

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[44] The dispenser, a Mr Randle Thompson, served until the early 1830s; the additional visiting apothecary was only briefly in post. MS 1759 1/2/1 Committee Minutes, 23 April 1800.

[45] The administrative arrangements, including the regular meetings of both the managing committee and the medical committee, were common features of dispensaries; Loudon, 'Origins and Growth', pp. 328-30.

[46] Subscribers of one guinea were entitled to recommend five individuals for treatment, four sick patients and one for midwifery.

[47] These rulings were printed on the recommendation letters; BAH MS 1759 1/2/1, Rule 40; Committee Minutes, 19 November 1794.

[48] John Woodward, *To Do the Sick No Harm: A Study of the British Voluntary Hospital System to 1875* (London: Routledge & Kegan Paul, 1974), pp. 45-7.

[49] Loudon, 'Origins and Growth', pp. 334-6; Croxson quotes Dr John Millar of the Westminster Dispensary on similar restrictions there; Croxson, 'Eighteenth-Century London Dispensary Charity', p.133.

The injunctions to avoid expense can be seen as reflecting the businesslike attitudes of the founding governors; medical officers occasionally commented on the strictness of subscribers when approached for recommendations. In the annual report in 1829, they referred to the 'caution' of subscribers, and the 'extreme difficulty' that some would-be patients found in securing a recommendation. Late in the following decade, Dr Ogier Ward referred to the 'difficulty of procuring a ticket of admission' which in emergencies was 'often extremely injurious…if not fatal'.[50] The cautious, frugal attitudes of governors and subscribers will be discussed below, in a section below that addresses dispensary governance in the 1820s (after the move to new premises – see figure 7).

The dispensary gained most of its income from annual subscriptions, augmented by occasional donations and legacies. Like most voluntary organisations, the dispensary was officially a subscribers' democracy, but its regular business was conducted by a small oligarchy, the members of the managing committee. These governors, elected annually by subscribers, mostly comprised clergymen and more substantial merchants and manufacturers.[51] Some of these, and their allegiances, will be discussed further in the section exploring governance.

As activity and staffing slowly increased, the original premises came to seem inadequate, and consequently the governors in 1806 proposed a more convenient new building. A subsequent appeal was circulated to subscribers and neighbouring landowners, the cost being estimated at £1000 (although the eventual total was at least twice this amount).[52] The new premises opened in

[50] BUSC R944, Medical report, Birmingham General Dispensary annual report for 1828--29, pp. 6-8; J. Ogier Ward, 'Report of Medical Cases in the Birmingham Dispensary', *Transactions of the Provincial Medical and Surgical Association (Trans PMSA)* 6 (1838), 429-46, p. 405.
[51] R. J. Morris, 'Voluntary Societies and British Urban Elites, 1780–1850: An Analysis', *The Historical Journal* 26 (1983), 95–118, pp.101-2
[52] Hutton and Guest state the final cost as £3000. Wiiliam Hutton and James Guest, *The History of Birmingham: With Considerable Additions* (6th ed., Birmingham: James Guest, 1835 (orig. ed 1783)), p. 23.

1808 in Union Street, still centrally located but in a less commanding position than previously (figures 7 & 8).[53] The new building, designed by William Hollins was imposing, with a sculptural relief above the main entrance, portraying the healing deity Hygeia.

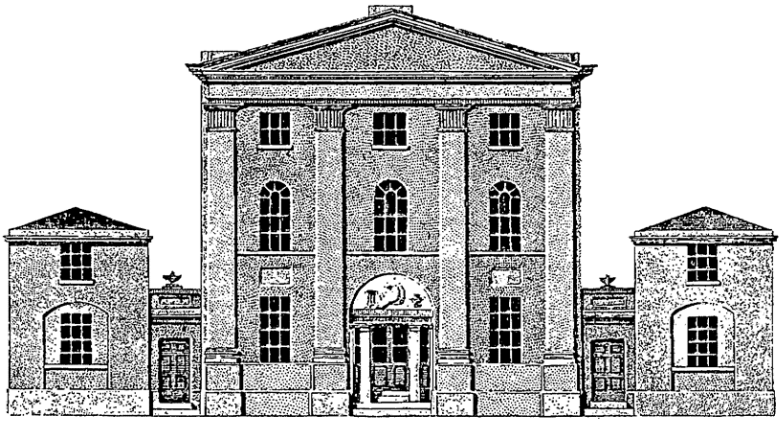

Figure 7: New Dispensary Building in Union Street, 1808, designed by William Hollins (Architect's drawing, BAH L46.4; also W. Stephens (ed), *Victoria History of the County of Warwick, 7: City of Birmingham* (London: VCH, 1964), p.43.

Its main block housed the waiting hall, consulting rooms and committee rooms, flanked by wings for the accommodation of the resident apothecaries and midwives. The honorary staff normally included three physicians and several (usually between five and seven) surgeons who attended the dispensary in rotation. The apothecary or house surgeon treated most patients attending each morning, passing appropriate cases to the honorary surgeons, and identifying the more seriously ill for the duty physician, many of the latter being seen at home. Each physician served two weekdays in rotation, also being responsible for a particular section of the town, while the surgeons' arrangements seem to have been more *ad hoc*.

[53]New Dispensary Building in Union Street 1808. See W. Stephens, ed., *Victoria History of the County of Warwick, 7: City of Birmingham* (London: Victoria County History, 1964), p.43.
MS 1759/1/1/1 BGD General Meetings, 7 November 1806, 11 November 1806.

From the 1820s, the richer sources include printed annual reports, whose lengthy subscribers' lists (when combined with local directories) suggest the varied background of the dispensary's supporters. The subscribers (Table 3) included a few substantial businessmen and other wealthy people, some professional men, but a much larger group of small and medium-sized manufacturers and tradesmen. The means of some subscribers may not, indeed, have been much greater than those of the charity's intended beneficiaries.[54] The table also suggests the growing significance of collective support by employers or by groups of workpeople (a theme explored further in Chapter 6).

Those select subscribers forming the ten committee members in 1824-25 included three clergymen: Edward Burn, an Evangelical Anglican; John Kentish, a long-serving Unitarian minister; and, rather surprisingly, the Roman Catholic cleric John Moore.[55] Four other members were prominent Unitarians: the glass merchant William Beale, the silversmith Thomas Ryland, the merchant Jeremiah Ridout, and the surgeon James Russell. Both Quakers and Unitarians were relatively small but important groups in Birmingham society (as discussed in Ch.1). The Unitarians tended to be professionals and substantial businessmen, as in other large towns, while the Quakers also included some

[54] Birmingham General Dispensary: Annual Reports*,* various years (BUSC, RA 988.B5); West's *Warwickshire Directory* 1830, Pigot's *National Directory*, 1835; in 1829-30 the first fifteen entries in the subscription list included the following: chemist & druggist, saddler, gunsmith, tailor, clothes dealer, awl maker, wire drawer, butcher, and chemical manufacturers.

[55] Burn will be discussed below; John Moore, apparently the only Catholic priest elected as a governor, served at St Chad's Church, later the cathedral, and in 1848-53 was head of the theological college at Oscott, north of Birmingham (I am indebted to Dr Ruth Barbour for this information); John Kentish (1768-1853) was a noted scholar, both wealthy and generous, and accordingly was widely respected; R K Webb, 'Kentish, John (1768–1853), Unitarian minister' *Oxford Dictionary of National Biography.* 23 Sep. 2004; last accessed 24 Aug. 2021. https://0-www-oxforddnb-com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-15427

important business families (such as Cadbury and Lloyd).[56] The governors included several Unitarians in this and subsequent decades. They tended to be members of prominent families, such as Beale, Clark, Russell, and Ryland, who typically became officials at the New Meeting House, then the leading Unitarian place of worship.[57] Sharing with other Dissenters a desire for practical philanthropy, they may have found its exercise more congenial at the General Dispensary rather than in the Tory-Anglican atmosphere of the contemporary General Hospital.[58] Morris argues that voluntary societies could assist in resolving ideological tensions, as between Evangelicalism and Utilitarianism (and Birmingham, perhaps also between different religious viewpoints).[59] Edward Burn, the (Evangelical Anglican) minister of St Mary's chapel, supported the dispensary from its early days. During the 1780s he had vociferously opposed Joseph Priestley's radical theological ideas but several decades later, was cooperating pragmatically with Dissenters.[60] Indeed, as observed by Davidoff and Hall, such collaboration became a feature of the 1820s, both in evangelising efforts among artisans and in campaigns for moderate political reform.[61]

Cawood and Upton suggested that religious motivations extended to the dispensary medical staff and probably influenced their activities. John Darwall

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[56] Emily Bushrod, 'The History of Unitarianism in Birmingham from the Late Eighteenth Century to 1893' (Unpublished MA Dissertation, University of Birmingham, 1954) pp.103-7; John Seed, 'Theologies of Power: Unitarianism and the Social Relations of Religious Discourse, 1800-50', in R. J. Morris, ed., *Class, Power, and Social Structure in British Nineteenth-Century Towns*, (Leicester: Leicester University Press, 1986), 107-56, pp.116-8.

[57] Bushrod, 'Unitarianism in Birmingham' p. 89.

[58] Dennis Smith, Conflict and Compromise: Class Formation in English Society 1830-1914 (Routledge & Kegan Paul, 1982) pp. 144-5.

[59] R. J. Morris, 'Voluntary Societies and British Urban Elites, 1780-1850: An Analysis.' *The Historical Journal*, 26, no. 1 (1983): 95-118, p.113

[60] Alexander Gordon and Philip Carter. 'Burn, Edward (1762–1837), Church of England clergyman and theological writer', *Oxford Dictionary of National Biography*. 23 Sep. 2004; last accessed 24 Aug. 2021. https://0-www-oxforddnb-com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-4040.

[61] Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class 1780-1850* (London: Routledge, 1992), pp. 81-4, 96-9.

and William Sands Cox, respectively physician and surgeon at the dispensary in this period, were staunch Anglicans influenced by evangelical ideas, while James Russell, Frederick Ryland, and Walter Lloyd were Dissenters.[62]

Table 4: Birmingham General Dispensary: characteristics of subscribers, 1829-70 (from annual reports):

Year	1829-30	1853
Total number (%)	620 (100)	595 (100)
Titled or MPs	8 (1.3)	8 (1.4)
Female	116 (18.7)	86 (14.5)
Clergy	22 (3.5)	21 (3.5)
Company	32 (5.2)	44(7.4)
Workpeople	1 (0.2)	4 (0.7)
Religious congregation	7 (1)	8 (1.4)
Club/ Benefit society	4 (0.6)	11 (1.8)
Charity	3 (0.4)	4 (0.7)
Source: Birmingham General Dispensary annual reports for 1829-30, 1853, (BUSC R944)		

Certain policies of the dispensary very much fit with the 'ideals of economy, frugality…and financial rectitude', that Hilton linked with evangelical beliefs.[63] These include the reluctance to appoint a second house surgeon (discussed below), and the parsimony of subscribers in providing

[62] Most of those cited wrote articles or reports on public health and social conditions, explored later in the Chapter. Russell and Ryland were Unitarians, while Lloyd was a Quaker from the banking family; Cawood and Chris Upton, '"Divine Providence': Birmingham and the Cholera Pandemic of 1832', *Journal of Urban History,* 39 (2013), 1106-24, pp.113-14.

[63] Hilton, *Age of Atonement*, p.7.

recommendations, especially for periods of treatment longer than a few weeks. Most contemporary medical charities offered roles for the aristocracy and landed gentry, as patrons, presidents, or vice-presidents, but in its first decade, the Birmingham dispensary had no such positions.[64] From 1803, however, a regional landowner or other prominent outsider was invited to preside at each annual meeting. The first appointment, in 1803-4, was the honourable Heneage Legge.[65]

In the early nineteenth century, some friction developed between the medical staff and the governors, prompted by the committee's desire to extend the catchment area to cover a greater area of the expanding town. In 1812 the medical committee opposed this, at least without additional resident staff. They pointed out that the current visiting apothecary needed to visit as many as seventy-nine patients in one day.[66] In January 1824 the governors again proposed enlargement and were once again resisted by the medical staff because of the 'house surgeon's excessive duties.' Over the previous 10 months, he had treated 1301 patients, as against 574 by all the other medical officers. The governors initially ignored the request for an additional 'apothecary and surgeon'. In June, they asked the medical officers to reconsider extending the boundaries, provoking an exasperated response. The latter reminded the governors of the medical opinion earlier that year and twelve years previously.[67]

On the later occasion the professional view carried the day, an additional resident surgeon being appointed and each junior practitioner

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[64] For such roles, see Porter,'The Gift Relation pp. 158-61; Loudon, 'Origins and Growth', p. 328.

[65] Heneage Legge (1788 –1844) was the second son of the third earl of Dartmouth. The family's principal estate was at Sandwell, northwest of Birmingham, land where the exploitation of coal reserves had added much to the family's wealth. Family members were Evangelical Anglicans and active both in local and London charities. Later dispensary presidents included Birmingham mayors and members of Parliament.

[66] BAH 1759 1/2/1 BGD papers, Medical Committee Minutes, 7 November 1812; West's *Warwickshire Directory*, 1830.

[67] BAH, MS 1759/1/4/1, Medical Committee Minutes, 9 January 1824, 26 June 1824; unusually, all six surgeons and all three physicians attended the later meeting. There is no mention of workload in the minutes between 1812 and 1824.

covering half the town. The new appointee requested a horse, as the dispensary provided for his colleague. By the spring of 1825 the extended boundaries that the governors favoured had been implemented, these allowing more potential patients access to attention. The medical officers commented in their report that the new arrangements were working well, both the changed boundaries and the staffing increases.[68] To modern eyes, the response of medical officers to the resident surgeon's high workload between 1812 and 1824 seems lacking in assertiveness but could perhaps be explained by evolving differences in status between governors and medical practitioners, as suggested by Pickstone for Manchester (and noted at the start of the Chapter).[69]

The dispensary's midwifery service is considered only briefly here (as it is explored more fully in Frances Badger's study of Birmingham midwifery in the period).[70] As explored by Badger, some conflicts developed between practitioners of medicine and midwifery, especially in the middle decades of the century. Various midwives delivered women on behalf of the dispensary, supervised by chief midwives such as Elizabeth Maurice (1819-35) and Elizabeth Hallett (1838-42). The management committee was critical of certain financial arrangements, such as those adopted by Mrs Maurice when she sub-contracted work to outside midwives, paying them per case.

[68] The governors approved the expenditure involved in keeping the horse that the new appointee needed to visit patients (according to him and the existing medical officers). The medical officers' later (positive) comments were in the Birmingham General Dispensary Annual Report 1824-5, p. 8. One of the two residents was soon designated as 'senior', with an addition to his salary, and presumably some supervisory duties.
[69] Pickstone's point was discussed above in relation to the foundation of the dispensary; Pickstone, 'The Professionalisation of Medicine in England and Europe', p.44.
[70] Badger, 'Delivering Maternity Care', pp. 70-101.

Table 5: Birmingham General Dispensary: Patient Statistics 1794 — 1860 (in quinquennia, except 1794-1800)

Years	Admissions (Sick patients)	Years	Admissions (Sick patients)
1794-1800	5429	1831-35	13992
1801-05	5607	1836-40	14475
1806-10	9006	1841-45	13951
1811-15	10188	1846-50	15631
1816-20	11610	1851-55	15696
1821-25	12791	1856-60	20642
1826-30	17523		

Poor women locally could also obtain help from the lying-in charity, which initially provided all its services in women's homes but in 1842 extended its services with a hospital in Broad Street. During the next three years, a decline in the number of confinements under the dispensary's care prompted the management committee to change its policy. In 1845, the dispensary appointed a resident surgeon-accoucheur in place of the midwife, who was to be responsible for the conduct of all births. Badger suggests that, in practice, many were conducted by 'pupils', presumably Birmingham medical students or the apprentices of local surgeons.[71]

[71] This charity continued to be mainly domiciliary, although most infants were delivered from this point by medical practitioners rather than midwives. Badger, 'Delivering Maternity Care'; dispensary midwives, pp. 89-105; Lying-in Hospital, pp. 105-108.

The dispensary was one of several institutions serving the sick poor of the town. Table 5 shows the broadly comparable numbers attending the slightly older General Hospital, and the Poor Law service; surgeons acting for the latter body treated paupers at the 'dispensary' (outpatient department) of the Birmingham Town Infirmary, as well as in patients' own homes.[72] Officially, the Poor Law system (especially after 1834) was a service for the destitute, the aged and disabled, and unsupported women and children, but it seems likely to have served other groups. These probably included people in middle age with chronic illnesses, but the existing historiography provides little fine detail.

New Dispensaries in Birmingham *c*.1830

In the years around 1830, 'self-supporting' dispensaries were attracting interest as an efficient and economical means of providing working-class health care. Birmingham developed such institutions on distinctive lines, which will receive brief attention here (and together with the more general movement, in greater detail in Chapter 5). In April 1828 a group of citizens met to plan a new type of dispensary that would, they hoped, 'encourage a spirit of independence among the poor', suggesting an emphasis on self-help rather than charity. The chief founder was a Mr Sanders, surgeon, together with three colleagues. The boundaries were set at 4 miles from St Philip's Church, while the surgeons themselves practised from their own premises. Instead of paying a weekly sum, (as in the self-supporting dispensaries at Southam and other smaller Warwickshire places) the member would purchase a ticket for four shillings, permitting six weeks treatment for himself or a relative.[73] The honorary members paid subscriptions funding the attendance of those unable to pay.

[72] Alistair Ritch, 'New Poor Law Medical Care in the Local Health Economy', *Local Population Studies*, 99.1(2017), 42-55

[73] The citizens included various prominent clergymen, as well as Thomas Attwood and Joshua Scholefield, leaders of the Political Union and later Birmingham's MPs; 'Birmingham Self-Supporting Dispensary', *Birmingham Journal,* 26 April 1828.

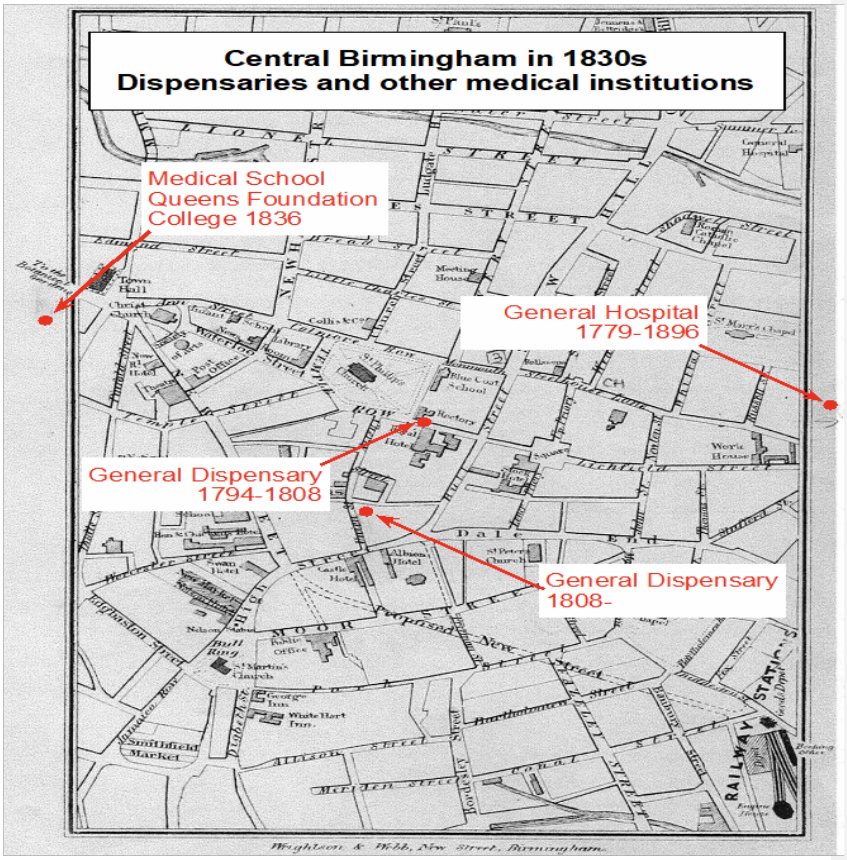

Figure 8: Map Showing locations of Birmingham General Dispensary (also of General Hospital and the Medical School). Adapted from map of Central Birmingham in Thomas Roscoe, *the Book of the Grand Junction Railway* (1839), p.186 (Wikimedia Commons, downloaded 12 March 2020); adapted by D. Steele.

In 1833, the original dispensary merged with a similar institution in Deritend to become the 'Birmingham and Deritend Self-Supporting Dispensary', with twelve surgeons, who likewise attended dispensary patients at their own premises.[74] In 1833-4 1406 patients who were attended included 1372 sick patients and 34 for midwifery.[75] The founders claimed that their system resembled that established

[74] In 1858 the Birmingham and Deritend Self-Supporting Dispensary was still operating, served by twelve surgeons, as listed in the *General and Commercial Directory of the Borough of Birmingham*, 1858.

[75] J. Aaron, 'Self-Supporting Dispensaries (Letter to Editor)', *London Medical and Surgical Journal* 5 (1834), 727-9.

by Henry Lilley Smith in and near Southam but adapted to local circumstances. Charles Bracebridge (a philanthropic gentleman of Atherstone in North Warwickshire) attempted to establish a dispensary closer to Lilley Smith's original model in Aston, but evidently this institution failed.[76]

Coventry 1829-32: the struggle to establish a Dispensary

During the years 1829-32 pressures for political reform in England resulted in a lengthy crisis, eventually eased by the passage of the Great Reform Act. In Coventry, such political tensions reinforced other difficulties, which together influenced the lengthy campaigns to establish local dispensaries. From 1830 a local political union was pressing for reform of both parliamentary and local political structures, while a deep slump in the silk trade was causing much distress among the working population.[77] A restive mood occasionally erupted into public disorder, such as the machine-breaking riot of November 1831. The original dispensary of 1789 having (apparently) failed early in the century, Coventry remained without provision for the sick working poor**.**

Newspapers regularly urged the re-establishment of medical charity, the *Coventry Herald* suggesting in early 1828 two nearby institutions as possible models. These were 'self-supporting' dispensaries, one the original institution started in Southam in 1823 and the other just founded in Atherstone.[78] Both drew on quasi-mutual contributions from users that supplemented the customary charitable support. Henry Lilley Smith, the Southam surgeon and originator of the new form, argued that such contributions enhanced thrift and independence among working people.[79] Smith was a persuasive public speaker, who addressed several meetings in Coventry during 1829-30 on such 'self-

76This was the 'Duddeston, Aston and Nechells Self-supporting Charitable and Parochial Dispensary'.
77 Nancy Lopatin-Lummis, 'Popular Politics in the Midlands: The Coventry Political Union and the Great Reform Act', Midland History 20 (1995), 103-18.
78 Editorial, Coventry Herald, 11 January 1828.
79 The story of Henry Lilley Smith and the new type of dispensary will be explored in Chapter 5 of this thesis; also see Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London: Routledge, 2001), pp. 91-2; Simon Wheeler, 'Dr Henry Lilley Smith and the Invention of Self-Supporting Dispensaries', Warwickshire History XIII (2007), 180-96.

supporting, charitable and parochial dispensaries.' One lecture audience in April 1829 was sufficiently convinced of the new system's advantages to elect a provisional committee aiming to establish a local self-supporting dispensary.[80] Thereafter the committee led a lengthy and contested campaign for a new local foundation. Their resolve may have drawn strength from contemporary reform movements, but allegiances were not straightforward, as some prominent reformers later allied themselves not with the self-supporting dispensary but with the rival gratuitous institution.[81]

Two reformist Whigs illustrate some such complexities: Henry Cadwallader Adams of Ansty Hall and the ribbon manufacturer Abraham Herbert. Adams (1779-1842), a Warwickshire magistrate for thirty years, came from a family settled at Ansty (five miles northeast of Coventry) since the seventeenth century. Herbert (1779-1847) was described in 1838 as 'a weaver in his youth but now a man of wealth'.[82] In October 1831, both men were among the Liberals and Radicals who addressed a large public meeting in Coventry, called after the House of Lords voted down the Reform Bill. They and other speakers attacked the arrogance of the bishops and the Lords in general.[83] Reformers in and around Coventry, including members of the local Political Union, desired change in local administration at least as much as in national politics. They were critical of the Corporation's partisan approach to its charitable and legal functions and its direct role in the corruption and violence

[80] 'Self-supporting dispensaries', Meeting Report, *Coventry Herald*, 24 April 1829; in the following pages, the 'dispensary committee' or simply 'committee' will refer to the body formed at this time.
[81] Peter Searby, 'Paternalism, Disturbance and Parliamentary Reform: Society and Politics in Coventry, 1819-32', *International Review of Social History* 22 (1977), 198-225. Peter Searby, *Coventry Politics in the Age of the Chartists, 1836-1848* (Coventry: Historical Association, Coventry Branch, 1964) pp. 4-8.
[82] Evidence of Joseph Fletcher to the Select Committee, Select Committee on the Health of Towns, *Report* (London: HMSO, 1840), p. 69
[83] Other speakers at this meeting were the banker James Beck, the surgeon Percy Fitzpatrick, Alderman Merridew, and the weavers' leaders, E. Goode and David Smith. Peter Searby, 'Weavers and Freemen in Coventry, 1820-1861: Social and Political Traditionalism in an Early Victorian Town' (Unpublished PhD Thesis, University of Warwick, 1972), p.143.

of parliamentary elections. Both Adams and Herbert criticised such abuses when they testified at the parliamentary Select Committee on Municipal Corporations in 1835; both were elected to the reformed city council that December, and afterwards served as mayors of Coventry.[84] While Herbert consistently supported the self-supporting dispensary, Adams had in 1831 become an officer of the purely charitable general dispensary. The original self-supporting dispensary committee embraced various political viewpoints (Table 6). Among its number were some with Whig or Radical views; these included the Congregationalist minister John Sibree, the 'ultra-Liberal' Sibley Whittem, and the two Cash brothers, Quaker stuff manufacturers.

Their chairman, however, was a High Churchman usually considered a Tory. This was Walter Hook, the vicar of the central parish of Holy Trinity, a 'mercurial, eccentric…[but also] cultivated, humane, and well loved' man.[85] At Coventry and later at Leeds, Hook did much to develop new Anglican approaches to pastoral work among industrial populations. While moved by the plight of his poor parishioners, he was convinced that increased thrift would ease their hardships.[86] The committee's manifesto, 'an Address to the Inhabitants of Coventry', appeared in September; it argued that self-supporting dispensaries fostered self-help and removed barriers to medical care, as people would not require tickets of recommendation. The committee (evidently

[84] Their views reflect the convictions among many reformers that prized probity and financial rectitude; see Hilton, *The Age of Atonement*, p.7; for details of their appearance before the committee, see Frédéric Moret, *The End of the Urban Ancient Regime in England* (Newcastle on Tyne: Cambridge Scholars Publishing, 2015) pp. 32-3, 152-3. Adams was elected mayor in 1836 and Herbert in 1838.

[85] Other early members were the banker James Beck, Richard Bury, 'gentleman', the silk manufacturers Jenkins and Thomas Morris, and a Mr Sharp (a hatter); Meeting report, *Coventry Herald* ,24 April 1829. For the general background, Peter Searby, *Coventry Politics in the Age of the Chartists, 1836-1848* (Coventry: Historical Association, Coventry Branch, 1964) pp. 4-8, quote p. 7.

[86] George Herring, 'Hook, Walter Farquhar (1798–1875), dean of Chichester', *Oxford Dictionary of National Biography.* 23 Sep. 2004; Accessed 24 Aug. 2021. https://0-www.oxforddnbcom.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-13687. Hook's letters urged the foundation of a local self-supporting dispensary, e.g., letter from 'A Subscriber', *Coventry Herald*, 23 October 1829.

mindful of the earlier dispensary's failure) estimated that charitable funds subscribed by the prosperous would reach about £300 per annum. Such a sum would cover the costs of a modest traditional dispensary but could enable a more ambitious 'self-supporting' institution, as the contributions made by working people would augment the funds available.[87] There were thus pragmatic reasons for planning a dispensary of the new type, apart from the claimed advantages in fostering independence and self-help. While the *Coventry Herald* cautiously welcomed the new plans, local medical men were mobilising opposition.[88] First assembling in July 1829, the city's ten surgeons and five physicians declined to cooperate with any self-supporting dispensary.[89] Their claim that '[such] principles are not adapted to the locality' they later glossed as referring to the markedly fluctuating earnings of Coventry weavers. They declared themselves willing, however, to cooperate with citizens founding a dispensary on traditional lines.[90] A pseudonymous newspaper correspondent (almost certainly Walter Hook) challenged the practitioners, questioning whether they were truly unanimous, and asking if self-interest underlay the medical 'combination' and its rejection of the new style of dispensary. The city's artisans might, he suggested, prefer to pay dispensary subscriptions rather than medical fees.[91] Dr Edward Bourne, a senior physician who acted as the medical spokesman, testily rejected such imputations, claiming that public interest was their main (if not only) motivation.[92]

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[87] 'Address to the inhabitants of Coventry ', *Coventry Herald*, 4 September 1829; Hook spoke on this theme at the civic dinner in October, 'Charter Officers' Dinner, *Coventry Herald*, 23 October 1829.

[88] Editorials, *Coventry Herald*, 4 September 1829, 23 October 1829. The editor then was Nathaniel Merridew, a Congregationalist and silk warehouseman.

[89] The first (private) meeting was on 15 July 1829, summarised by 'a Friend to Dispensaries' in a letter to the *Coventry Herald*, 31 July 1829; a meeting on 10 November reaffirmed the earlier views, as recounted by the surgeon John Bury; J. Bury, letter to Editor, *Coventry Herald*, 1 June 1832.

[90] Dr E Bourne, letter to Editor, *Coventry Herald*, 11 December 1829.

[91] 'A Subscriber', Letter to Editor, *Coventry Herald*, 18 Dec 1829, 12 January 1830, 22 January 1830.

[92] In this and other letters, Bourne insisted that his colleagues were motivated by public concerns and not self-interest. Letter to Editor, *Coventry Herald,* 18 December 1829, 25 December 1829, 1 January 1830, 8 January 1830.

In November 1829, in the face of the resolute professional opposition, the committee, for a time, laid aside plans for a self-supporting dispensary. [93] Thereafter there was a lengthy impasse, which persisted through the whole of 1830. The medical men seemed to be waiting on action from their fellow citizens to initiate a dispensary. For their part, the members of the original committee were those best placed to implement a new institution. Those individuals remained convinced that a self-supporting dispensary was the best policy. Local newspapers criticised such inaction, the *Coventry Herald* in September 1830 urging practitioners to resolve their differences, especially 'considering the smallpox outbreak then raging'.[94] In February 1831 the local Poor Law authorities urged a dispensary for both paupers and poor people generally, as they were 'most severely afflicted with smallpox, measles and other fevers'.[95] The original committee and the medical men shortly afterwards petitioned the mayor for a meeting, and when this took place on 15 March 1831, consensus or compromise may have seemed within reach.[96]

At the meeting, however, committee members reiterated their original plan as the best basis for a new institution. Speaking for the profession, Dr Bourne admitted the need for a dispensary, it being 'a disgrace' that none existed. His colleagues agreed, several restating various objections to the self-supporting principle. Some questioned the viability of such institutions elsewhere in Warwickshire, while the radical surgeon Percy Fitzgerald objected to working 'under the direction of a 'committee of manufacturers and gentlemen'. Edward Goode, the weavers' leader, stated that working-class feeling was decidedly for a dispensary, but without favouring either type. Soon after this meeting, the opposing positions hardened. Committee members canvassed the inhabitants of central city wards for their willingness to pay a

[93] Editorial (committee meeting 12 November) *Coventry Herald,* 20 November 1829.
[94] Editorial, *Coventry Herald,* 3 September and 4 September 1830.
[95] Notice by Directors of the Poor, *Coventry Herald*, 25 February 1831; under a local Act of 1801, ratepayers for the three parishes elected 18 Directors; Peter Searby, 'The Relief of the Poor in Coventry, 1830–1863', *The Historical Journal* 20 (1977), 345-61
[96] 'Meeting to establish a Dispensary', *Coventry Herald,* 18 March 1831.

weekly penny (for a single individual; increased amounts for families) as contributions.

The advocates of a self-supporting dispensary were thus taking steps to put this into effect: local medical practitioners continued to refuse their cooperation, but at last were willing to seek allies in establishing a separate, purely charitable, dispensary. The self-supporting committee advertised for medical officers, later appointing two young practitioners from Southam thoroughly familiar with Lilley Smith's ideas and practice: Charles Nankivell, who was for some months his assistant, and Edward Bicknell, his brother-in-law and ex-apprentice.[97] Meanwhile, there was a response from local working people sufficient for committee members to open the Coventry Self-Supporting or 'Benevolent' Dispensary, which started to treat patients from 18 July 1831.

Among Coventry practitioners, Dr Robert Arrowsmith was a recent arrival in the city and more favourable than most of his peers to self-supporting dispensaries. When he declared his opinion at a meeting in June 1831, he mentioned his belief that some colleagues tacitly shared his views but had felt unable to voice them at the medical meetings because of Bourne's partisan chairmanship. Arrowsmith recognised the scale of unmet need, as over two months, one thousand people had applied to him for gratuitous treatment.[98] The surgeon John Bury, a vigorous controversialist, questioned such high figures and accused him, understandably, of inconsistency in his views, while further allegations of bad faith were regarded as insults.

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[97] Wheeler, 'Dr. Henry Lilley Smith', pp.190-1; both men continued for decades in Coventry (Charles Nankivell 1805-86, MRCS 1829; Edward Bicknell 1806-81, MRCS & LSA 1830).

[98] 'Meeting to establish a gratuitous dispensary (22 June)', *Coventry Herald*, 1 July 1831; Arrowsmith also evidently published a pamphlet regarding dispensaries in early 1831, but this has not been traced; such gratuitous treatment by physicians was a common practice, as discussed by Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 2002), pp. 174-5, 251-2.

Table 7: Committee Members of Coventry Dispensaries in 1831-2

Coventry General Dispensary			Coventry Provident (self-supporting) Dispensary					
Name	**Occupation/ description**	**Notes**	**Name**	**Occupation/ description**	**Notes**	**Name**	**Occupation/ description**	**Notes**
Henry Adams	Gent, JP, Ansty Hall	Liberal, Mayor 1836	Charles Bray	Ribbon manufacturer	Liberal	J. Jenkins	Ribbon manufacturer	
James Beck	Banker, Allesley Hall	Liberal, Mayor 1837	Richard Bury	Gentleman		S. S. Morris	Ribbon manufacturer	
Revd Walter Bromley	Clergyman (CoE)		Capt. Bunney	Banker	Conservative	Thomas Morris	Ribbon manufacturer	Liberal, Mayor 1830 & 1831
Thomas Cope	Ribbon manufacturer	Mayor 1848	Joseph Cash	Stuff Manufacturer	Quaker, Liberal	Mr Osmond	Currier	
Edward Goodall	Banker		Josiah Cash	Stuff Manufacturer	Quaker, Liberal	Abijah Pears	Ribbon manufacturer	Liberal, Mayor 1842
Col. Francis Gregory	Gentleman, JP, Stivichall Hall	Liberal	Richard Crofts	Ribbon maker		Cleophas Ratliff	Ribbon manufacturer	
William Little	Banker		George Eld	Gentleman	Conservative, Mayor 1834	Thomas Sharp	Hat manufacturer	Hon. Secretary
Revd. R Simson	Clergyman (CoE)		Edward Gulson	Fellmonger	Liberal	Revd John Sibree	Clergyman (Dissenting)	
George Whieldon	Gentleman, JP, Colliery Owner,		Abraham Herbert	Ribbon manufacturer	Liberal, Mayor 1838	Mr Stott	Bookseller	
			Revd Walter Hook	Clergyman (CoE)	Conservative	Mr S. Wall, junior		
						Thomas J. Wilmot	Solicitor	Conservative

Accusations of misrepresentation or outright falsehood were traded back and forth in the columns of the Coventry newspapers and then in Leamington, which had its own current dispensary controversy. Certain subscribers to the Leamington Hospital and Dispensary favoured its conversion

into a self-supporting institution (a debate discussed in Chapter 5).[99] Professional relationships in Coventry evidently did not improve, Arrowsmith writing in May 1832 that he had 'separated himself' from most of his colleagues, who had countered by expelling him from the Coventry Medical Society.[100] Table 7 details committee members for both dispensaries.[101]

The Coventry General Dispensary 1831-39

Most of the city's medical men assembled, initially on 22 June 1831, to determine the practical functioning of a purely charitable dispensary. They were joined by lay allies and the meeting was chaired by the trusted and respected figure of Henry Adams. The dispensary opened on 23 October, based in Star Yard, off Earl Street (figures 9 & 10). Its honorary medical officers included several active in the recent campaign (Drs E Bourne and R Mellor as physicians; J. Bury, F. Laxton, and P. Fitzgerald as surgeons, the last-named replaced in 1832 by N Troughton).[102] Subsequent newspaper reports of its annual meetings vary in detail, but the dispensary dealt with around 600 patients annually. These generally included a relatively high proportion of 'surgical' patients, few however requiring major operations. In 1838 the dispensary's 738 patients included 624 attending with a letter of recommendation and 114 treated for injuries, including various fractures and dislocations. This dispensary's statistics (see Table 11) will be discussed later in the Chapter, together with those for the self-supporting dispensary.

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[99] R Arrowsmith, letter to Editor, *Coventry Herald,* 25 May 1832, 8 June 1832, 22 June 1832; John Bury, letter to Editor, *Coventry Herald* 22 June 1832.

100 R. Arrowsmith, letter to Editor, *Coventry Herald,* 25 May 1832; Advertisements (signed by Joseph Morris), *Coventry Standard* 15 June 1832, *Coventry Herald* 22 June 1832.

[101] 'Meeting to establish a Dispensary', *Coventry Herald*, 16 March 1831; J. Bury, *Leamington Spa Courier*, 24 April 1832; Dr R Arrowsmith, *Leamington Spa Courier*, 9 June 1832

[102] The two surviving medical officers from the earlier dispensary remained in the background; Dr F. Simson attended some meetings, while Samuel Whitwell did not participate (he was mayor from 1829-31 and perhaps on those grounds reluctant to take sides).

The growing number of casualties in the mid-1830s underlined the need for a local hospital, and the solicitor Thomas Wilmot indeed mooted this in a pamphlet in 1837. The 'Coventry and Warwickshire Hospital' was launched in 1838, although it needed some months to accumulate the funds needed to open. Evidently it admitted patients to its twelve beds in Little Park Street in early 1840, and having negotiated with both dispensaries, also merged with the General Dispensary. Those governing the Provident Dispensary disapproved of the gratuitous treatment of outpatients and therefore remained separate. The thirty initial hospital governors included supporters of both dispensaries, while its medical staff comprised those who served at the General Dispensary, with the addition of Dr Arrowsmith.[103]

The sources of support for the General Dispensary, at least in its early days, can be gauged from a list of subscribers in July 1831, comprising 114 names, 76 (65.5 per cent) of them identifiable in local directories. [104] These included one peer, two landed gentlemen, eight other gentry, four clergymen (all Anglican), 16 women, 6 medical men, 6 attorneys, 2 bankers and 11 ribbon manufacturers. There were twenty tradesmen of different types. The subscribers elected a committee (see table 7), which therefore comprised mainly wealthy individuals, including bankers, clergymen and the landed gentry, the only ribbon manufacturer being the proprietor of a large concern. Most lived in large houses in Coventry 's rural hinterland, places almost all later absorbed into the expanding city.[105] They were thus, in general, a privileged group, and indeed John Bury claimed their superior social status as an advantage.[106] While no subscription list survives for the self-supporting dispensary at its outset, its honorary members seem likely to have included most of the twenty-one members of the provisional committee, active 1829 -

[103] Desmond Thomas Tugwood*, The Coventry and Warwickshire Hospita*l 1838-19*48* (Book Guild, 1987), pp. 2-12.
[104] 'Subscriptions to Coventry General Dispensary', *Coventry Herald*, 8 July 1831.
[105] Thomas Cope then employed about 400 weavers in his loom-shops; Searby, 'Weavers and Freemen', pp. 83-4).
[106] J. Bury, letter to editor, *Leamington Spa Courier*, 24 April 1832.

1831. They included ten manufacturers, seven of them ribbon makers, and a few other tradesmen (table 7). The manufacturers had businesses of varying size, suggesting that this body better represented middling groups in Coventry. The limited evidence regarding political allegiances suggests that both committees were probably mixed. In terms of attitudes to charity; the general dispensary governors might, perhaps, have been more inclined to traditional paternalism. Their counterparts at the self-supporting dispensary may have preferred to focus philanthropic support on those who could demonstrably help themselves. As dispensary members fell in this category, as they were required to make regular contributions. These appear typically evangelical attitudes to charity, even if by no means all were evangelicals.[107]

The Coventry Self-Supporting or Provident Dispensary from 1831

Inhabitants of Coventry flocked to join the dispensary from its opening in July 1831. Some hundreds became members each month, by March 1832 totalling 2280.[108] The membership was initially limited to 2500, as the committee calculated that 2500-3000 individuals would need its services (about ten per cent of the population). Arrowsmith identified three types of patients: some who had hitherto received no medical aid, often with neglected chronic conditions; those previously treated free by practitioners but buying medicines from druggists; and a third group, whose income made payment of medical fees 'precarious'. Unlike Southam and some other places, the dispensary had only 'free' members and did not treat pauper or charity patients (both groups having other provision).[109]

[107] Walter Hook, for instance, was a High Churchman; Hilton, *The Age of Atonement*, pp. 101-04.

[108] Robert Arrowsmith, 'An Account of the Coventry Self-Supporting Dispensary', *London Medical Gazette* XII (1833), 426-29 p. 427; each member, or family, paid contributions based on one weekly penny per adult.

[109] Arrowsmith, 'Account of the Coventry Self-Supporting Dispensary', p. 427.

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Figure 4 Coventry: Detail from Board of Health O.S. Map, 1851. The Provident Dispensary was located t centre right. Old Dispensary Yard, just below, probably refers to the original dispensary of 1789. The General Dispensary of 1831-40 was in Old Star Yard off Earl Street just below the picture.

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110 Robert Arrowsmith, 'An Account of the Coventry Self-Supporting Dispensary', *London Medical Gazette* XII (1833), 426-29 p. 427; each member, or family, paid contributions based on one weekly penny per adult.

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Having discussed the background to its foundation, this section will explore the practical working of the new style of dispensary. The 'Coventry Provident Dispensary' was within a few years the official name for the self-supporting institution founded in 1831, initially and confusingly also known as the 'Benevolent Dispensary'. While its own contemporary documents have not survived, much of its working can be reconstructed from articles in medical and general publications two articles. These include two pieces in the *London Medical Gazette*. He became a strong advocate of the self-supporting dispensary by Robert Arrowsmith and was its consulting physician from early 1832. [112]

The dispensary's first premises were in Bayley Lane, close to the location of the 1789 General Dispensary. In 1842 it moved to a new building a little to the north, facing the east end of St Michael's Church (figures 5 & 6).[113] In its second year (1833-4), the surgeons treated 1668 individuals (67 per cent of the 2500 members), and dealt with similar numbers thereafter.[114] Charles Bracebridge, a North Warwickshire gentleman who was a supporter of this and

[111] Arrowsmith, 'Account of the Coventry Self-Supporting Dispensary', p.427
112 Report of meeting on 1 July, *Coventry Herald* 11 July 1831, Rev J Sibree, letter to editor, *Coventry Herald*, 10 February 1832
113 Benjamin Poole, *The History of Coventry* (Coventry: T. Lewin, 1852), pp. 113-4
114 Robert Arrowsmith, 'Progress of the Coventry Self-Supporting Dispensary', *London Medical Gazette* XIII (1834),

other dispensaries, in 1858 published a paper illustrating institutional functioning to that point (see Table 8).[115] As was normal in a provident dispensary, the sum of the free members' contributions, after certain deductions, was divided between the surgeons, up to 1850 amounting to about £250

In the 1850s the dispensary removed restrictions on numbers, gaining 4539 new members over the four years 1853-57, these changes probably being connected with the appointment of a third surgeon in 1852. The number of members increased as the town grew, amounting to 8-10 per cent of the population up to 1860. Clubs and friendly societies could join for collective cover at reduced rates, and in 1838 over twenty societies had a dispensary such and protection contract.[116] The dispensary seems to have served most of the fifty societies in 1851.[117] Its close links with friendly societies was likely to have fostered its popularity, such societies being so important in Coventry for both sociability and security.

[115] Bracebridge delivered his paper in September 1858 in Leeds, at the British Association for the Advancement of Science; Charles H. Bracebridge, 'Notes on Self-Supporting Dispensaries, with Some Statistics of the Coventry Provident Dispensary', *Journal of the Royal Statistical Society* 21 (1858), 460-63.
[317] Prest, Industrial Revolution in Coventry, p.73

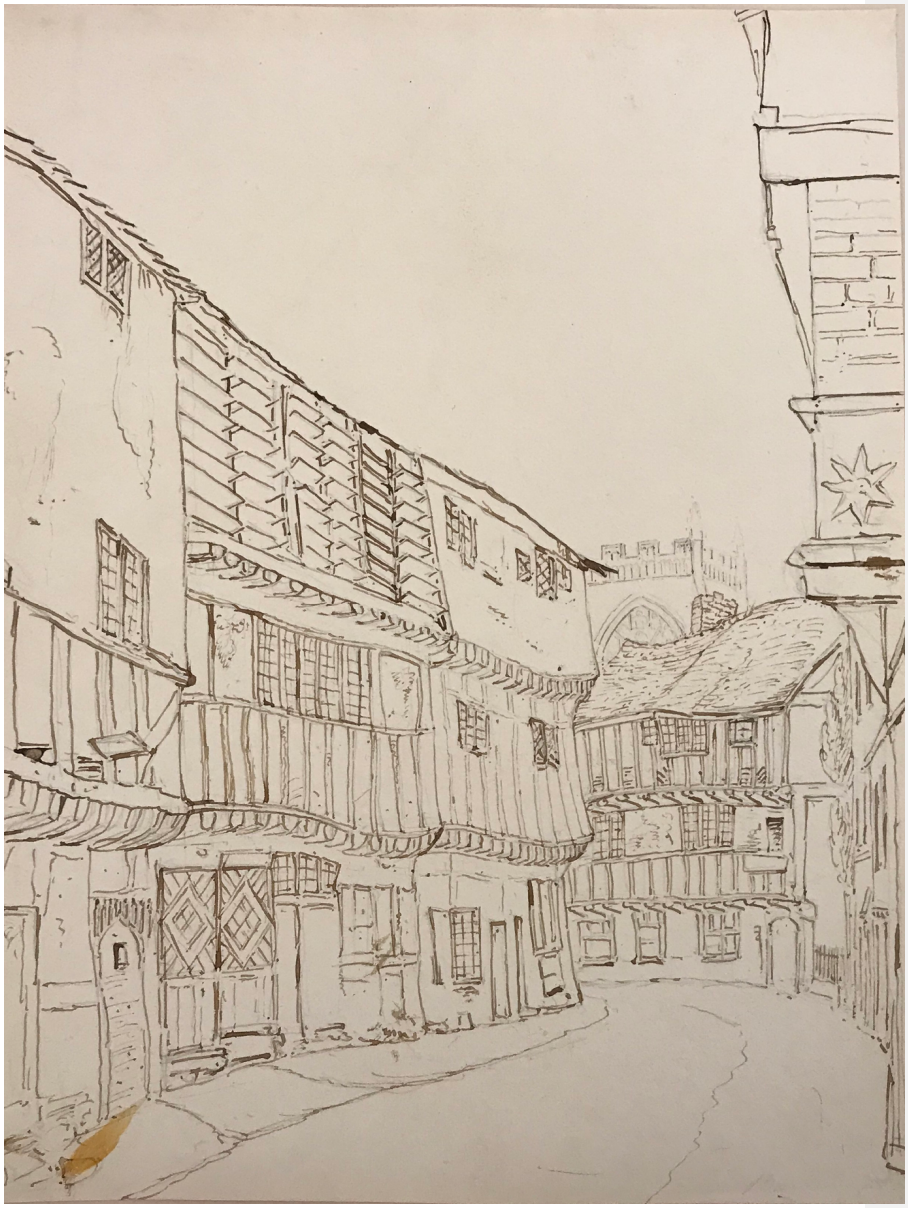
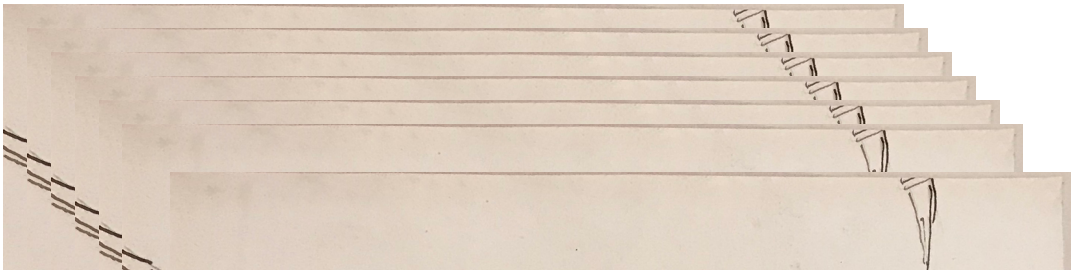


Figure 10: Bayley Lane, looking north from Earl Street (?c.1850). The original dispensary of 1789 probably occupied one of the buildings on the right (and the provident dispensary was initially located nearby). This is one of the many sketches of Coventry by Nathaniel Troughton MRCS (Coventry Archives W32/40/20 L ACC).



Some observers based elsewhere paid close attention to the Provident Dispensary, as an apparently fair and economical means of providing health care. They included two Manchester practitioners, the dispensary physician James Phillips Kay, and a surgeon, P.H. Holland. Alarmed by the sharp growth in numbers attending free dispensaries, Kay argued that self-supporting or provident policies, like those operating at Coventry, encouraged independence and self-reliance among the urban working classes. [118] Holland visited Coventry in 1838, when he questioned one hundred people who had received treatment; sixty-nine of them preferred the new system.[119] A verdict on several decades' experience was offered in October 1858, by the mayor, A.B. Herbert (son of the earlier mayor who was one of the original dispensary founders). Speaking at a public meeting attended by leading citizens, but no 'outside' medical practitioners, he commended the Coventry Provident Dispensary as 'eminently successful'. [120]

Local practitioners, as noted above, were opposed from the start to the new style of dispensary and seem unlikely to have become reconciled. Potential threats to their income may have contributed to their objections but these may have had other roots. Here one could draw on Brown's concept of a new sense of collective medical identity, an 'imagined community', that crystallised around 1830 (discussed further in Ch. 5). An important aspect was an emphasis on the primacy of professional expertise in medical institutions (one of Bourne's points in letters to the press).[121] Brown analysed the professional objections to two controversial dispensaries in London and Sheffield; in their case, medical grumbles focused largely on their charitable

[118] James Phillips Kay, Defects in the Constitution of Dispensaries and Suggestions for Their Improvement (London: Ridgway, 1834), pp. 9, 11

[119] P. H. Holland, *An Essay on Dispensaries* (Manchester: Love & Barton, 1838), p.20.

[120] A.B. Herbert was the son of the Herbert who was closely concerned in the setting up of the dispensary. 'Provident Dispensary: Report of meeting on 21 October', *Coventry Herald* 29 October 1858.

[121] Among the promoters of the self-supporting dispensary there was nobody medically qualified, Bourne's letter, *Coventry Herald,* 8 January 1830.

aspect, especially when this was administered with undue laxity. [122] By contrast in Coventry, medical antagonism concentrated on the 'self-supporting' principle.[123] What strength did the bitter dispensary controversy draw from contemporary Coventry's general politics? Some recent scholarship has challenged older accounts that interpreted the actions of the local elite as guided by an ethos of benign paternalism, at least up to the 1830s. These revisionist views focus on the many instances of conflict between civic leaders and the city's artisans, or those allied to either group, especially at election times. [124] Perhaps such tensions flowed into the debate about medical provision. A fictional equivalent is portrayed in *Middlemarch*. In her novel, George Eliot portrayed the supporters of rival institutions forming into opposing camps, just as they did in Coventry during 1829-32.[125]

[122] The dispensaries concerned were Aldersgate in London and the Sheffield Public Dispensary. They are considered in ch.5 of this thesis; Michael Brown, 'Medicine, Reform and the 'End' of Charity in Early Nineteenth-Century England', English Historical Review CXXIV (2009), 1354-88.

[123] Brown, *Performing Medicine*, pp.6-7, 120-40.

[124] The traditional views are in Prest, Industrial Revolution in Coventry, and in Peter Searby, 'Weavers and Freemen in Coventry, 1820-1861: Social and Political Traditionalism in an Early Victorian Town.' (Unpublished PhD Thesis, University of Warwick, 1972); Peter Searby, 'Paternalism, Disturbance and Parliamentary Reform', pp. 198–225; they are challenged by Lopatin-Lummis, 'Coventry Political Union', esp. pp. 106-7, 113-5, and Sarah Boote Powell, 'Coventry Corporation and the Myth of Paternalism: Electoral Politics in Coventry, 1826–1835', Midland History, 34 (2009), 77-97.

[125] George Eliot, *Middlemarch* (Harmondsworth: Penguin, 1974 (orig. pubn. 1871)); Prest, *Industrial Revolution in Coventry*, pp.143-45; Asa Briggs, 'Middlemarch and the doctors' in *Collected Essays*, 2 (Chicago: University of Illinois Press,1985 (orig. pubn. 1948), 49-67.

Disease and the Dispensaries in Birmingham and Coventry

Patterns of urban ill health can be traced through the annual reports of the dispensaries and published papers by their medical officers and others (Tables 7, 9 & 10). These can be compared with data from other towns, such as Doncaster and Newcastle-on-Tyne, which had dispensaries from 1792 and 1778 respectively.

Such institutional statistics, however, need to be interpreted with caution, based as they were on observations by different practitioners over decades of rapidly changing pathological ideas. During the early 1820s, John Darwall collated data on his personal caseload to publicise statistics for the Birmingham General Dispensary (nearly one-third of the total patients), a process reiterated in the 1830s by his successor T. Ogier Ward; see table 8. [126] Also reflected in the table are the statistics from the 1840s onwards, compiled by the medical officers jointly from their individual records. However, from this point onwards, the accounts of dispensary clinical experience never matched the laborious detail evident in the articles by Darwall and Ward. From 1840 the annual dispensary reports included tables embracing surgical as well as medical conditions (but frustratingly for the historian, omitting death rates). The broad diagnostic groupings in early reports came to be subdivided; many cases of 'fever' in children being later categorised as, for instance, measles or whooping cough. Charles Rosenberg has noted how more precise diagnostic habits gradually became apparent in nineteenth-century institutional reports. He argues that they reflect not merely refinements in statistics but a profound

[126] John Darwall was a Birmingham native and Edinburgh graduate who became a physician at the Birmingham dispensary in 1821, soon after graduating. His career will be explored closely in Chapter 4; also see Jonathan Reinarz, 'Darwall, John (1796–1833), physician' *Oxford Dictionary of National Biography*, 3 Oct. 2013; last accessed 24 August 2021,https://www.oxforddnb.com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-62849; John Darwall, 'Diseases of Birmingham', *Edinburgh Medical and Surgical Journal (EMSJ)*, 19 (1822), 631-3 ; John Darwall, 'Report of Diseases of Birmingham, July -- October 1822', *EMSJ,* 19 (1823), 157-62 ; John Darwall, 'Diseases of Birmingham', *EMSJ,* 23 (1825), 218-20 ; John Darwall, 'Diseases of Birmingham', *EMSJ*, 20 (1823), 159, 316-9 ; John Darwall, 'Diseases of Birmingham', *EMSJ*, 21 (1824), 226-8.

change in medical thinking, in his view more significant than the (later) germ theory of disease causation. The 'zymotic' diseases causing childhood fevers, for instance, were increasingly conceived as specific entities, each typically with a single underlying pathological process.[127]

From their founding in the late eighteenth century, dispensaries dealt with large numbers of fever cases, especially the 'continued fevers'. Their early clinicians used their opportunities to study the 'natural history' of such diseases and to disseminate their findings.[128] A local instance is the severe outbreak in Birmingham during 1799-1800, described (in a book apparently now lost) by the dispensary physician Robert Bree.[129] In publications around 1800, dispensary physicians reported attending more fever cases than of any other condition. Given the high prevalence and significance of continuing fevers, it seems appropriate to describe their features. They are now understood as a mixture of typhus and typhoid, Loudon suggesting that typhus predominated until about 1820, while later experience comprised both diseases in roughly equal numbers.[130] Even a mild episode typically lasted 2-3 weeks, with 'fever, sweating and shivering, restlessness…intolerable pains in the back, limbs and

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[127] 'Zymotic' diseases, such as childhood fevers, were so named from the Greek word for ferment; now, of course, they are considered infectious diseases. Charles E. Rosenberg, 'The Tyranny of Diagnosis: Specific Entities and Individual Experience', *The Milbank Quarterly* 80 (2002), 237-60

[128] Loudon, 'Origins and Growth', p. 332, N36; Ulrich Tröhler, 'The Doctor as Naturalist: The Idea and Practice of Clinical Teaching and Research in British Policlinics 1770 — 1850', in H Beukers and J Moll, (eds)., *Clinical Teaching, Past and Present* (Amsterdam & Atlanta, GA: Rodopi (Clio Medica), 1989), pp. 27-31.

[129] This was the case for six dispensaries in the late eighteenth century, in London and provincial towns, that published their experience; Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon, 1986), pp. 57-60; a Birmingham example is by Robert Bree*, Essay on the Nature and Treatment of a Putrid Malignant Fever* (London Rivington, c.1800). The title of Bree's work (which itself has not been traced) suggests the confusingly varied labels for the continued fevers; see also Arthur H Grant and Joan Lane, 'Bree, Robert (bap. 1758, d. 1839), physician', *Oxford Dictionary of National Biography*. 23 Sep. 2004; last accessed 24 Aug. 2021. https://0-www-oxforddnbcom.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-3307

130 Indeed, typhoid may have made its first appearance in Great Britain in the late 1820s; Charles Creighton, *History of Epidemics in Britain*, 2 (Cambridge: Cambridge University Press, 1891), pp. 17-18.

head'. A faint rash 'resembling flea-bites' gave clues to the diagnosis; in turn, patients often developed vomiting and diarrhoea, and some subsequently delirium and coma.[131] The typical case-fatality rate of untreated cases was around 10 per cent, although in children only 5 per cent. In epidemics 20 or even up to 45 per cent of patients might die, while the recovery of survivors was protracted.[132] Typhus is now known to be caused by the bacterium *Rickettsia,* spread by body lice, while typhoid results from *Salmonella typhi* infecting foodstuffs or (more commonly) contaminated drinking water. The first disease results from poverty, economic dislocation, overcrowding, and deficient hygiene, while the second is caused by contaminated water supplies (such circumstances, of course, often overlapping).[133]

Early nineteenth-century clinicians had no knowledge of the bacteria causing fever, but many recognised the significance of poor social conditions. In Birmingham in 1825 John Darwall noted that the worst cases came from 'close and dirty streets', often among the Irish in lodging houses. He linked the illness to 'crowded apartments, exhaustion…deficient nutriment, and want of clothing'.[134] Darwall observed fluctuations in continuing fever in the 1820s, while his successor Thomas Ogier Ward noted high levels of cases in 1837. Most of the latter cases occurred in a localised outbreak (discussed in his second paper in 1838; see Table 8 in this Chapter). Ward linked the twenty-two fever cases the previous year with atypical weather conditions, namely a summer drought which resulted in the River Rea becoming a 'stagnant…*cloaca*

[131] Loudon, Medical Care and the General Practitioner, pp. 59-60.
[132] Epidemic forms of typhus resulted in the highest mortality rates, but these were rare in Birmingham after 1800. Anne Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900* (Oxford: Clarendon Press, 1993), pp. 191-2, 202-3; Hardy based her figures on Bill Luckin, 'Typhus and Typhoid in London', in Robert Woods and John Woodward, (eds), *Urban Disease and Mortality in the Nineteenth Century* (1984), p.104.
[133] Hardy, *Epidemic Streets*, pp. 191-2.
[134] John Darwall, 'Diseases of Birmingham', *EMSJ*, 23 (1825), 218-20, p. 219; see also Darwall, 'Observations on the Medical Topography of Birmingham and the health of the inhabitants', *Midland Medical and Surgical Reporter*, 1 (1828), 106-12, 40-53; for comments on the Irish inhabitants of Birmingham, p.111.

maxima', the circumstances later typically associated with typhoid. [135] Notwithstanding such outbreaks, nineteenth-century Birmingham suffered fewer outbreaks of severe continued fever than other industrial towns, and in general the illness seemed to decline in later decades.[136] In Coventry's crowded conditions, numbers of such fevers also reduced, but less strikingly so (see Tables 10 & 11). At the Doncaster Dispensary, continued fever was similarly infrequent (64 cases 1835-48, 6.2 per cent or all cases). It was much more common in Newcastle, where the dispensary treated 7848 with 'putrid fevers' in 1820-49, or 18.4 per cent of the total (42551) cases. This strikingly high figure is unexplained, but may plausibly have arisen from intense local poverty, crowded housing conditions, and perhaps the liability of a port city to contagious disease.[137]

The detailed reports of both Darwall and Ward do more than reveal the common afflictions of Birmingham's poorer citizens in the 1820s and 1830s (table 8). Their findings also reflect a shared professional ethos, based on the close observation of patients combined with pathological or chemical investigation. These are the features of the Paris-influenced scientific medicine

[135] See Table 8; Darwall, 'Diseases of Birmingham' in *EMSJ,* 19 (1822), 631-3, 20 (1823), 157-9, 316-9, 21(1824), 226-8; T. Ogier Ward, 'Report of Medical Cases in the Birmingham Dispensary', *Trans. PMSA* 6 (1838), 429-46; he discusses the cases of 'typhoid fever' on pp. 436-38; in 1822 Darwall diagnosed 58 cases of continuing fever, making 5.4 per cent of the total; in 1824, 20 cases or 2 percent; Ward in 1838 reported 22 or 4.8 per cent.

[136] Birmingham Poor Law practitioners also treated relatively few cases of continuing fever. During 1831-5, two surgeons attended a total of 45,591 cases during the five-year period, including 3108 with continuing or other fever (4.9 per cent of the total attended, with a mortality of 163 or 5.2 per cent); reports by J.M. Baynham and F. Ryland, quoted in Committee of Physicians and Surgeons, *Report on Public Health in Birmingham* (Shannon: Irish Universities Press, 1971 (orig. pubn 1841), pp.199-200.

[137] Marland, *the Doncaster Dispensary*, p. 46; Graham A. Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne, c. 1750-1850' (unpublished PhD thesis, Newcastle, 2013) pp. 177-199.

of the early nineteenth century.[138] As an instance, Darwall used his 1823 paper to report the case of a young girl who had scarlet fever, followed by persistent back pain and a tender left kidney, who was also passing dark-coloured urine. Darwall detected protein in the urine, leading him to diagnose nephritis, a condition of great interest during this period.[139] Contemporary practitioners were also interested in the exotic treatment called 'acupuncturation'; used by Darwall in 1822 for rheumatic arm pain. Finally, Darwall is recognised as a pioneer in 'diseases of artisans.' In 1823-4, Darwall noted that four out of 19 patients with chronic bronchitis worked in dusty workshops (in metalworking or pearl-button grinding).[140] With his dispensary colleagues, he attempted to investigate occupational diseases among 500 dispensary patients in 1829-30, although inferences were limited by deficiencies in the medical records. Nevertheless, among 68 individuals with consumption (tuberculosis), fourteen (including twelve followed employment that was thought to contribute to their illness. Most years' reports included a few cases of 'painter's colic' (lead poisoning), among decorators, plumbers, and metal workers in contact with lead compounds.[141] For comparison, the Poor Law surgeons' statistics for Birmingham during the 1830s included 6642 with pulmonary diseases (evidently

[138] It should be noted that pathological investigation in this period was mainly autopsy, in the dispensary context being conducted in the patient's home; a surely distressing and unpleasant (and as we now understand, risky) process for the family; see W.F. Bynum, W.F., *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), pp.25-40, 55-72; Christopher Lawrence, *Medicine in the Making of Modern Britain, 1700-1920*, 2nd Ed (London: Routledge, 2006), pp. 1944, 1952; Darwall's contemporaries highlighted his skill with the recently introduced stethoscope and his use of the microscope; Reinarz, 'John Darwall', *ODNB.*

[139] When her urine was gently heated a 'coagulable' deposit of albumen developed. Darwall's findings resembled those published by the much better-known Richard Bright of Guys Hospital, the condition becoming known as Bright's disease; Darwall, 'Diseases of Birmingham', *EMSJ* 20 (1823), p. 179.

[140] Darwall, 'Diseases of Birmingham', *EMSJ,* 21*,* 1824 pp. 485-6.

[141] BGD Annual Report 1828-9; Ward, Medical Cases in the Birmingham Dispensary', *Trans PMSA* 5 (1837), 405-22.; T. Ogier Ward, 'A Report of Cases Treated at the Birmingham Dispensary 1837-8', *Trans PMSA,* 6 (1838), 429-46 . His papers largely follow a standardised format, as recommended by a PMSA committee; Charles Cowan, 'Introductory Observations to a Proposed Plan for the Reports of Infirmaries and Dispensaries', *Trans PMSA,* 6 (1838), 107-22.

often resulting from current or former occupations), of whom 308 (4.6 per cent) died. Ward's dispensary statistics of the 1830s are included in table 8 and include more demographic detail than most previous publications. [142] The dispensary patients are shown to be predominantly young and middle-aged adults (67 per cent being aged between 30 and 60) and 65 per cent of them were female. Ward remarked that many suffered from chronic diseases, although they only received intermittent attention from the dispensary. Ward carefully followed up former patients when no longer eligible for dispensary treatment; hence his relatively high reported mortality rates (in his two papers, respectively 9.74 and 6.84 per cent of those treated). In comparison, the age distribution of Newcastle dispensary patients was similar to Ward's reports, while females there comprised 53.6 per cent of total patients.

Marland remarked of working men in Huddersfield and Wakefield that they were considered 'sturdy' and self-reliant. This supposition was used to explain why they appeared reluctant to seek the necessary recommendations for hospital or dispensary treatment; they were, however, happy to self-medicate or to consult unorthodox practitioners (or indeed, do both).[143]

[142] Thomas Ogier Ward, 1803-79, MD Oxford 1834, is a rather obscure figure; he practised in and near Wolverhampton, including in the severe cholera outbreak there in 1832; after his work as a physician in Birmingham c.1835-1838, he moved briefly to Shropshire, and eventually settled in Kensington.

[143] Butler, 'Medicine and the Urban Poor in Newcastle', p.161; Marland, *Medicine and Society in Wakefield and Huddersfield*, p .206.

Table 8: Diseases at the Birmingham General Dispensary 1822-63									
Date (year(s) covered)	**1822**	**1823**	**1828-9**	**1835-6**	**1837**	**1840**	**1846**	**1853**	**1863**
Months in sample	**12**	**6**	**12**	**15**	**12**	**12**	**12**	**12**	**12**
Source (also see below)	Darwall 1822 & 1823	Darwall 1824	Annual Report (text)	Ward, 1837	Ward, 1838	Ann. Report (text)	Ann. Report (table)	Ann. Report (table)	Ann. Report (table)
Diseases – *Zymotic*									
Fever unspecified	6	3	211	32		170	292	8	
Continuing fever	8	0			2				2
Diarrhoea	193	3	8	12			103	8	2
***Other* –**									
Asthma	108	7					8	6	4
Bronchitis, acute & chronic	9	4		88	8		187	268	424
Phthisis (tuberculosis)	9	1			9	211	211	257	404
Dyspepsia & gastritis	133	04	63	0	3		58	17	47
Intestinal disorders	3	5		8	7		4	0	1
Rheumatism & joint disease	0	5	5	0	0		16	6	24
Percent female					65%				
Deaths			120 (3.87)	57 (9.74%)	31 (6.84%)				
Total patients in series	1068	1013	3097	585	453	2979	3075	3086	5718

Sources: John Darwall, 'Diseases of Birmingham' in *Edinburgh Medical and Surgical Journal* 19 (1822), 631-3, 20 (1823), 157-9, 316-9, 21(1824), 226-8; J. Ogier Ward, 'Report of Medical Cases in the Birmingham Dispensary', *Trans. Provincial Medical and Surgical Association* 5 (1837), 405-22, and 6 (1838), 429-46; Birmingham General Dispensary Annual Reports for 1828-9, 1840, 1846, 1853 and 1863

At the Coventry Provident Dispensary, local newspaper summaries of annual reports also became more detailed, while the pattern of diseases (table 10) resembled the Birmingham experience. Both here and in Birmingham, stomach and bowel ailments formed the largest category (tables 8 and 10). Of these the commonest was 'dyspepsia'. Ogier Ward defined this as 'uneasiness of the stomach after meals, with acidity [and] flatulence'.[144] 'Intestinal disorders' at Birmingham comprised mainly constipation and worm infestations. Diarrhoea, on the other hand, was regarded as a zymotic disease, mainly affecting young

[144] Ward, 'Medical Cases in the Birmingham Dispensary', p.415

children. In Coventry, the weavers' long hours at the loom had various effects on their health. They were particularly prone to digestive disorders, which affected 'two in every five' of them attending the dispensary (in contrast with the 'hardier' dyers). Their constrained working position, the 'want of air… and the frequent over-exhaustion' all seemed injurious.[145] In a local lecture, the dispensary surgeon Charles Nankivell described how he 'witnessed the effect of anxiety and depression of mind on the public health'. The periodic slumps in the silk trade typically 'caused an immediate increase in the number of dispensary patients. This occurred long before 'privation of food and comforts' could operate. The stomach symptoms, therefore, seemed to arise largely from anxiety arising from the uncertainty of the weavers' lives. In Manchester, the dispensary practitioner Dr James Kay observed the high prevalence of digestive symptoms among cotton workers, which he attributed to hurried, poor-quality meals; later historians have also pointed to the adulteration of everyday foods common in the era.[146] Nineteenth-century medical men reported rising numbers of digestive complaints, which they often linked with nervous disturbances. Observations of this sort have led some recent scholars to revisit the era's preoccupation with the stomach and its implications for general health. Stomach disorders were seen as embodying corporeal responses to modern life, indeed being emblematic of the state of the nation.[147]

[145] Evidence by C.B. Nankivell; quoted by Fletcher, *Assistant Commissioners' Reports* (*Handloom Weavers Commission),* pp. 300-1.
[146] James P. Kay, *The Moral and Physical Condition of the Working Classes Employed in the Cotton Manufacture in Manchester* (1832), p.22, cited in Pickstone, *Medicine and Industrial Society*, p. 55; for food adulteration, F. Barrymore Smith, *The People's Health, 1830-1910* (London: Croom Helm, 1979) pp. 208-14.

Table 9: Coventry Provident Dispensary: patient statistics 1831-58

Ar	Members (% of last census population)	Cases	Home visits	Midwifery cases	Deaths
1831		1500		10	19
1832	2280 (8.4%)	2437		55	30
1833		1668		52	20
1834		1624	778	47	27
1835		1500		41	17
1836		1610		53	28
1837		1382		31	26
1838		1638		48	34
1839		1921		39	39
1840		2001		51	37
1841		1772		39	28
1842		1773		40	29
1843		1847		61	22
1844	2400 (7.79%)	2128	550	61	39
1845		2135	400	67	33
1846		2193		50	27
1847		2044		50	35
1848		1878		30	49
1849		2060			39
1850		1795			32
1851		1664		52	28
1852		1788			28
1853		1912	549	28	35
1854		2287	720	35	57
1855		2445	816	29	64
1856		2654	643	25	53
1857		2927	852	48	
1858	4500 (10.9%)				
Source: CH Bracebridge, 'Notes on Self-Supporting Dispensaries', pp. 462-3.					

The prevalence of chest disease, tending to rise over time at both Birmingham and Coventry dispensaries, reflects environmental conditions in a direct way. In the medical sections of annual reports, atmospheric states in some years were often cited as contributing to higher levels of bronchitis and other chest diseases. The increases over time seem very likely to be linked with air pollution, resulting from both the coal fires associated with increasing urban density and growing numbers of steam-powered factories.[148]

Table 10: Coventry Provident Dispensary -- Disease Statistics and Outcome 1834-60

Year	1834-35	1839-40	1844-45	1849-50	1854-55	1859-60
Total cases	1629	1921	2128	2004	2207	3523
'Cured' (%)	1454 (89)	1744 (91)	1941 (91)	1920 (96)	2059 (93)	3073 (87)
Died (%)	27 (1.7)	39 (2)	39 (1.8)	49 (2.4)	35 (1.6)	68 (1.9)
Continued fever (%)	170 (10.4)	68 (3.5)	149 (7)	82 (4.1)	97 (4.3)	115 (3.2)
Chest disease	275	231	339	216	325	354
Digestive disorders	497	698	570	254	313	607
Diarrhoea				276		282
Source (*Coventry Herald* -- date)	30 April 1835	24 April 1840	9 May 1845	25 April 1850	4 May 1855	11 May 1860

[148] Ian Miller, *A Modern History of the Stomach: Gastric Illness, Medicine and British Society, 1800-1950* (London: Pickering and Chatto, 2011), esp. pp. 9-10, 18-19.

For the Coventry General Dispensary, the city's purely charitable institution, less is known concerning the diseases treated, as local newspaper report of meetings included much less detail. The death rates (in relation to admissions) are considerably higher than experienced at the Provident Dispensary in the 1830s, ranging respectively from 2.5 to 4.4 per cent, as against 1.7 to 2.2 per cent (tables 10 and 11).

Table 11: Coventry General Dispensary: annual report statistics 1833-39

Year	1833-4	1834-5	1836-7	1837-8	1838-9
Admissions	595	598	639	658	632
'Cured'	320	328	347	360	308
Died	15	21	25	27	28
Mortality %	2.5	3.5	3.9	3.8	4.4
Surgical		147		186	
Vaccination	11	44	114	504	56
Comments					297 visits
Source	*CH* 10 Oct 1834	*CH* 2 Oct 1835	*CS* 13 Oct 1837	*CS* 14 Oct 1838	*C*S 11 Oct 1839

CH - Coventry Herald; CS - Coventry Standard

Treatment at the General Dispensary required a recommendation from a subscriber, based on 'neediness', while provident dispensary members were automatically covered for all treatments. The latter were probably healthier in general (and, perhaps, younger), as the structure of the membership fees encouraged joining when in good health.[149]

[149] At the Coventry Provident Dispensary, to join when sick required either an additional 10s payment, or the entry of two healthy individuals at the same time; see Bigsby's pamphlet (quoting notes from Dr Arrowsmith) in John Bigsby, *A Brief Exposition of those Benevolent Institutions Denominated Self-supporting Dispensaries* (Newark: Ridge, 1832), p. 39.

A predominance of mild conditions may explain why the proportion of home visits was relatively low.[150] About 90 per cent of those treated at the Provident Dispensary were deemed 'cured' after treatment as against around half at the General Dispensary. This may suggest that their general health of the latter was worse overall, and impaired by chronic illnesses; they seem likely on average to be older and perhaps also poorer.

Treatments at the Dispensaries

Dispensaries provided medication as their principal form of treatment (as, of course, their name implied). At Birmingham the dispenser played a key role in daily institutional life, being required to prepare medicines accurately, and to maintain general tidiness, opening and closing the premises.[151] At Coventry, as in other provident dispensaries, the dispenser also acted as clerk, collecting contributions from members, and rendering these to the committee. The Birmingham and the Coventry dispensaries each employed a housekeeper and either a 'dispenser's boy' or a 'surgery boy', presumably carrying out errands and simple tasks.

Early experimental therapy at the Birmingham dispensary included observations in the 1790s on 'factitious airs' or medical gases**.** This arose from connections developed between local practitioners**,** Lunar Society members and Thomas Beddoes, the Bristol-based physician-chemist and political radical.[152] Boulton and Watt's firm manufactured the relevant equipment for the dispensary (and for practitioners elsewhere). Apart from one asthmatic patient who was aided by oxygen, little is known about the extent or effects of such

[150] Loudon suggested that a dispensary's home visits would typically form one-third of the total attendances, but only in 1855 (Table 5) did the Coventry figures match that proportion. In other years they ranged from 19% to 29%; Loudon, 'Origins and Growth', p. 329.

[151] BAH MS 1759 1/1/1, 1 November 1799

[152] Trevor H. Levere, 'Dr Thomas Beddoes (1760–1808) and the Lunar Society of Birmingham: Collaborations in Medicine and Science', *Journal for Eighteenth-Century Studies,* 30 (2007), 209-26.

treatments.[153] In the 1820s, John Darwall's reports mention clearing the bowels with castor oil, or sometimes relying on calomel (a mercurial compound) both as a purgative and a panacea for fevers and other disorders; occasionally Darwall also employed cinchona bark. Intestinal worms were treated with turpentine.[154]

Bleeding and cupping were also frequent dispensary treatments, especially in the earlier days. Generalised depletion by removing large quantities of blood gradually gave way to its localised release, using bloodsucking leeches or cupping.[155] In the latter, glass or porcelain cups were applied to the skin and the oxygen evacuated with a flame. 'Closed' cupping produced disc-shaped bruises intended as counter-irritation, while in 'open' or 'wet' cupping blood was released into the cup through a small incision. By the mid-nineteenth century, most medical opinion regarded these methods as outdated, suitable only for occasional use.[156] Nevertheless, the lay public continued to seek such treatments (which survive today as folk or 'alternative' therapies). [157]

All the dispensaries provided surgical as well as medical treatment. During the first two years of the Coventry Provident Dispensary, its surgeons performed a thigh amputation and operated on two strangulated hernias and two cataracts.[158] In Birmingham in 1837, Mary Darby, a schoolgirl of twelve years, developed a severe sore throat and breathing difficulties (the clinical

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[153] MS 1759/1/2/1, 12 December 1794 Medical committee: 'resolved that the pneumatic apparatus be put up immediately'; those involved were the dispensary surgeon John Barr and the physician John Carmichael; see Thomas Beddoes and James Watt, *Considerations on the Medicinal Use of Factitious Airs: And on the Manner of Obtaining Them in Large Quantities* (London: Bulgin & Rosser, 1794).
[154] Darwall, 'Diseases of Birmingham', Darwall, (1822), p.632, 20 (1823), p. 319,
[155] Darwall's preference for this approach is expressed in Darwall, 'Topography of Birmingham', p.140
[156] BGD Annual Reports, 1829-30, 1853; J. L. Turk and Elizabeth Allen, 'Bleeding and Cupping', Annals of the Royal College of Surgeons of England 65 (1983), 128-31
[157] White's Warwickshire Directory for 1850 lists 'bleeders with leeches', and 'cuppers'; J Randle Thompson, dispenser at the Dispensary 1800-- c.1832 but then in independent business, appears as both 'druggist' and 'cupper'.
[158] Arrowsmith, 'Progress of the Coventry Self-supporting dispensary', p.234

picture of diphtheria). Dr Ogier Ward summoned his surgical colleagues in the small hours to perform a tracheotomy, but despite this desperate measure, she died within hours.[159] However the treatment of most 'surgical' patients was much less dramatic, mostly comprising the provision of dressings, trusses, or stockings, rather than invasive surgery. At Birmingham, there were 256 such cases n 1853 and 207 in 1863 (forming respectively 8.2 and 3.6 per cent of the total numbers). Loudon has shown that managing leg ulcers was a major task for early nineteenth-century dispensaries and infirmaries, forming between 20 and 50 per cent of their surgical cases.[160]

Preventive Medicine and Public Health

The Birmingham dispensary offered vaccination from 1801, three years after Jenner's publication demonstrating the prevention of smallpox through the administration of cowpox material. In September 1800 the physician Dr Robert Bree discussed this still unfamiliar treatment with his colleagues and shortly afterwards at a general meeting of subscribers. He admitted that the procedure carried risks, but that these were much less than the natural disease (or indeed of traditional inoculation).[161] The honorary surgeons held vaccination sessions twice weekly from the start of 1801, mostly among infants (the procedure later being delegated to the house surgeons). The numbers attending steadily increased, despite the need to revisit the dispensary to ascertain that the procedure had produced a local skin response, or 'taken'. In 1819, when smallpox was 'extremely prevalent' locally, the medical committee noted 'the prejudices of the poor' regarding vaccination. By 1838, however, the public

[159] T. Ogier Ward, 'A Report of Cases Treated at the Birmingham Dispensary 1837-8', *Trans PMSA* 6 (1838), 429-46, pp.439-40.
[160] Irvine S. L. Loudon, 'Leg Ulcers in the Eighteenth and Early Nineteenth Centuries', *The Journal of the Royal College of General Practitioners* 31 (1981), 263–73, p.264.
[161] The older technique of inoculation or variolation used matter collected from the blisters of a smallpox patient. Robert Bree (1759-1839) was a physician at the Dispensary c.1796-1805 and at the General Hospital 1801-06. Then he moved to London, where he gained office in the Royal College of Physicians and served at the National Vaccine Exchange, a government-funded body for coordinating vaccination. BAH MS 1759, BGD general minutes 29 Sept 1800, Special General Meeting 13 Oct 1800; Grant and Lane, 'Robert Bree', *ODNB.*

were said to have developed a 'just confidence in the measure'.[162] From the early nineteenth century, both general dispensaries and specialised institutions (several in London, a few in other towns) gave large numbers of vaccinations, mostly to young infants.[163] Other providers in Birmingham that became involved included the General Hospital, and later the Poor Law medical service, following the first Vaccination Act of 1840 (table 11). In Birmingham by the 1820s slightly more than half of the infants born were probably covered, but the Coventry statistics were less impressive (with annual figures of 37-114 at each of the two dispensaries).[164]

Table 12: Vaccination at the Birmingham General Dispensary 1801-1860

Decade	Number vaccinated at Dispensary	Vaccinated elsewhere
1801-10	7970	
1811-20	6706	
1821-30	14410	1821 General Hospital – 905
1831-40	27456	
1841-50	16620	From 1841 Poor Law service –1481 that year
1851-60	14789	

The demographic historian, Peter Razzell, has written extensively on smallpox and its significance. He argues that the large numbers inoculated or vaccinated at dispensaries, especially in London, were sufficient to reduce overall population mortality. Razzell also suggested that dispensary practitioners may have encouraged higher levels of personal hygiene among the poor. Professional ideas and practice were influenced by authorities on naval and military medicine, including Sir Giilbert Blane, James Lind and Sir John

[162] MS 1759/1/1/1 Medical Committee, 10 December 1819; BUSC R911 BGD Annual Report 1838.
[163] Deborah Brunton, The Politics of Vaccination: Practice and Policy in England, Wales, Ireland and Scotland, 1800–1874 (Rochester: University of Rochester Press, 2008) p.13
[164] Coventry Dispensary Annual reports (newspaper summaries), 1832-40.

Pringle, who from the middle eighteenth century advocated increased ventilation and habits of cleanliness, for everyone but especially among the sick. Razzell quoted the London dispensary physicians J.C. Lettsom and R. Willan, the first claiming that his dispensary's work had spread an appreciation of the benefits of improved hygiene, while the latter was much more sceptical.[165] More recent research (using additional data) confirmed that vaccination reduced smallpox mortality in London, while the earlier practice of inoculation had little effect.[166] Perhaps disappointingly, other scholars do not appear to have revisited Razzell's argument concerning education in personal hygiene.

'Public health' of course extended well beyond individual treatments. From their origins, dispensaries, or rather their medical officers, were concerned with poor living conditions and the resulting impaired health. However, this was often a concern of individual practitioners rather than a corporate vision; the Birmingham dispensary, for instance, hardly mentions public health in its annual reports. Dispensary physicians had commonly studied at Edinburgh, where Cullen and his successors emphasised the environment as a leading cause of disease.[167] The published accounts of such practitioners, together with those of Poor Law colleagues, gradually influenced public opinion in favour of legislation and local action. John Darwall offers early examples in his papers describing conditions in Birmingham during the 1820s.[168] Two decades later, national bodies addressing public health drew on reports by many local practitioners. In Birmingham most members of the 'Committee of Physicians and Surgeons' including its chairman, Joseph Hodgson, were current

[165] Peter E. Razzell, ''An Interpretation of the Modern Rise of Population in Europe' - a Critique', *Population Studies* 28 (1974), 5-17, for effects of vaccination, see pp. 10-11; for more general benefits pp. 12-14.
[166] Romola Davenport, Jeremy Boulton. and Leonard Schwarz, 'Urban Inoculation—A Reply to Razzell' *The Economic History Review* 69 (2016), 188-214.
[167] Christopher Hamlin, 'State Medicine in Great Britain', in *The History of Public Health and the Modern State,* ed. by Dorothy Porter (Amsterdam Altlanta, Ga: Rodopi, 1994), 132-64, pp. 135-7; M. W. Flinn, Editor's Introduction, Edwin Chadwick, *Report on the Sanitary Condition of the Labouring Population of Great Britain* (Edinburgh: University Press, 1965), pp. 19-25.
[168] e.g. John Darwall, 'Report of Diseases of Birmingham, July -- October 1822', *EMSJ* 19 (1823), 157-62; Darwall, 'the Medical Topography of Birmingham', pp. 107-12.

or former dispensary medical officers.[169] Despite the evident flaws in Birmingham's fabric, they expressed a broadly optimistic view of the town; despite certain insalubrious localities, most of its inhabitants were well housed and well nourished, and fevers were uncommon. A further report in 1849 was intended as a prelude to sanitary action. By then the tone of the medical evidence, from Joseph Hodgson and James Russell, was much more critical. Both surgeons, close friends from their apprentice days, were then acting as unpaid public health medical officers. They pointed to the poor drainage and ventilation of some courts, abundant 'nuisances' and the appalling state of the River Rea.[170]

During the 1840s Coventry practitioners also reported on medical concerns to public bodies. The city's unmodernised ancient fabric meant that the living conditions of the poor were particularly cramped and crowded.[171] As Arrowsmith and his colleagues reported, fever was commonest among those living close to the slow-flowing and polluted River Sherbourne. Outbreaks of influenza, measles, scarlet fever, and diarrhoea caused a high mortality. The last named had caused fifty deaths among the 330 workhouse inmates in January 1838. In 1849, the engineer William Ranger's report quoted, among others, Edward Bicknell (both a dispensary and Poor Law medical officer). He described

[169] Committee of Physicians and Surgeons, *Report on Public Health in Birmingham*. The committee reported both to the Select Committee on the Health of Towns in 1840 and Chadwick's commission in 1842.

[170] Robert Rawlinson, Report to the General Board of Health on a Preliminary Inquiry into the Sewerage, Drainage, and Supply of Water, and the Sanitary Condition of the Inhabitants of the Borough of Birmingham (London: W. Clowes & Sons for H.M.S.O., 1849); the medical officers' reports were on pp. 82-97. Hodgson and Russell were Dissenters, respectively Quaker and Unitarian. They first met in 1805 while apprentices to local surgeons; see Rachel Franklin, 'Medical Education and the Rise of the General Practitioner, 1760-1860' (Unpublished PhD thesis, Birmingham, 1950), pp. 64-69. The author is better known as Dame Rachel Waterhouse (1923-2020), historian and consumer champion. The two surgeons seem likely to have been largely motivated by their religious convictions in this unpaid work, both tedious and unpleasant. See also Cawood and Upton, ' Birmingham and the Cholera Pandemic of 1832', pp. 113-14.

[171] J. R Martin, 'Part ii Appendix: Coventry: Report on Its Sanatory Condition', in *Royal Commission on the State of Large Towns and Populous Districts,* ed. by Duke of Buccleuch and HM Commissioners (London: W. Clowes & Co for HMSO, 1844), 258-66, pp. 259-60.

several central streets as 'the seats of epidemic, endemic, and other contagious diseases'.[172] By 1854 he and other medical men could be more positive regarding local sanitary policy, praising the contemporary efforts of the civic authorities.[173] By his retirement in 1872, Bicknell felt able to commend the great reduction in infectious disease resulting from sanitation and housing improvements over the previous two decades.[174]

Cholera and the Dispensaries

Cholera deserves special consideration, starting with its arrival in Britain from Asia late in 1831. This appeared as a 'shock disease' that could bring to the surface 'latent social antagonisms', especially as the epidemic coincided with the lengthy political crisis associated with the Reform Bill.[175] The dispensaries participated in local responses to the disease, from relatively early in the first national epidemic in 1831-32. In November 1831 national authorities (the Privy Council) required every parish, or group of parishes, to appoint a board of health. Birmingham had a small board with eight members, led by the scientist-industrialist Samuel Tertius Galton.[176] There was a separate medical committee chaired by Dr J. K. Booth, of the General Hospital, with Dr J.R. Corrie and J.M. Baynham of the General Dispensary as secretaries.[177] The authorities in Coventry took a different approach. They dealt with any residual antagonisms from recent conflicts (over the dispensaries and more general reform) by including all possible viewpoints in the Board, chaired by Dr E. Bourne.

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172 William Ranger, *Report to the General Board of Health on a Preliminary Enquiry into the Sewerage, Drainage, and Supply of Water, and the Sanitary Condition of the Inhabitants of the City of Coventry* (London: W Clowes & Co for HMSO, 1849). The report quoted three Poor Law doctors (including the dispensary practitioner Edward Bicknell, pp. 5-6). Over 12 months the provident dispensary had attended 251 cases of fevers and diarrhoea, 13.9% of its total cases (Dispensary Annual Report 1848-9).

173 Annual meeting report, Coventry Provident Dispensary, *Coventry Herald*, 5 May 1854

174 'Mr E. Bicknell's presentation', *Coventry Standard*, 25 October 1872

175 R. J. Morris, *Cholera 1832: The Social Response to an Epidemic* (London: Croom Helm, 1976), first quote, p.14; Michael Durey, *The Return of the Plague: British Society and the Cholera, 1831–2* (Dublin: Gill & Macmillan, 1979), second quote, p.1.

176 Cawood and Upton, 'Birmingham and the Cholera Pandemic of 1832' pp. 1107-8.

177 'Medical Board of Health', *Aris's Birmingham Gazette*, 21 November 1831.

Members included the entire city council, every clergyman, every medical man, and sundry worthies, a total of 80 members.[178] Unsurprisingly this unwieldy body met rarely, but the city appeared somehow to cope with the local outbreak. In Birmingham, the surgeons of the (Poor Law) Town Infirmary urged householders to clean and whitewash their dwellings and exhorted the 'Poorer Classes … to be clean in their persons'.[179] Later the Medical Board warned against the 'unwholesome practice, so common in this town, of making manure heaps and having pigsties close to habitations'.[180] In Coventry, the surgeons of the Benevolent Dispensary (an early name for the self-supporting institution) urged the removal of 'accumulations of refuse matter near dwellings'.[181] Everywhere people were warned against consuming raw fruit, undercooked vegetables, and especially, ardent spirits. Local boards generally lacked the sanctions that could have enforced hygienic measures, but they managed to mobilise medical assistance through temporary hospitals and *ad hoc* dispensaries.[182] Dispensaries made their services available to any local inhabitants, without payment or other formalities; their practitioners also served as medical officers, treating cholera victims, and offering advice to the Boards of Health.[183]

The epidemic and the associated sanitary precautions overlapped, however, with heightened political tension and popular concern about body snatching and anatomising. In cases with a fatal outcome, the swiftness of decline could arouse suspicions of poisoning, directed both at the authorities and at medical practitioners. Thus, in Birmingham, the death and rapid burial of the workhouse inmate John Britton on 13 August prompted a riot in which his

[178] 'Board of Health', *Coventry Herald*, 15 June 1832
[179] Notice, *Aris's Birmingham Gazette*, 14 November 1831.
[180] 'Medical Board of Health', *Aris's Birmingham Gazette*, 3 July 1832.
[181] Notice, *Coventry Herald*. 30 December 1831.
[182] Durey, The Return of the Plague, p. 42.
[183] Twelve small dispensaries were established across Birmingham, often in shops, where people could obtain suitable medicines free of charge; a temporary fever hospital was created in the public baths in Bath Row, near the later Queen's Hospital; Cawood and Upton, 'Birmingham and the Cholera Pandemic of 1832', pp. 111-12.

coffin was disinterred, and a crowd of hundreds of people attacked the workhouse. The recent establishment of a local medical school, where the surgeon William Sands Cox conducted anatomy classes and dissections, added to the tensions. Eventually Birmingham experienced 31 cases and 21 deaths in 1832, while Coventry had 41 cases and 18 deaths.[184] In 1848-49, in a less highly charged atmosphere, there were 35 deaths in Birmingham and Aston and 202 in Coventry.[185] The relatively heavy death toll in Coventry in the mid-century outbreak influenced local opinion in seeking much-needed sanitary improvements there.[186]

Poverty became a concern of the dispensaries, especially as regards the plight of sick breadwinners earning no wages, such circumstances being a result as well as a cause of illness. The Coventry Provident Dispensary in its first year established a 'ladies' committee' that was reappointed at annual meetings. Those who took part, presumably mainly from the households of the honorary members, visited sick individuals at the request of medical officers, providing linen, meat, and broth. Such female associations were, unsurprisingly, often associated with lying-in charities but also with some dispensaries and infirmaries.[187] It was common for women of the wealthier classes to visit poor families, especially when sick; some such visits would be performed on behalf of the dispensary.[188] At Birmingham in 1843, the dispensary subscribers

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[184] Tina Young Choi, 'Cholera Returns in Great Britain (1832)', in Michelle Allen-Emerson, Christopher Hamlin, and Tina Young Choi (eds), *Sanitary Reform in Victorian Britain,* 1 (London: Pickering & Chatto, 2012), 45-65

[185] Wiliam Farr, *Report on the Mortality of Cholera in England, 1848-49* (London: W. Clowes & Co, 1852), p.157.

[186] Repeated local petitions begged for sanitary improvements, prompting the City Council to approach central authorities, e.g. 'The Public Health Act', *Coventry Herald,* 18 January 1849. .

[187] Birmingham, Coventry, and some smaller towns established lying-in charities as noted in Badger, 'Delivering Maternity Care', pp.113-8; elsewhere, the Ladies' Committee in Wakefield was particularly active; Marland, *Medicine and Society in Wakefield and Huddersfield,* pp. 163-71

[188] Frank Prochaska, *Women and Philanthropy in Nineteenth-century England* (Oxford: Oxford University Press, 1980); favoured by Evangelicals and Dissenters, pp. 8-11; oversight of charities, especially domestic arrangements, pp.141-3; see also Badger, 'Delivering Maternity Care', pp. 27, 52, 106.

established a new committee 'for the relief of destitution', which was all-male and usually included several clerical members. In 1853 the fund was commended as 'useful' by the medical officers.[189] The amounts dispensed through these channels were modest, being just under £15 at Coventry in 1843 and £30 at Birmingham in 1844. At Birmingham assistance was soon provided through tickets linked with named suppliers. The £55 disbursed in 1863 included £22 for wine and spirits (by then considered useful for treating inflammation).[190]

Professional Education and Medical Careers

Medical teaching (initially on a small scale) was established at an early date at dispensaries, in 1776 in Edinburgh and in 1783 at Carey Street in London.[191] Medical education became a formal responsibility in early nineteenth-century dispensaries in London, in Scottish centres, and in several English provincial towns. Their use as educational sites was stimulated by the 1815 Apothecaries Act, which required attendance at a recognised hospital or dispensary for six months (in 1824 increased to nine months and in 1830 fifteen months). In 1834 there were fifteen London and fourteen provincial dispensaries associated with medical schools.[192]

The story of organised medical teaching at Birmingham is usually considered to start in 1825 when the young surgeon William Sands Cox commenced a series of lectures at his home in Temple Row (which he shared with his father, the surgeon Edward Townsend Cox). In 1828, with the approval of his seniors, Sands Cox launched a medical school, the teaching to be given by clinicians at the General Hospital, the General Dispensary, and the Town Infirmary. The Cox family constructed a new building at Snow Hill (the location of the present railway station). Dispensary staff appointed as lecturers included

[189] BUSC R 911, BGD Annual Report 1843 p.9; Annual Report 1853, Medical Section, p.7
[190] BGD Annual Report: Report of Relief Committee, 1863.
[191] Zachary Cope, 'The Influence of the Free Dispensaries Upon Medical Education in Britain', *Medical History* 13 (1969), 29-36 p.30
[192] Cope, 'Dispensaries and Medical Education', pp. 32, 34

Sands Cox himself (anatomy), Dr John Eccles (*materia medica*), and John Ingleby (midwifery and diseases of women and children). From 1829 Dr John Birt Davies lectured on forensic medicine and George Elkington offered anatomical demonstrations.[193] As at other teaching centres, they offered lengthy courses of lectures (between 60 and 140 each).[194] Otherwise, little is known of the teaching methods used, other than references in the prospectus to students 'following the practice' of the dispensary.[195] In 1836 the school became the 'Royal School of Medicine and Surgery' and in 1843 became part of the new Queen's College. Queen's Hospital opened in 1841 near the boundary of Edgbaston; this was a new foundation associated with the college and soon became the principal teaching hospital. With such developments, teaching at the dispensary seems likely to have declined, encouraged by ever-stricter regulations by the Royal College of Surgeons that required attendance at hospitals rather than dispensaries as a precondition for the MRCS examination of the College.[196]

What part did dispensary service play in medical careers? The posts could act as stepping-stones to more prestigious appointments at voluntary hospitals, but other career paths are also worth considering.[197] Although not often discussed in the period, the large number of patients treated at dispensaries must have helped to hone the skills of their medical officers, and not only of the house surgeons who were mostly at the start of their careers. Several individuals are mentioned here, selected to illustrate the variety of career patterns. They were identified from dispensary annual reports, and both local and medical directories were also consulted. Of the nineteen honorary physicians and surgeons identified at the Birmingham General Dispensary

[193] Davis also became the first medically qualified Coroner in Birmingham in 1839.
[194] Jonathan Reinarz, *Health Care in Birmingham: the Birmingham Teaching Hospitals, 1779-1939* (Woodbridge: Boydell, 2009), pp. 54-55.
[195] J.T.J. Morrison, *Wlliam Sands Cox and the Birmingham Medical School* (Birmingham: Cornish Bros, 1926), pp. 22, 25-7.
[196] Jonathan Reinarz, 'Towards a History of Medical Education in Provincial England', *Medical History Bulletin (Liverpool Medical History Society)* 17 (2006), 30-37.
[197] Reinarz, Health Care in Birmingham, p. 57.

during 1820-60, fourteen later held similar posts at either the General or Queen's Hospitals.

Nearly all the surgeons were also general practitioners, describing themselves as such in the *Medical Directory* and elsewhere. They could combine their relatively light duties at the General Dispensary with work at other institutions, such as those established to treat bodily regions or categories such as women and children. Certain dispensary staff seized such opportunities. For instance, Martin Shipton was an honorary surgeon in the 1830s, while also serving at the Town (Poor Law) Infirmary and the Institute for Bodily Deformity, later known as the Orthopaedic Hospital. The latter institution was indeed based for a time in his house in Newhall Street. By 1847 he was in practice at Clevedon in Somerset. Frederick Ryland (MRCS 1827, FRCS 1844) became senior surgeon to the Eye Infirmary as well as writing a treatise on the larynx. His Unitarian co-religionists probably provided a basis for his private practice; in 1851 he was living at Frederick Road, Edgbaston, as the next-door neighbour of Richard Tapper Cadbury, the patriarch of that Quaker trading and manufacturing family. Some of the resident staff can be traced through directories, such as Edward Clarke (MRCS, LSA 1831). He was resident surgeon in 1840, and later practised in Meriden, near Coventry; he became bankrupt when his practice failed and died early. John Carter (LSA 1832 MRCS 1843) was a resident and then senior resident for a total twelve years. In 1846 his 'zealous and efficient' performance of his duties was recognised by the managing committee with a gratuity of £100. Soon afterwards he was in practice in Edgbaston, but continued an association with the dispensary, later becoming a dispensary governor and a trustee.

The addresses of dispensary medical officers, as noted in directories, give clues to some of their social and financial circumstances. Most of the honorary staff at the Birmingham dispensary, up to around mid-century, lived in a small number of the prosperous central streets. These included Temple Row, Colmore Row and New Hall Street, all within a few minutes' walk of St Philip's Square. The medical households have not been investigated in detail, but in

broad outline, their circumstances appear to resemble those practitioners in nineteenth-century Wakefield and Huddersfield who secured similar honorary posts. As in Yorkshire, those connected with prominent families were probably more likely to gain dispensary and hospital appointments, or indeed to succeed in private practice.[198] Their names include Elkington and Ryland (respectively members of Anglican and Unitarian silversmithing families), Lloyd (Quaker bankers) and Russell (Unitarian businessmen). Recurring medical family names include Amphlett, Blount, Cox, Freer, and Russell, a few of whom were already in practice in the eighteenth century. Their home addresses contrast with the poorer streets in outlying localities, where the surgeons of the self-supporting dispensaries lived among their working-class patients. Later in the century, the physicians and surgeons at hospitals and dispensaries were increasing attracted to the leafy surroundings of Edgbaston.

In the smaller town of Coventry there were fewer career opportunities, but medical officers of both dispensaries played a part in public life. The surgeons at the Provident Dispensary did not have Coventry roots or connections, which indeed was one of the objections to them. Edward Bourne, the General Dispensary physician, chaired the Board of Health in the cholera year of 1832 (as noted above), while his counterpart at the Provident Dispensary, Dr Robert Arrowsmith, became a Justice of the Peace. Arrowsmith's surgical colleague, Charles Nankivell, had strong scientific interests, lectured to the Coventry Mechanics' Institution, embraced liberal causes, and became friends with Charles Bray. He has been suggested as a possible model (alongside others) for Tertius Lydgate in *Middlemarch.*[199] In 1844, poor health prompted

[198] Marland, *Medicine and Society in Wakefield and Huddersfield*, pp. 285-301, esp. pp. 298-99.

[199] Other possibilities include Edward Clark (see above) who married Eliot's sister; his practice in Meriden failed, he went bankrupt and died in his forties. The Leeds physician Clifford Allbutt has also been suggested, and as some scholars argue, it seems plausible that Lydgate was modelled on an amalgam of several such figures. Gordon Haight and Hugh Witemeyer, *George Eliot's Originals and Contemporaries: Essays in Victorian Literary History and Biography* (New York: Macmillan, 1962), p.18; Patrick J McCarthy, 'Lydgate, "The New, Young Surgeon" of Middlemarch.' *Studies in English Literature*, *1500-1900* .10, no. 4 (1970): 805-16.

him to leave Coventry for Italy. Perhaps supported by private means, he studied at Pisa and gained an MD in 1848.[200] When in Coventry, Nankivell occupied a substantial Georgian house in Priory Row Near Holy Trinity Church. His colleague Edward Bicknell (1806-81) lived a quieter life, remaining unmarried and living modestly in lodgings in Union Street.

Conclusions

The story of the Birmingham and Coventry dispensaries reveal both a changing society and an evolving medical scene, extending in this Chapter over about seventy years. In both Birmingham and Coventry, the dispensaries came into being in troubled times, and in response to very real distresses. The initiative in Birmingham seemed largely to be prompted by the tensions of the 1790s, and especially to the urban conflict evident in the Priestley riots. The founders of dispensaries in Coventry could be seen as reacting, originally, to the poverty of the 1780s, and then several decades later to the immiseration of poorer inhabitants. In both towns, the originators were members both of local elites and of middling social groups. It seems likely that certain locally prominent individuals, such as Matthew Boulton in Birmingham or the surgeon Bradley Wilmer in Coventry, had a major influence in encouraging fellow citizens to lend support. For the Coventry foundations of 1831, Walter Hook and Henry Adams were probably significant figures but not of an equivalent stature. The voices of the working people, the intended users of the dispensaries, are hardly heard. A few names were mentioned in the medical officers' reports quoted above, although we can only guess at their opinions. An example of a public figure is the Coventry weavers' leader, Edward Goode, who in 1831 supported the principle of a dispensary (without committing to a particular version). More general (if not unanimous) approval of Coventry's new style of dispensary is

[200] Charles Nankivell (1805-86) was born in South Carolina of British parents. After suffering poor health in 1844, he resigned his post, and moved with his family to Italy, studying at Pisa. Having gained an MD degree in 1848, he settled at Torquay in Devon, where he became physician to the Dispensary and later to the Consumption Hospital.

suggested by Holland's survey in 1838.[201] However, hostility to medical institutions and practitioners was evident in the disturbances during the cholera outbreak in Birmingham, including the attack on the workhouse.202 What strength did the bitter dispensary controversy draw from the general politics in contemporary Coventry? Recent scholarship has challenged an older view that emphasised the predominance of a broadly benign paternalism in the city's social life up to about the 1830s. These revisionist interpretations focus on the many instances of conflict between the local elite and the city's artisans or those allied to them, in elections and otherwise.[203] Perhaps a mood of hostility and confrontation spread from the political and industrial arenas to the debate about medical provision. However, the new style of dispensary was originally opposed by local medical practitioners, who recruited supporters to their cause. The professional opposition may have arisen from perceived threats to their income, but may also have had other, deeper, roots. Here one could draw on the idea concept of a new sense of collective medical identity crystallising around 1830. This was argued by Brown, who adopted from Benedict Anderson the concept of an 'imagined community'. The collective self-concept of practitioners stressed the primacy of professional expertise in decisions about medical institutions (one of the points that Bourne made in letters to the press).[204] While local medical opposition around 1830 focused on the 'self-supporting' principle, elsewhere (especially in London) objections were to an excess of charity or its over-lax administration.[205]

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[201] *Coventry Herald*, 18 March 1831, Holland, *Essay on Dispensaries*, p.20.
[202] Cawood and Upton, 'Birmingham and the Cholera Pandemic of 1832', pp. 111-12.
[203] The traditional views are in Prest, *The Industrial Revolution in Coventry*, and Searby, 'Weavers and Freemen in Coventry, 1820-1861'; Searby, Paternalism, 'Disturbance and Parliamentary Reform'; they are challenged by Lopatin-Lummis, 'Coventry Political Union', esp. pp. 106-7, 113-5; Boote Powell, 'Coventry Corporation and the Myth of Paternalism', 77-97.
[204] There was nobody medically qualified among the promoters of the self-supporting dispensary; see Bourne's letter, *Coventry Herald,* 8 January 1830.
[205] Brown, *Performing Medicine*, pp.9, 120-40; Michael Brown, 'Medicine, Reform and the 'End' of Charity in Early Nineteenth-Century England', *English Historical Review* CXXIV (2009), 1354-88; Brown, *Performing Medicine,* pp.6-7, 30-40.

To turn to the governance of the dispensaries established in both Birmingham and Coventry, their policies were set by middle-class supporters, generally the wealthier and more prominent of them.[206] The composition of the governing committees reflected the Anglican and Dissenting convictions of wider groups in each town. Their politics were also diverse but seem likely to have leaned towards Liberalism, while most seem likely to have shared values prizing probity and rectitude.[207] Much day-to-day routine administration was performed by the resident medical officers and the dispensers. Especially in Birmingham in the first quarter of the century, governors and medical officers struggled for institutional power. Later in the century this would become a more prominent theme at institutions in both cities (to be discussed in Ch. 6). Both institutions had a small role in the relief of poverty (that part of it flowing directly from illness and consequent inability to work). At Coventry, like many other places, it was probably women in the households of the managing committee who played a role in these welfare relief efforts.

From the 1820s, the statements of medical officers in published articles and the relevant sections of annual reports provide indications of current epidemiology. Regrettably, after Ogier Ward's departure c.1838, later medical staff failed to match the level of detail and vividness evident in his writings or those of John Darwall. As an ironic sidelight on the clinical gaze, from both clinicians' case reports, one gains a clear picture of the sufferings of some dispensary patients.

There is sufficient evidence to suggest some evolution in the diseases treated. Continuing fever overall became less common, which may reflect a limited rise in living standards or improved levels of personal hygiene. Increases in chest disease seem likely to reflect increasing levels of air pollution, as urban densities increased, and steam engines proliferated. Stomach ailments, common everywhere but especially prominent in Coventry, may reflect the anxiety and uncertainty of ribbon weavers' lives. During the 1840s, the clinical

[206] As Morris suggested; Morris, 'Voluntary Societies and British Urban Elites', p.113.
[207] Hilton, *Age of Atonement*, pp. 7-8.

experience of the medical officers, in parallel with their Poor Law colleagues, informed reports to the bodies concerned with urban public health. The best-known of these was Chadwick's commission of 1842, which gave prominence to the report from practitioners in Birmingham. Near the end of the decade, similar reports to sanitary engineers underlay the mid-century urban changes in water supply and sewage arrangements.

To sum up their role and importance, the dispensaries in both large towns were significant institutions that provided much medical care; they played a part in medical education and provided advice to local and national authorities on public health; acting as sites for in-service training, they were significant in medical careers. Up to about mid-century, dispensaries could offer up-to-date treatment and provide suitable settings for medical education. From this point hospitals would dominate medical teaching and research as well as becoming a more popular source of everyday medical attention for patients.

Chapter 3

'Medical Advice and Remedies' in a country town: the Stratford-on-Avon Dispensary and Infirmary, 1823 -*c.*1860

> A Public Dispensary [in Stratford-on-Avon] for supplying the sick with advice and medicines is liberally supported; its objects being materially assisted by a Benevolent Society, the members of which (ladies) visit the poor and provide them with the comforts needful in sickness**.** [1]

Introduction

A modest building in central Stratford-on-Avon housed the first charitable institution dedicated to medical care in the town, the dispensary founded in 1823.[2] Its governors and medical officers were active in Stratford's civic affairs, later also contributing to local activities celebrating Shakespeare and his works. The Stratford Public Dispensary was one of several early nineteenth-century institutions in smaller towns in central and south Warwickshire, the others being at Leamington, Southam and Warwick (respectively founded in 1816, 1823 and 1826). The origins of these medical charities can be compared with contemporary institutions elsewhere. In Northwest England in the same period, dispensaries were often founded in smaller towns unable to support an infirmary, but two of the Warwickshire towns also had small hospitals.[3] The founders of Warwickshire dispensaries were largely members of local elites but also included medical practitioners (a relationship that will be explored more fully slightly later in this Chapter). All these were charitable institutions, while

[1] Anonymous, *The Stratford-Upon-Avon Guide* (London: Whittaker & Co, 1837), pp. 5-6.
[2] This was 21 Chapel Street (figure 2)
[3] Leamington and Stratford had small wards for in-patients. John V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and Its Region, 1752-1946* (Manchester: Manchester University Press, 1985), pp. 16-17.

Southam was the first 'self-supporting' dispensary. Its quasi-mutual funding model was an influential innovation, which complemented its charitable funds with small regular contributions from working people, its potential users (Southam and its imitators will be explored in detail in Ch.5).

Themes of Chapter

The historiography of dispensaries generally concerns institutions in metropolitan or industrial settings. By contrast, this Chapter will present a study of a small market town, providing opportunities for comparisons with Warwickshire's other smaller towns as well as its larger industrial centres. The themes for analysis comprise, firstly, the foundation, organisation, and funding of the dispensary, as well as the composition of the social groups supporting it.[4]

It seems appropriate to consider how far the urban middle classes collaborated with others, such as the landed gentry, in organising and financing local medical charities. Motivations prompting philanthropic activity also require consideration; how far were these altruistic, prudential, or focused on gaining social capital? [5] Secondly, the existence of a detailed admission register offers unusual opportunities to explore the actual work of the dispensary. This will include the diseases afflicting them and, occasionally, their treatments, as

[4] Irvine S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine* 55: (1981), 322-42

[5] Pickstone, *Medicine and Industrial Society,* pp. 17, 64-65, 67-70; Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in Lindsay Granshaw and Roy Porter (ed), *The Hospital in History* (London: Routledge, 1990), 149-78, pp. 153-4, 158-60; Pickstone also explored the varying relationships between institutional medical officers and the wealthier donors in John V Pickstone, 'The Professionalisation of Medicine in England and Europe: The State, the Market and Industrial Society', in Teizo Ogawa (ed), *History of the Professionalisation of Medicine: Proceedings of the 3rd International Symposium on the Comparative History of Medicine, East and West, Japan 1979* (Osaka, Japan: Taniguchi Foundation, 1987), pp. 40-45; R. J. Morris, 'Voluntary Societies and British Urban Elites, 1780–1850: An Analysis', *The Historical Journal* 26 (1983), 95–118.

well as the social and geographical characteristics of the patients.[6] Thirdly, the Chapter will outline how the dispensary aimed to meet local health needs more completely through its evolution into an infirmary. In a fourth theme, the Chapter will discuss the characteristics of local medical men, including their background, training, and social roles. This will include their participation in municipal affairs, especially in addressing public health problems, and finally their contribution to the town's growing cultural significance.[7]

The sources for the Stratford dispensary and the later infirmary (in existence 1838-84) are mostly scanty. Minute books have survived but only two printed annual reports. Local newspapers announced general meetings, but only briefly summarised their proceedings.[8] As noted above, however, the manuscript admission register is especially valuable. Covering the first decade, this lists patients' demographic details, their diagnoses, and the subscribers who recommended them.[9] The last point permits inferences regarding the social and economic background of dispensary supporters. More significantly, the three thousand names in the register provide the basis for a random sample of the dispensary's early users, analysing ages, occupations, location, and morbidity. This document therefore more than compensates for deficiencies in other extant sources. It is the smaller-scale equivalent of similar registers at

[6] Some studies that consider morbidity include: Hilary Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge: Cambridge University Press, 1987), pp. 34-44, 103-08; Graham Butler, 'Disease, Medicine and the Urban Poor in Newcastle-on-Tyne, C. 1750-1850' (Unpublished PhD Thesis, Newcastle-on-Tyne, 2012), esp. pp. 147-95; John Wilmot, ''Indeed a Health Resort'? Mortality at the Leamington Provident Dispensary, 1869-1913'', *Local Population Studies* 93 (2014), 54-67.

[7] Such wider roles of the profession have been less studied, but authors who touch on this include; Marland, *Medicine and Society in Wakefield and Huddersfield*, pp. 348-66; and two authors who consider mainly income and status -- Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon, 1986), pp. 189-207, and Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), pp. 224-53.

[8] *The Warwick and Warwickshire Advertiser* carried the notices; only in 1860 did the town gain its own newspaper, the *Stratford Herald.* Those connected with the Dispensary evidently did not send copies of their reports to the press.

[9] Stratford-on-Avon, Shakespeare Centre Library and Archive (SCLA) DR 253/1, Dispensary patient register. Entries include names, addresses, ages, and occupations, as well as the recommending subscribers.

Newcastle-on- Tyne, which enabled Butler to explore the relative contribution of the hospital, the dispensary, and Poor Law services to the medical care of the poor.[10] In general, institutional histories tend to rely on annual reports, including their summary statistics. While useful sources, these are less rich than patient registers.[11] This study also draws on Stratford's municipal and parish records and uses their details of local administration and public health measures. However, information about local medical provision between 1835 and 1861 remains relatively sparse.

The Stratford-on-Avon Public Dispensary: contexts and beginnings

As discussed in Chapter 1, early nineteenth-century Stratford-on-Avon was a market town with little manufacture. Following an eighteenth-century economic decline, early in the new century its mildly revived prosperity was stimulated by improved canal and river links,.[12] After several decades of relative inactivity, from about 1823 the borough council is said to have become more active in managing its urban responsibilities.[13] During the nineteenth century, the town became more prosperous, as a result of the success of concerns devoted to brewing, milling and timber processing (conducted, respectively, by the Flowers, Lucy and Cox families). From the later 1820s Stratford's citizens also increasingly celebrated Shakespeare through local associations and festivals, thereby raising the town's cultural profile.[14]

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[10] Butler, 'Disease, Medicine and the Urban Poor in Newcastle-on-Tyne', esp. pp. 147-95.

[11] A point underlined by Jonathan Reinarz, *The Birth of a Provincial Hospital: The Early Years of the General Hospital, Birmingham, 1765-1790* (Stratford-on-Avon: Dugdale Society with Shakespeare Birthplace Trust, 2003), No. 43, pp. 2-3; Ch. 2 of this study; Loudon, 'Origins and Growth', pp. 337-8; earlier personal research used both annual reports and registers; see John F. Wilmot, '"Advice and Medicine for the Working Classes": The Leamington and Warwick Provident Dispensaries 1869-1913', *Warwickshire History,* XV (2014), 26-42; J. Wilmot, ''Indeed a Health Resort'?'.

[12] Stratford's population in 1831 was 4229; all population figures are taken from the census data summarised in William Page (ed.), 'Table of Population, 1801 to 1901', in *A History of the County of Warwick*, 2 (London: Victoria County History, 1908), 182-92.

[13] Philip Styles, ed.,'The Borough of Stratford-Upon-Avon: Historical Account', in *A History of the County of Warwick,* 3 (London: Victoria County History, 1945), 234-44, pp. 238-9, 254-8.

[14] Philip Styles, 'Shakespearean Festivals and Theatres' in *VCH Warwickshire*, 3, pp. 244-45.

This seems an appropriate point to compare and contrast the social and economic characetersitics of the smaller Warwickshire towns that established medical charities in the eighteen-twenties. Warwick had important roles as the county town but was overshadowed as a commercial and industrial centre by Coventry, and later by Birmingham. Among the smaller towns, Leamington was a special case, growing rapidly in the 1820s and 1830s as a new leisure town, with significant roles in medical provision. Southam was much smaller than the others and grew less in the nineteenth century. It remained a small market town at the junction of important routes but was bypassed by both canals and railways. The modest prosperity of Stratford, together with a growing sense of its own cultural significance, may have aided the success of new local charitable initiatives.

Like other market towns, Stratford provided a base for professional people, including the medical men who served the dispensary.[15] Local directories between 1828 and 1866 typically show one physician and between five and eight 'surgeons', the latter sometimes being in two-man partnerships.[16] While the numbers seem large for a small town, some practitioners remained only a year or two, perhaps because they were unable to establish a viable practice. Others (mainly those with local connections) settled for decades. While the physicians arrived with degrees from Scottish universities, in this period the surgeon-apothecaries (increasingly known as general practitioners) followed local apprenticeships, nearly all of them completing their training at London medical schools.[17]

It is uncertain where the 'sick poor' found medical help in the eighteenth and early nineteenth century, whether in Stratford or elsewhere. Joan Lane remarks that 'most illnesses were treated in the home', often using domestic

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[15] Penelope Corfield, *Power and the Professions in Britain, 1700-1850* (London: Routledge, 1995).
[16] The directories used were Pigot's 1828-9, 1835, 1841; West's *Warwickshire* 1830; White's *Warwickshire* 1850 and Morris's *Warwickshire* 1866.
[17] This was the typical pattern for British general practitioners up to the 1850s; Loudon, *Medical Care and the General Practitioner*, pp. 35-53.

remedies or preparations of common plants.[18] Practitioners may sometimes have treated the poor without charge, but more commonly the Poor Law was involved, as Lane explored through Stratford's parish records.[19] The surgeon John Gamble treated the poor of Stratford (and in six other parishes) for about 40 years (1792 – c. 1830); he was replaced in the early 1830s as 'medical attendant to the poor' by James Pritchard (who was also a dispensary surgeon).[20] In 1833 an assistant Poor Law commissioner noted approvingly that the sums spent in Stratford on parish assistance had reduced from 1821 to 1829 (the total annual rates falling from £1647 to £911).[21] This suggests that through the eighteen-twenties parochial aid may have become less available to poor people, encouraging them to seek help from a medical charity. From 1836, under the new Poor Law, Stratford became the head of a union of 36 parishes, the Union Workhouse opening in 1837 on vacant land at the western edge of the borough.[22]

To recur to a question posed above; why did the inhabitants of Stratford establish a dispensary? As already discussed, humanitarian impulses must have played a large part, while local prosperity facilitated charitable action.[23] As Morris argued (and as discussed in Chapter 2) associative philanthropy enabled the developing middle classes to develop a shared identity. They could counter urban problems through applying their own values, of hard work, sobriety, and

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[18] Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London: Routledge, 2001), p. 2.
[19] Joan Lane, ' 'A Little Purging and Bleeding': Poverty and Disease in Eighteenth-Century Stratford', in Robert Bearman (ed), *The History of an English Borough: Stratford-Upon-Avon, 1196-1996* (Stroud: Sutton/Shakepeare Birthplace Trust, 1997), 126-38.
[20] Lane, 'Poverty and Disease in Eighteenth-Century Stratford', p.137; for James Pritchard, see SCLA, BRT 8/4, Vestry Minutes, 14 April 1831, 30 March 1833.
[21] This was Charles Villiers, who later entered parliament, duly becoming President of the Poor Law Board; Charles Pelham Villiers, 'Report from Warwickshire and Worcestershire', in *Extracts from the Information Received by Hm Commisioners on the Poor Laws,* ed. by Poor Law Commissioners (London: W.Clowes & Co for HMSO, 1833), 158-61, pp. 159-60.
[22] Peter Higginbotham, 'The Workhouse in Stratford-on-Avon, Warwickshire', in Peter Higginbotham (ed.), *The Workhouse* (2018), www.workhouses.org.uk/StratfordOnAvon/, last accessed 1 July 2021
[23] As suggested by Loudon, 'Origins and Growth', pp. 330-31

thrift, values which they might spread more widely. [24] Pickstone suggests the part played, especially in a country town, by the construction of alliances between the rural gentry and the urban middle classes:

> The movement establishing infirmaries [should perhaps] be seen as part of the social dynamics of the country town, a means of integrating landowners and townsmen, a means of demonstrating benevolence to the lower classes.[25]

Pickstone argued that such institutions were important 'in (re)defining the place of medical men in local society' as they gained prestige by their work in them. Citizens may also have been inspired by civic pride, as in Northern towns during the same period, and have been keen to avert dependence on Poor Law provision.[26] Prudential and pragmatic considerations seemed to underlie local remarks in Stratford about dispensary treatment being able to 'prevent [the sick poor] from becoming dependent on the parish in the case of temporary illness.'[27] However, as Fraser suggests (and as discussed in Ch. 1), motivations were complex and likely always to have been mingled.[28]

On 16 August 1823, four medical practitioners announced their proposal for a new 'public dispensary' in Stratford-on-Avon to supply the sick poor, not receiving parish assistance, with 'medical advice and remedies' (Fig. 11).[29] Their proposed regulations resembled those of other dispensaries, including attendance by medical officers on stated days and home visits when necessary (but only to patients living in the town or its suburbs). The work would be supported by subscriptions of at least half a guinea, those subscribing one

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[24] Morris, 'Voluntary Societies and British Urban Elites', pp. 96, 101-07.
[25] Pickstone, 'The Professionalisation of Medicine in England and Europe', p. 40.
[26] Marland, *Medicine and Society in Wakefield and Huddersfield*, p.124; Pickstone, *Medicine and Industrial Society*, pp. 64-70.
[27] SCLA 362/127/3, Twelfth Annual Report of Stratford Dispensary, 1835, 'Aims of the Dispensary'.
[28] Derek Fraser, *The Evolution of the British Welfare State: A History of Social Policy since the Industrial Revolution* (4th ed, Basingstoke: Palgrave Macmillan, 2009), pp. 7-12.
[29] Advertisement placed by local medical practitioners in *Warwick and Warwickshire Advertiser*, 16 August 1823.

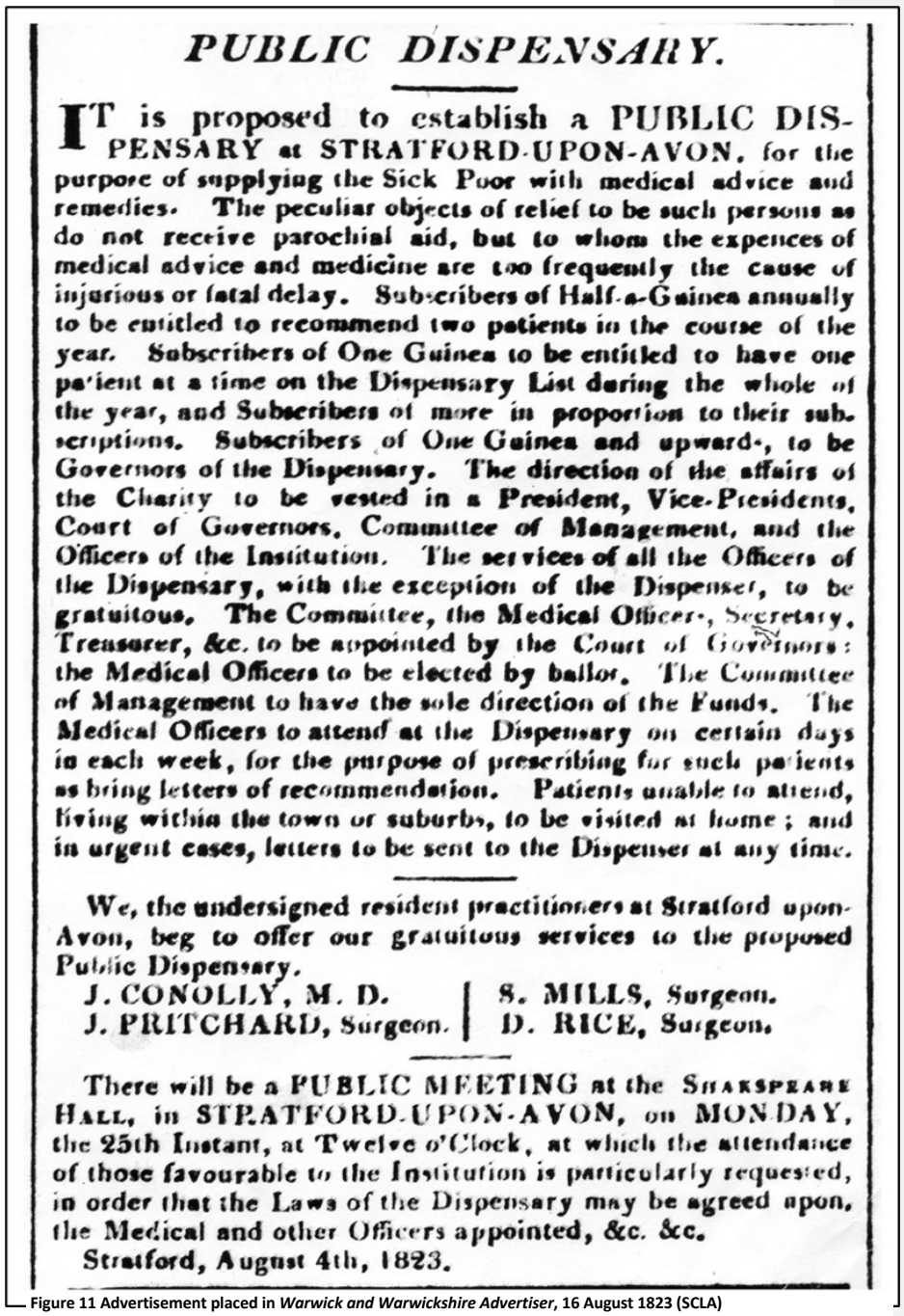
guinea annually becoming 'governors' and thereby entitled to elect the charity's officers, including its medical staff.[30]The inaugural public meeting nine days later implemented these plans with little change.

Sir Gray Skipwith, Bart, of Alveston Lodge near Stratford, chaired this meeting and was elected president of the institution, together with six members of the clergy and gentry (chosen to balance opposing political viewpoints). The general meeting also elected the honorary secretary, treasurer and eight committee members, drawing heavily on members or officials of the borough corporation (to be discussed in more detail later in the Chapter). The four original proposers became medical officers, all honorary apart from David Rice (a recently qualified surgeon-apothecary, paid £20 per annum as the dispenser).[31] The founders moved swiftly, the management committee assembling on 26 August and choosing as its chairman Stratford's current mayor, Captain Thomas Saunders. Other committee members included a clergyman, two solicitors, and three 'gentlemen'.[32]

[30] Advertisement, *Warwick and Warwickshire Advertiser*, 16 August 1823; Loudon, 'Origins and Growth', pp. 328-30.

[31] A further notice, summarising the agreed policies, was inserted in the *Warwick and Warwickshire Advertiser*, 30 August 1823. The medical officers included John Conolly, whose biography is covered in Chapter 4, (1792-1866, MD Edinburgh 1821); the surgeons had more local origins, such as James Pritchard (1770-1859, MRCS LSA 1792) son of a 'gentleman' of Hampton Lucy; David Rice (1799-1860, LSA 1821, MRCS 1822) was the son of the vicar of Alderminster; Samuel Wells (1789-1846) was a Stratford surgeon's son who lacked formal qualifications. For medical officers' qualifications, see SCLA DR 324/1/1 Minutes 24 April 1834; see also *Medical Directory*, various years from 1846.

[32] According to local directories, e.g. West's *Warwickshire*, 1830.



PUBLIC DISPENSARY.

IT is proposed to establish a PUBLIC DISPENSARY at STRATFORD-UPON-AVON, for the purpose of supplying the Sick Poor with medical advice and remedies. The peculiar objects of relief to be such persons as do not receive parochial aid, but to whom the expences of medical advice and medicine are too frequently the cause of injurious or fatal delay. Subscribers of Half-a-Guinea annually to be entitled to recommend two patients in the course of the year. Subscribers of One Guinea to be entitled to have one patient at a time on the Dispensary List during the whole of the year, and Subscribers of more in proportion to their subscriptions. Subscribers of One Guinea and upwards, to be Governors of the Dispensary. The direction of the affairs of the Charity to be vested in a President, Vice-Presidents, Court of Governors, Committee of Management, and the Officers of the Institution. The services of all the Officers of the Dispensary, with the exception of the Dispenser, to be gratuitous. The Committee, the Medical Officers, Secretary, Treasurer, &c. to be appointed by the Court of Governors: the Medical Officers to be elected by ballot. The Committee of Management to have the sole direction of the Funds. The Medical Officers to attend at the Dispensary on certain days in each week, for the purpose of prescribing for such patients as bring letters of recommendation. Patients unable to attend, living within the town or suburbs, to be visited at home; and in urgent cases, letters to be sent to the Dispenser at any time.

We, the undersigned resident practitioners at Stratford upon-Avon, beg to offer our gratuitous services to the proposed Public Dispensary.

J. CONOLLY, M. D. | S. MILLS, Surgeon.
J. PRITCHARD, Surgeon. | D. RICE, Surgeon.

There will be a PUBLIC MEETING at the SHAKSPEARE HALL, in STRATFORD-UPON-AVON, on MONDAY, the 25th Instant, at Twelve o'Clock, at which the attendance of those favourable to the Institution is particularly requested, in order that the Laws of the Dispensary may be agreed upon, the Medical and other Officers appointed, &c. &c.

Stratford, August 4th, 1823.

Figure 11 Advertisement placed in *Warwick and Warwickshire Advertiser*, 16 August 1823 (SCLA)

Figure 12 The original Stratford dispensary building: 21 Chapel Street, currently the Chaucer Head bookshop

The committee also identified a suitable house for a dispensary building (at 21 Chapel Street, figure 12) and appointed a Mrs Dyer as matron-housekeeper. Her tasks would include nursing patients in the in-patient beds in the upstairs rooms of the dispensary house.[33] These six beds were an important addition to the original medical plans and were evidently decided at the initial public meeting (rather than being recommended by the local practitioners). In doing so, the governors were probably influenced by the distance of the closest general

[33] As noted above, contemporaries commonly referred to 'medical men', and medical women did not exist until late in the century; SCLA, Dispensary Papers, DR 324/1/1 Minute Book

hospital, 28 miles away in Birmingham. Other small towns likewise added in-patient accommodation to their dispensaries when they were relatively isolated and serving scattered populations. In 1836 a survey of twenty-nine dispensaries revealed that six had between three and sixteen beds, two were planning them, and two others had developed infirmaries with provision for 30-35 in-patients. In his article on early dispensaries, Loudon identified fourteen with associated hospitals or infirmaries, again mostly in smaller towns.[34] Stratford's dispensary building was a former bank in the centre of the town, close to the Town Hall and the grammar school. Now a bookshop, its Georgian frontage gives little clue to its sixteenth-century origins.[35] Medical men were often the co-founders of dispensaries and played varying roles at all the institutions in smaller Warwickshire towns (see figure 13 for locations). In Stratford they participated fully in management after advancing the first proposals, probably at the prompting of John Conolly. He was a recent arrival from Chichester in Sussex and had served at the dispensary there.[36] Elsewhere in the county, Henry Lilley Smith initiated the first self-supporting dispensary in Southam in 1823, five years after founding his local Eye and Ear Infirmary.[37] At Warwick in 1826, the leading founder and first chairman was a local gentleman, William Staunton. He may have been influenced by his son, Dr John Staunton, who was then practising in Leamington and became a physician to the Warwick dispensary in

[34] John J. Bigsby, *Suggestions toward the improvement of the dispensary at Newark…*(Newark: S & C Ridge, 1836); Two of Loudon's instances also appeared in Bigsby's pamphlet; Loudon, 'Origins and Growth', p. 333

[35] The present Chaucer Head bookshop: 'From 1597 to 1636 [this was] the home of Julius Shawe, a friend of Shakespeare and witness to his will.' The façade dates from 1790 when it became Stratford's first bank; Robert Bearman, *Stratford-Upon-Avon : A History of Its Streets and Buildings* (Nelson: Hendon, 1988), p. 21.

[36] Loudon, 'Origins and Growth', pp. 323-4.

[37] Lane, *Social History of Medicine*, pp. 91-3

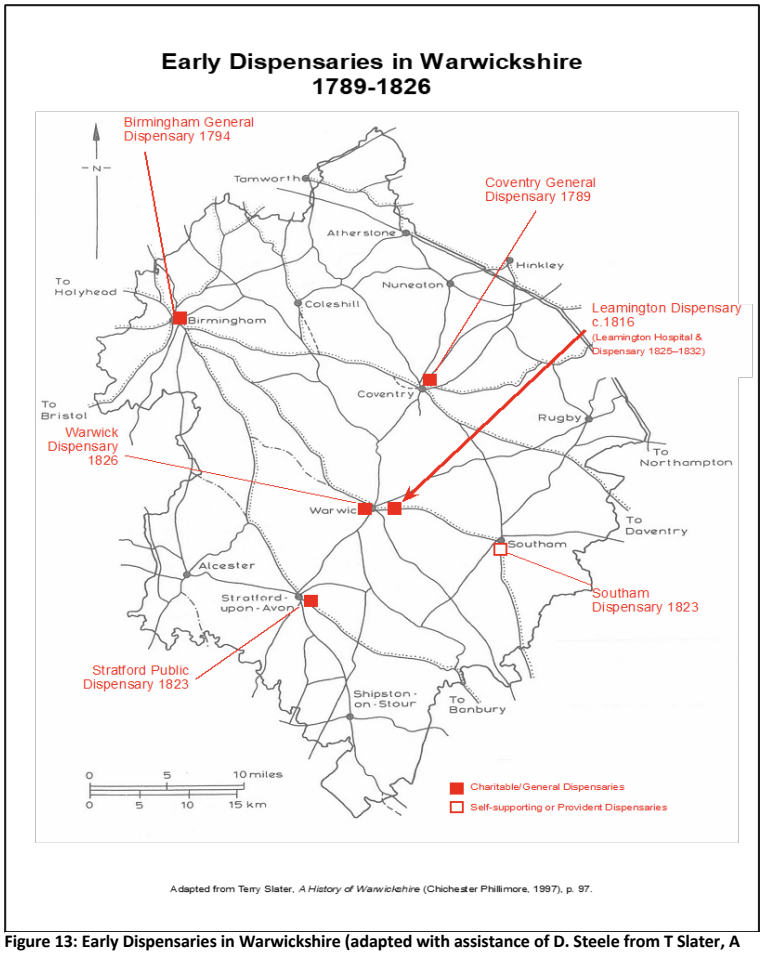


Figure 13: Early Dispensaries in Warwickshire (adapted with assistance of D. Steele from T Slater, A History of Warwickshire (Chichester:1997), p.97

1828.[38] Leamington offers another example, albeit less clear in its chronology and administrative detail. A Dr Amos Middleton founded a dispensary close to his house c.1816. By c.1825 this had evolved into the 'Leamington Hospital and Dispensary', whose persisting financial problems were eased by its refounding,

[38] 'Warwick Dispensary', Warwick and Warwickshire Advertiser, 18 March 1826, 15 April 1826; Warwick County Record Office (WCRO), Tibbits family papers, E G Tibbits, 'History of Warwick Dispensary', CR 1185/23; in 1834 Staunton was replaced by John Conolly, by then settled in Warwick.

using additional finance, as the Warneford Hospital in 1832.[39] There were informal links between all these institutions and their governing bodies, with overlapping membership and doubtless social contacts (between both governors and medical staff).

The role played by medical practitioners in founding dispensaries (or infirmaries) may be linked to their relationship with leading donors, including their relative social standing. Pickstone argues that 'in a country town infirmary the doctors were fellow members of the benevolent class…giving their time where their fellow citizens gave money'; while in large industrial towns prominent merchants and manufacturers came to regard them similarly to factory managers or engineers, people with useful skills but occupying a somewhat subservient position.[40] Loudon argued that the social standing of general practitioners was higher in country towns than in London and other large cities, his views on the matter nuancing the interpretations of Peterson.[41]

At its first meeting the Stratford dispensary committee also decided to raise funds through a charitable ball (on this occasion, to cover the initial costs of furnishings and equipment). The inaugural ball was held in October and became an annual event, albeit at varying times of year. The organisers were conscious of the need to avoid clashes with similar nearby events, notably the annual ball at Warwick in aid of the town's lying-in charity and later its own dispensary.[42] Such balls in country towns provided useful funds for medical charities, the Stratford event raising £23 in 1823 and £53 in 1834 (the subscriptions in the latter year totalling £113).[43] They also became significant

[39] Leamington's population was 1640 in 1821 and 6655 in 1831; Lyndon F. Cave, *Royal Leamington Spa: Its History and Development* (Chichester: Phillimore, 1988), pp. 96-7; Craig D. Stephenson, *The Warneford: A Hospital's Story* (Warwick: South Warwickshire General Hospitals NHS Trust, 1993), pp. 8-9.
[40] Pickstone, 'The Professionalisation of Medicine in England and Europe', p. 44.
[41] See Loudon, *Medical Care and the General Practitioner*, pp. 199-201; he was responding to M Jeanne Peterson, The *Medical Profession in Mid-Victorian London* (Berkeley and Los Angeles: University of California Press, 1978); also 'Gentlemen and medical men: the problem of professional recruitment', *Bull. Hist. Med*, 58 (4)(1984), 457-73.
[42] 'Stratford Dispensary Ball', *Warwick and Warwickshire Advertiser*, 4 November 1826.
[43] SCLA, DR362/127/3, Stratford Dispensary, 12th Annual Report, 1834-35.

occasions in local social calendars, where urban professionals and business figures could mingle, in a carefully regulated manner, with the landed elite.[44] Elsewhere 'Ladies' Committees' organised such functions, but at Stratford a 'Lady Patroness' presided at each ball, assisted by several male stewards (members of the committee or medical officers).

Table 13: Subscribers to the Stratford Dispensary and Infirmary 1823-62						
Year and source	**1823-32 Register Sample**		**1833-4 Dispensary Annual Report**		**1861-2 Infirmary Annual Report**	
Total (%)	53	100%	115	100%	174	100%
Clergy	12	23	22	19	29	17
Landed families	3	6	6	5	7	4
Female	10	19	26	23	37	21
Medical & legal	4	8	6	5	4	2
Firms	__		2	2	2	1
Charities & benefit clubs	__		0		3	2
Corporate bodies	__		1		1	

The early subscribers resembled their counterparts at the Warwick Dispensary founded in 1826. The 116 names there included 31 females and fifteen clergymen, as well as other professionals and members of the gentry. The Southam Dispensary did not have subscribers as such, but the fifteen members of its committee included seven clergymen and five landed

[44] Leonore Davidoff, *The Best Circles: Society, Etiquette and the Season* (2nd ed, London: Cresset Library, 1986 (orig pbn 1973)), pp. 57, 65-7.

gentlemen; in 1831 the Coventry Provident Dispensary had two clergymen and eleven manufacturers on a twenty-strong committee. [45]

The Anglican clergy were thus much more conspicuous as subscribers and governors in the 'country' dispensaries than in Birmingham and Coventry, where manufacturers of varying size dominated the lists of institutional founders and supporters.[46] At the Birmingham General Dispensary in 1830, clergymen formed 3.5 per cent of the 620 subscribers, while the majority were small and large business proprietors. The dominance of the businessmen in larger towns and the strong clerical presence in small-town and rural society can be seen as reflecting their relative prominence in the two settings. While the landed gentry had a small but very visible role as presidents and vice-presidents, the working members of the Stratford committee were mostly professional men (mainly solicitors and clergymen, as noted above) and the urban gentry. The chairman in 1830 and c.1850 was Thomas Mason, urban landlord and non-practising lawyer. The main supporters of the dispensary in its early years can be compared with the founders of similar foundations in the north of England. In Lancashire, Pickstone identified the latter as mainly conservative Anglican figures, whose charitable efforts he interpreted as attempts to prop up 'a hierarchical social order'. He contrasted the growing number of those with liberal and Dissenting convictions in the 1820s cotton towns. In Stratford in that decade the established church was still dominant (as discussed in Chapter 1), but some dispensary governors and supporters had distinctly reformist political views.[47]

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[45] See Ch.2, esp. Tables 1 and 3.

[46] At least in Birmingham and in Coventry in 1831; the first Coventry General Dispensary in 1789 was, however, founded by four medical practitioners; see Ch.2.

[47] Pickstone, *Medicine and Industrial Society,* pp. 73-4, quote p. 73; Fogg, 'Tracts and Bills Galore: Political Processes in Victorian Stratford', in Robert Bearman (ed), *The History of an English Borough: Stratford-upon-Avon, 1196-1996* (Stroud: Sutton/Shakepeare Birthplace Trust, 1997), 139-159; the 1832 Reform Act was to gain wide local support, while the views of the Anglican clergy ranged from the arch-Tory Vicar, Dr James Davenport, to the highly liberal Fortescue Knottesford, pp. 143-45.

The dispensary's patients: origins and characteristics

The dispensary was open for patients between 11 and 12 on Tuesdays and Fridays (other than for accidents or sudden emergencies). These were the days of the week when carriers operated local journeys, Friday also being a market day; such circumstances seem likely to have eased travel for those travelling from outlying villages.[48]

The admission register was used as a basis for identifying the characteristics of the patients served; a random sample of one hundred was drawn from the register entries covering the period from the opening in 1823 until 1832 (see Table 14).[49] The majority lived in Stratford, but thirty-nine people came from twenty-three other villages and hamlets in South Warwickshire and one in Gloucestershire (Mickleton, which was the most distant at nine and a half miles). Fifty-eight of the sample were female, and ages ranged from 10 weeks to 85 years. Many dispensaries (certainly those in larger towns) had the important function of treating groups, like children and aged people, who were not welcome in general hospitals.[50] The rural patients at Stratford included fewer elderly people and many fewer children than the urban dwellers. The difference may lie in their greater difficulty with travel to the dispensary from more distant villages. They might go on foot (or if more fortunate, on a cart; town residents might, of course, be visited at home by the medical officers).[51] Most register entries mentioned employment, generally of the head of the family. They were most often described as 'labourer', especially the rural dwellers. In the countryside, twenty-eight of thirty-nine individuals (71 per cent) were labourers, four were servants, and others were said to be a carpenter (two), carrier, widow and 'schoolmistress's sister' (aged eight). Among the sixty-one urban inhabitants, thirty-eight (62 per cent) were

[48] Six carriers were listed as leaving Stratford on Tuesdays and eight on Fridays; see West's *Warwickshire* 1830, p. 546.
[49] SCLA DR 253/1, Dispensary patient register; random number tables were used to select individuals from the nominal list (all uniquely numbered) in the register.
[50] As discussed by Loudon, 'Origins and Growth', pp. 334-5.
51 The register does not distinguish between those attending the dispensary and those visited at home; Loudon suggests that about one-third of all contacts were home visits; Loudon, 'Origins and Growth', p. 329.

labourers, and six were servants; others were bakers and coopers (two of each), a letter carrier (a woman aged 65), bootmaker, miller, and a painter. Census data for 1831 show that of 673 families in Stratford borough, 49.7 per cent were occupied in trade and manufacture and 7.1 per cent in agriculture; among 330 families elsewhere in Old Stratford parish, the proportions were 36 and 44 per cent respectively. [52] In their spread of occupations, dispensary families thus seem to be reasonably typical of local manual workers, including both artisans and unskilled workers.

Table 14: Stratford Dispensary Patients 1823-32: Age Breakdown

	Urban ***n* (%)**	**Rural** ***n* (%)**	**Combined** ***n (%)***
1. Under 5	12 (20)	3 (8)	15
2. 5-15 years	16 (26)	2 (5)	18
3. 16-35 years	13 (21)	17 (44)	30
4. 36-60 years	10 (16)	12 (30)	22
5. 61 and over	7 (11)	3 (8)	10
Age not recorded	3 (5)	2 (6)	5
Total	61	39	100

The patients needed, of course, to obtain recommendation letters from subscribers before attending. Printed rules stated the desirable behaviour for those seeking aid:

> (Rule 1) It is expected that [patients] will present themselves in as clean and decent state as their circumstances will admit…
>
> (Rule 4) Patients must procure for themselves vials, gallipots, etc. for medicines…

[52] H.M Census 1831, 'Enumeration abstract for County of Warwick', Part 2, p. 668.

(Rule 5) When discharged [they] shall receive letters of thanks to the governors or subscribers who recommended them…

(Rule 6) When cured… they shall return Public Thanks to Almighty God at their respective Parish Churches or Place of Divine Worship.[53]

In the countryside the squire and the parish clergyman were not only sources of benevolent aid but also embodied power structures as representatives of the 'local state'. As authority in the town was more diffuse, the dispensary patients there could (and did) seek recommendations from a wider range of prosperous neighbours. As the above rules implied, the giving of help implied gratitude and deference in response.[54] It could thus be interpreted as part of a system of 'social control', a much debated concept in recent decades, but perhaps now rather out of favour.[55] Paternalism is sometimes considered a more benign form of relations between classes, but in this era it was seen as calling for paternal strictness as well as kindness.[56] There are connections with the more general debate about philanthropy and its motivations, as discussed early in the Chapter. However, as Fraser suggests, it may be impossible to disentangle complex motivations, and the 'mixed economy of welfare' has become a favoured term to deal with the overlapping and shifting boundaries between public assistance, charity, and mutual aid.[57]

In the dispensary's first year, 340 patients were admitted, with similar numbers being treated each year thereafter (averaging 359 over the first nine

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[53] SCLA 25/3/13/1, 'Rules to be observed by Patients' (on printed recommendation letters). At least some did so, as shown by a bundle of forms expressing thanks surviving in the church records of Halford (near Shipston-on-Stour); WRCO DR 468/65/1-7, 9.

[54] Anne Digby discussed this topic in 'The Local State' in E. J. T. Collins and Joan Thirsk, (eds)., *The Agrarian History of England and Wales, 7* (Cambridge: Cambridge University Press, 2000), pp. 1427-8.

[55] The debate is explored in Marland*, Medicine and Society in Wakefield and Huddersfield*, pp. 145-9, 152-3, 156-7; for an overview of social control, see A. P. Donajgrodzki, *Social Control in Nineteenth Century Britain* (London: Croom Helm, 1977). For a summary and critique of the concept, see F.M. L. Thompson, 'Social Control in Victorian Britain', *The Economic History Review,* 34 (1981), 189-208.

[56] David Roberts, *Paternalism in Early Victorian England* (London: Croom Helm, 1979), pp. 1-10.

[57] Fraser, *Evolution of the Bristish Welfare State*, pp. 7-12.

years). The largest number in the decade was 453 in 1826-27. The register does not make it clear which individuals became in-patients, although the number was probably small (in 1833 there were ten inpatients and 369 outpatients).[58] The activity levels at the three contemporary local dispensaries appear broadly comparable (despite their differing populations), Warwick Dispensary treating 281 patients in its first year and Southam 270 in its second; rather later, in 1830-31, the Leamington Hospital and Dispensary treated 54 inpatients and 180 outpatients. Using population figures for 1831, the Stratford dispensary treated 8.4 per cent of the town's population, Warwick 3.4 per cent, Leamington 3.5 per cent, and Southam 23.2 per cent.[59] In early minutes there are certain entries, intially puzzling, concerning payments made on behalf of in-patients:

> 27 October 1823: that Thomas Henn, a poor boy of Hampton Lucy, be allowed a sum of 10s.
>
> 28 August 1824: that 5s per week be allowed to Ann Beesley during the time that she should remain in? the dispensary.
>
> 13 June 1825: that the expenses of Board due to the Matron from Aaron Smith, a Gypsy who has had … a leg amputated shall be charged to the dispensary account at 7s a week for 15 weeks, viz £5 5s [Aaron Smith, aged 19, had suffered a severe leg injury].[60]

The last entry suggests that inpatients were expected to pay for board, at least notionally; but as most were unable to do so, the dispensary funds covered the cost. During the first few years the matron evidently did not receive a salary but enjoyed free lodging; she also derived some income from the payments made

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[58] SCLA DR 253/1, Patient register; 324/1/1 Minutes 24 April 1834 (certain statistics were collated for a survey of hospitals and dispensaries by the Parliamentary Select Committee on Medical Education).
[59] 'Warwick Dispensary, 1st Annual Meeting', *Warwick and Warwickshire Advertiser*, 9 June 1827; 'Southam Dispensary, Report of 2nd Annual Meeting', *Warwick and Warwickshire Advertiser*, 24 September 1825; Leamington Hospital and Dispensary Annual Meeting Report, *Leamington Spa Courier,* 14 May 1831.
[60] SCLA 324/1/1 Dispensary Minutes, varying dates 1823-5.

by, or on behalf of patients. Such charges were made at the Southam Eye and Ear Infirmary (although there also often covered by the charity funds) and became the norm at the later cottage hospitals.[61] From 1828 the matron received eight pounds as annual salary. In 1835 Mrs Gutch, who had received an additional gratuity of £2 10s for her 'exemplary conduct' at the dispensary, resigned to become housekeeper to Evelyn Shirley, Esq., at Ettington Park, this of course being a responsible supervisory position.

The position of the dispenser, David Rice during the first decade, seems analogous to that of the apothecary or house surgeon in a large institution. He evidently kept the patient register (all entries being in a single hand) and he seems likely to have treated minor illnesses, only involving the physician or the other surgeons with more serious cases. The early 'Rules for Patients' included the injunction that untoward changes in their condition should prompt application 'to the Dispenser at his house', which was adjacent to the dispensary.[62] Following John Conolly's departure from Stratford (in late 1827) Rice took over the physician's duties until a new physician was appointed in early 1829, for a time receiving the increased salary of £50.[63] Revised regulations in 1857 stated that the dispenser should obtain, prepare and store the medicines;

> 'shall perform the minor operations of bleeding and cupping;
> …[and] shall assist the Physician in visiting patients [at home], and shall report to him from time to time such cases as may require his attendance.'

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[61] Simon Wheeler, 'Dr Henry Lilley Smith and the Southam Eye and Ear Infirmary'. *Warwickshire History*, XIII, 2, Winter 2005-6, 66-84, p.71; Steven Cherry, *Medical Services and the Hospital in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), p.47.

[62] His honorarium of £20 p.a. was the lowest for similar positions at 30 comparable dispensaries in 1836; see Bigsby, *Suggestions for the Dispensary at Newark*, pp. 30-1; SCLA 25/3/13/1, 'Rules to be observed by Patients'. Rice lived at 'Nash's House', which also adjoined New Place, the site of Shakespeare's home late in life. It is now used as a museum for New Place and its recent excavations.

[63] SCLA DR 324/1/1 Minute Book, 8 October 1827

Table 15: Stratford Dispensary Patients 1823-32: Diseases identified on admission

	Disease name	Modern term	Number of cases
'Zymotic' diseases	Continuing fever and typhus		11
	'Febricula'	Minor fever	4
	Other: catarrh, 'Cynanche', 'Erysipelas' (facial), influenza, whooping cough, 'rubeola' Abscesses	Common cold Tonsillitis Cellulitis Measles	14
Heart and lung disorders	Pneumonia/ pleurisy Bronchitis, breathlessness and cough 'Phthisis' (2)	Tuberculosis	8
Digestive disorders	Dyspepsia and 'gastrodynia' (5) Hepatitis, Diarrhoea, 'Vermes' (2)	Stomach pain Worms	12
Nervous System	'Cephalalgia' (3) Epilepsy Hysteria Vertigo (3)	Headache	9
Diseases of joints, bones and muscles	'Rheumatismus' Sciatica Curvature of spine Distorted foot	Rheumatism, arthritis	8
Injuries	Knee, sacrum 'Bent Radius' 'Laxatio pollicis'	Thumb fracture-dislocation	4
Other conditions	Cataract and other eye diseases (4) Leg ulcers (2) Women's disorders (5) Hernia, hydrocoele Skin disease (4) 'Colica pictonum'	Lead poisoning	24
Source: SCLA DR 253/1, Patient register (random sample of 100)			

Diseases treated by the Stratford Dispensary

The sample of one hundred names was also used to explore the diseases listed in the admission register (see Table 15). For each patient one, or occasionally two, disorders were noted at first contact ('admission' being to the benefits of the dispensary rather than to an inpatient bed, which would be the case for very few). The initial labels were, of course, 'presenting' conditions. Typically (as suggested by Loudon) patients would see a practitioner about three times before discharge and meanwhile medical ideas regarding their case might have changed.[64]

The register thus has obvious limitations, but its strength lies in allowing a broad overview of the range of diseases treated. As can be seen, they range from the trivial to life threatening. Twenty-one cases were categorised as surgical, including fractures treated by manipulation and leg ulcers receiving dressings. Nevertheless, the operations performed included amputation, hernia repair, and the lancing of abscesses.[65] In terms of the conditions treated (Table 15), the 'zymotic' diseases formed a substantial group, especially continuing fever and typhus (eleven cases together in the sample for 1823-32 –see comments below on these overlapping labels).

Mortality figures are shown in Table 16. The first year's mortality (in relation to all admissions) was the low figure of 2 per cent. A decade later (1833-4) when there were more infections (erysipelas, whooping cough, and tuberculosis), the figure was 6.9 per cent. In 1861-62, the death rate was 2.47 per cent in outpatients and 5.8 for inpatients. Such mortality statistics broadly resemble rates elsewhere, for instance ranging from 2.5 to 4.4 per cent for outpatients at the Coventry General Dispensary, and between 3.87 and 6.84 per cent at the Birmingham General Dispensary.[66] In a study of seven large provincial general hospitals, Cherry found mortality rates of between 2.7 and 12

[64] Loudon suggests an average between three and four attendances for each 'admission; possibly slightly fewer at a rural institution; Loudon, 'Origins and Growth', pp. 328-9.
[65] SCLA DR 253/1, Patient register, various dates.
[66] Ch. 2, Tables 2 and 3, with discussions in text.

per cent from the 1820s to the 1860s; at Worcester in this period, they were between 3.9 and 4.5. The mortality figures are thus comparable with those observed elsewhere.[67]

Table 16: Mortality at the Stratford Dispensary, 1823-35, and the Stratford Infirmary, 1839 onwards

Year	1823-4	1834-5	1861-2
Fever/zymotic diseases	3	4	1
Diseases of brain		1	3
Diseases of heart and blood vessels			4
Lung disease including phthisis	2	11	7
Diseases of digestive system	1	4	2
Age and debility		3	
Other diseases	1		5
Total deaths	7	23	22
Deaths			In-pat, 17 Out-pat 5
Mortality %: deaths/admissions	2	6.9	In-pat 5.8 Out-pat 2.47
Sources: SCLA DR 253/1, Patient register, 1823-4; 12th Annual Report 1834-5; 39th Annual Report 1861-2			

While due caution is needed because of small numbers, the proportion of continuing fever cases (11 per cent) was also close to levels in larger towns; 6.8 per cent at Birmingham in 1828-29; 10.4 per cent at the Coventry Provident Dispensary in 1834-35; and 13.2 per cent at Newcastle in 1820-29. About half the cases of 'continuing fever' in this period are believed to have been caused by typhoid, a water-borne infection; most of the remainder arose from typhus,

[67] S. Cherry, 'The Hospitals and Population Growth: Part 2, the Voluntary General Hospitals, Mortality and Local Populations in the English Provinces in the Eighteenth and Nineteenth Centuries ', *Population Studies* 34 (1980), 251-65 esp. p.260.

spread by close bodily contact.[68] The injuries, and probably also the 'rheumatismus', seem likely to have largely resulted from the hard physical work that most pursued. Lung diseases were common, forming a similar proportion of cases to larger towns (despite the probable lower level of air pollution in a country town). Gastric disorders were rather less common than elsewhere (5 per cent, as against 8.5 per cent in Birmingham in 1828-9 and 30.5 per cent in Coventry in 1834-5). Such differences, as discussed in Chapter 2, seem consistent with contemporary ideas concerning the relationship of gastric disorders with the stresses of urban and industrial life. The painter suffered from *colica pictonum*, the contemporary term for occupationally induced lead poisoning.

The register was also used for an analysis of the deaths in the first year (1823-24). Seven patients died, the only adult a labourer aged 60 with hydrothorax (fluid on the lung). The death of six children, so shocking to modern eyes, would probably have been thought sad but inevitable. One had continued fever, another pneumonia, two suffered complications from 'Rubeola' (measles), one had struma (thyroid swelling), and another tabes mesenterica (congenital intestinal syphilis). In this year five patients were deemed 'incurable'; three with tumours, a nine-year-old with epilepsy, and a woman of 55 with a leg ulcer. These were probably excluded from further aid from the charity.[69] Some dispensaries did operate similar exclusion policies, while they were, in most respects, less strict than general hospitals.[70]

In February 1833, Thomas Thomson, who had become physician to the institution in October 1829, offered some frank reflections on the dispensary's effectiveness and limitations.[71] His observations were based on four years in

[68] For Birmingham and Coventry statistics, see Ch. 2, for Newcastle, see Butler, 'Disease, Medicine and the Urban Poor in Newcastle-on-Tyne' p.171; for general remarks on current epidemiology, see Loudon, *Medical Care and the General Practitioner,* pp. 59-60.
[69] SCLA DR 253/1, Patient register, dates in 1823-4.
[70] The Birmingham General Dispensary had a similar rule from its inception (see Ch.2).
[71] Thomas Thomson (1802-1873) was a native of Edinburgh who qualified MD there in 1827; as physician to the Stratford Dispensary, he was a successor of the co-founder John Conolly, who had taken up a chair at London University in 1828 (see Ch.4).

Stratford together with experience elsewhere, and warrant John Conolly's depiction of the country practitioner as one who 'becomes familiar with the occupations, the habits and the characters of all his patients'. Through their dispensary work, practitioners like Thomson had opportunities to observe the living conditions of the poor not shared by colleagues elsewhere (certainly those only seeing wealthier patients).[72] Thomson stated that most patients treated over ten years, exceeding 3000, had been cured or greatly relieved.[73] However some individuals received little benefit because they lived far away and could attend only infrequently. He noted that the recovery of many was impeded by an insufficient or 'improper' diet. Nevertheless, he had always found it possible to obtain charitable help, especially through the ladies of the local Benevolent Society.[74] Patients could be irregular in taking medicines, and the physician would find it difficult to supervise cases at some distance. Adverse domestic circumstances included 'exposure to cold or damp air, or to excessive heat, and from an indifferent supply of bed and body clothing'; and finally, the 'lack of rest and quiet in the habitations of the poor'.[75] Although the Dispensary had six notional in-patient beds, only two were truly useable, leading Thomson to make some significant recommendations, to be discussed in the next section.

From Dispensary to Infirmary

Thomson's pamphlet argued that the dispensary's services would become more effective if it expanded into an infirmary with 10-15 beds. Experience elsewhere suggested that each bed would have annual running costs of twenty-three pounds, and the initial funds required could be found in currently unused

[72] John Conolly, 'A Proposal to Establish County Natiural History Societies', *Transactions of the Provincial Medical and Surgical Association* 1 (1833), 180-218, p.181; Loudon, 'Origins and Growth', pp. 331-2.

[73] Thomas Thomson, MD. *Observations on the present plan of the Stratford-on-Avon Dispensary* (Stratford-on-Avon; J. Ward, 1833) WCRO CR 928/2. The pamphlet, the text of an address to the Dispensary's Committee of Management on 19th February 1833, was circulated to governors and subscribers and was later discussed at general meetings.

[74] Thomson, *Observations on the Stratford-on-Avon Dispensary*, pp.4-5

[75] Thomson, *Observations on the Stratford-on-Avon Dispensary*, pp. 5-6

monies (£200 already accumulated) and through a new appeal.[76] The proposals gained wider support at a special general meeting and a building fund was launched. The deliberation of the governors now contrasted with their haste to open in 1823, five years being needed to accumulate the thousand-pound estimated cost of a new (or converted) building.

Various early dispensaries developed into infirmaries, including several of the twenty-nine instances surveyed by Dr Bigsby of Newark in 1836.[77] The Cheltenham Dispensary, founded 1813, gained a 'casualty ward' in 1821, and became a larger hospital in 1838.[78] At Doncaster, the early arguments (in 1845) resembled those made by Thomas Thomson, focusing on the poverty and the nursing needs of a scattered agricultural population. There the infirmary opened only in 1867, due to funding and other difficulties.[79] At Wakefield, the dispensary originating in 1787 only developed inpatient facilities in 1854 (after 67 years). At Huddersfield, a more dynamic town, the gap was a mere 17 years (1814 to 1831). In these growing towns inpatient facilities became pressing because of the nursing needs for those having surgery, as well as the increasing number and severity of industrial accidents.[80] In his pamphlet, Thomson surprisingly mentions neither accidents nor the needs of surgical patients (the former admittedly then relatively infrequent in a semi-rural area).

In 1838 a vice-president of the dispensary, Sir John Mordaunt, Bart, chaired a special general meeting to launch the new infirmary; he emphasized that it would continue the principles of the dispensary, while operating on a larger scale (with twelve to sixteen inpatient beds).[81] It was to be housed in a

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[76] Thomson, *Observations on the Stratford-on-Avon Dispensary*, pp. 6-7.
[77] See above; Bigsby, *Suggestions for the Dispensary at Newark*, pp. 30-1.
[78] Daphne Doughton, 'The Early Decades of the Cheltenham Dispensary', *Gloucestershire History* 8 (1994), 4-9.
[79] Hilary Marland, *The Doncaster Dispensary 1792-1867: Sickness, Charity and Society* (Waterdale, Doncaster: Doncaster Library Service, 1989), pp. 71-2.
[80] Marland, *Medicine and Society in Wakefield and Huddersfield*, pp. 24, 101-9, 133-5, 155-6.
[81] SCLA ER 25/3/13/1, Report of the Special General Meeting, November 1838. Sir Gray Skipwith was still President; Mordaunt, a Vice-President, had in 1836 been elected a Conservative member for South Warwickshire, together with Evelyn Shirley of Ettington.

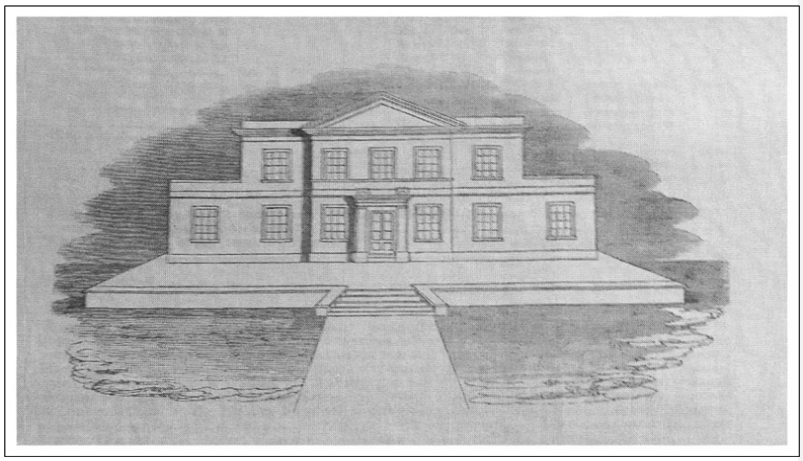

Figure 14: Architect's Drawing of the proposed new Infirmary, accompanying the report of the Special General Meeting in November 1838 (SCLA ER 25/3/13/1)

Figure 15: The former Infirmary in Chapel Lane with the additional wings of1858 (and small additions in modern times); currently offices for the Royal Shakespeare Company (Photograph: John Wilmot, 2018).

plain classical building in Chapel Lane, close to the river, which, rather oddly, was previously the town's first gasworks (figure 14). Donations from the dispensary's wealthier governors covered most of the costs involved, fifty-six**).**individuals having given amounts from five to fifty guineas, totalling £467, while the accumulated dispensary funds contributed an additional £300. The 'Stratford Public Dispensary and Infirmary' opened in September 1839, the final building cost being £1200.

The medical officers and others may have welcomed the more spacious working environment and its more salubrious setting, where the surrounding grounds and slightly elevated position would allow the highly desirable free circulation of air.[82]

The Stratford Infirmary 1838-1862

The Infirmary held outpatient sessions twice weekly, the times being unchanged from those at the original Dispensary. The number of in-patient admissions to the Infirmary (Table 15) may not have increased greatly, as far as can be judged from the scattered evidence. On census day in 1841 and 1851 there were respectively four and seven in-patients.[83] During the week ending 20 August 1857 there were ten inpatients, two admitted that week; there were 148 outpatients 'on the books', eight admitted and 18 discharged that week.[84] It is worth noting that the medical officers were still also visiting Stratford patients in their own homes. By the mid-1850s the building again seemed in need of modernisation. In 1856 a subcommittee, including the medical officers, recommended enlargement (to provide additional ward space and a waiting room for outpatients), improvements in services (hot and cold running water, water closets, and improved ventilation) as well as a 'dead house' or mortuary.[85] Once again fundraising was needed and the alterations, costing about £1500, were completed in 1858. The building continued in use until 1885, when a further rebuilding established the Stratford Hospital adjoining the workhouse.

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[82] A Coventry physician (Robert Arrowsmith) commented on the desirable attributes of a hospital site, stating his opinions on two locations mooted for the city's new general hospital. One was situated 'in a narrow alley, in the densest part of the city…while the other (his preferred option) [had] an attached garden…and rooms [which are] spacious and commodious.' Dr R. Arrowsmith, letter to editor, *Coventry Herald*, 11 May 1838.

[83] Each of these totals included children, so the local infirmary did not apply the restrictive policies of larger general hospitals; midwifery was never a service offered by the Dispensary or Infirmary; Census enumerators' Books, *HM Census 1841* and *1851*, via www.ancestry.co.uk.

[84] Stratford Infirmary weekly returns, *Leamington Spa Courier*, 22 August 1857

[85] SCLA 324/1/1, Infirmary Minutes 19 March 1856.

The dispensary and infirmary certainly did not meet all the needs of working people in nineteenth-century Stratford.[86] As elsewhere, friendly societies were a significant source of support. Certain of these were founded or fostered by the (Anglican) clergy of the district, who were eager to avoid the flaws evident in most current 'clubs'. In 1835 Canon Richard Seymour and others launched a benefit society that in a short time gained 290 members; in return for modest payments, this offered sick pay and medical attendance (like a sister society in Alcester). Seymour, of Kinwarton near Alcester, advocated the 'new' friendly societies, designed to be actuarially sound and avoiding tavern meetings (see also Ch.5). [87] Sources dealing with its later fortunes are scanty, but in 1844 Seymour's society was evidently known as the 'Provident Medical Institution and Victoria Benefit Society'.[88] This still existed in 1897, when its five medical officers were dealing with its thousand members in Stratford and nearby villages. These working-class members made modest contributions, so this was, in effect, a decentralised provident dispensary. [89] During much of the nineteenth century, poor women had few options for help during pregnancy and confinement. The dispensary and infirmary excluded pregnant women from their services, while the town for many years lacked a lying-in society; at least until 1862, when the Provident Institution was refounded with an associated lying-in charity.[90]

In 1872 the Church Workers' Association (an Anglican body) established a 'Nursing Institution'. Initially a nurse was established in a small house, with the task of providing domcilary nursing for the sick poor; additional funds would

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[86] Val Horton*, It's Not about Shakespeare: Aspects of Ordinary Life in Stratford-upon-Avon, 1775-1915* (Oxford: You Caxton, 2019), pp.120-22

[87] R. Seymour, *Old and New Friendly Societies, a Comparison between them. With an Account of the Becher and Victoria Clubs Recently Established at Stratford-on-Avon and Alcester* (London: Rivington, 1836).

[88] While these may have been separate bodies, they used the same premises and were served by the same secretary. SCLA DR 574/638, Draft bond from J.S. Leaver to the Treasurers of the Provident Medical Institution and Victoria Benefit Society.

[89] The contributions were 1s 6d quarterly for a single person; see SCLA DR574/728, draft affidavit of James Lyne, secretary of the Institution, also set of printed rules.

[90] SCLA DR574/728, rules, Stratford-on-Avon Provident Medical Institution and Lying-In Charity (re-founded in 1862).

be earned through nursing in the homes of the better-off. By 1876 donations allowed the institution 'to develop into a 'Nursing Home and Sick Children's Hospital' serving poor women and children in much expanded premises.[91]The instituion thus had several functions. In its domiciliary nursing role, it was a Warwickshire example of the district nursing associations that were founded, with similar aims, from the 1860s onwards. The majority had roots in the Church of England, although similar associations in Liverpool and Birmingham had nonconformist connections. These influenced the development of British nursing, although their contribution is less well recognised than the hospital-based reforms of Florence Nightingale.[92]

The infirmary's staffing in the middle decades of the century (c.1840 – c.1870) reflected contemporary patterns of medical practice in Stratford-on-Avon.[93] In 1839 James Pritchard, then nearing seventy, was named 'consulting surgeon' (in that era normally a retirement or semi-retirement post). Frederick Pritchard (his son) and Thomas Burman were then jointly elected to a post as honorary surgeons. After their partnership was dissolved in 1841, Burman held the position alone. By 1857 'Rice and Son' were likewise joint occupants of an honorary surgical appointment, Bernard Rice then being in partnership with his father David (while also acting as dispenser). John Nason, appointed an Infirmary surgeon c. 1858 soon after settling in the town, was later to be a prominent local figure.[94] Dr Thomson resigned in 1857 because of ill health and

[91] Horton, *It's Not about Shakespeare,* pp.120-22; Philip Spinks, 'The Stratford-on-Avon Convalescent Home, *Warwickshire History*, XIII,3, Summer 2006, 94-108. Stratford's current vicar, Dr J. L. Collis, and Canon Seymour were both active in fostering the new Institution.

[92] The Unitarian businessmen, William Rathbone and Timothy Kenrick, initiated associations in Liverpool and Birmingham, respectively; see Stuart Wildman, 'Local Nursing Associations in an Age of Nursing Reform, 1860 –1900' (unpublished PhD Thesis, Birmingham, 2012), pp. 100-110.

[93] The main source is the *Medical Directory* for 1847, 1851, 1853, 1857, 1861 and 1866; this publication had sections listing hospitals, dispensaries, and Poor Law medical officers.

moved to Leamington.[95] Dentistry was added to the infirmary services at the early date of 1851, the surgeon-dentist being John G Gamble (son of the local surgeon John Gamble, active early in the century).

The practitioners who became established in the town evidently had successful practices. David Rice occupied a large house adjoining the original dispensary, in 1851 with six children and three servants. Frederick Pritchard lived at 11 Bridge Street, then Stratford's broad marketplace. As a bachelor in 1841, he shared the house with his parents; Thomas Pritchard, an apprentice (presumably related); an assistant; and four servants. Ten years later his household included his wife, five children and six servants. Whether James Pritchard worked in his son's practice is unknown, but in 1851 (aged 81) he was medical officer to the Union Workhouse. Several of the town's practitioners (Henry Lane, John Nason and David Rice) held posts as Poor Law District Medical Officers for Stratford and nearby parishes.[96] The payments, generally of £50 per annum, were poor recompense for the laborious duties, which would include riding out to scattered rural dwellings. Motivations may have included practice consolidation and the discouragement of potential competitors.[97] The apparent prosperity of prominent medical families was in several cases curtailed by untimely death. In late 1859, James Pritchard died aged ninety, soon followed by his son Frederick at forty-nine. In the following year David Rice died at sixty, while in 1868 Henry Lane died aged forty-two, and Bernard, the son and professional partner of David Rice, was to die in 1879 at forty-eight. The causes of death are not known, but as Woods has shown, nineteenth-

[95] His Leamington retirement was only brief, as he re-entered medical practice and adopted various public roles before his sudden death, aged 71, in 1873. 'Dr. Thomas Thomson (obituary)', *Leamington Spa Courier*, 25 January 1873.
[96] Henry Lane, MRCS and LSA 1852, was an infirmary surgeon from c.1857 and dispenser in the 1860s.
[97] The Poor Law posts, one being held to a late age, might also suggest that in the town there was insufficient private practice to support the number of medical men. In the 1848 Medical Directory, 19% of all general practitioners held poor law posts, 12.5% at hospitals or dispensaries, and 3.5% both types; see Loudon, *Medical Care and the General Practitioner*, pp. 237-41 (figures p. 239); Digby, *Making a Medical Living,* pp. 244-49.

century medical practitioners had a higher mortality and lower life expectancy than other professions, and indeed than most other occupations**.** The causes of their excess mortality included accident, suicide, and diseases of the liver and digestive system (including cirrhosis). [98]

Medical Mayors and Sanitary Challenges: Professional Voices and Public Health

The eight medical practitioners who became mayors of Stratford-on-Avon during the nineteenth century indicate the extent of medical involvement in local affairs; five of them served two or more terms.[99] In earlier periods, official action would be prompted by epidemics, especially of smallpox, but from about the mid-nineteenth century municipal activism had a more explicit focus on improving public health in a more general sense. [100]

Until the nineteenth century, smallpox, with its high death rates and risks of disfigurement, was the most feared of diseases.[101] In eighteenth-century Stratford, among about two thousand inhabitants, there were several epidemic years with over one hundred deaths (about twice the usual number). [102] During epidemics, the corporation and vestry implemented simple public health measures, including isolation of patients, quarantine of contacts, and from the 1760s, inoculation, which by c.1780 had evidently contributed to a decline in mortality. When the disease re-appeared locally in July 1824, the dispensary played a small but significant part (as exemplified in the introduction). [103]

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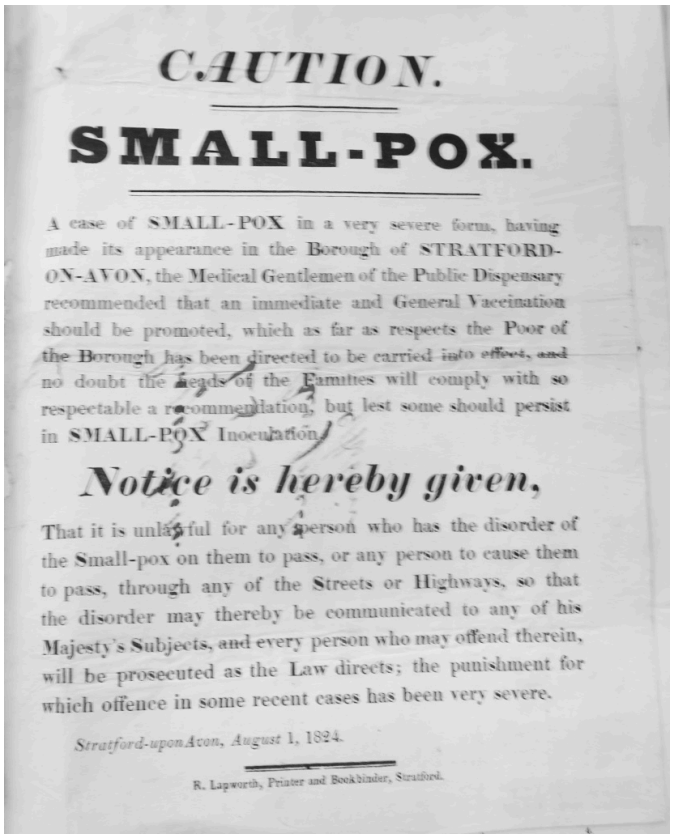
[98] Robert Woods, 'Physician, Heal Thyself: The Health and Mortality of Victorian Doctors' *Social History of Medicine*, 9(1996), 1-30, esp. pp. 7, 8-10., 17-18.
[99] There were fifty-one individuals serving as mayor in total; Stratford-upon-Avon Town Council, 'Civic History: Mayors of Stratford-Upon-Avon, 19th Century', (2018), https://www.stratford-tc.gov.uk/the-mayor/civic-history (last accessed 31 July 2021)
[100] Lane, 'Poverty and Disease in Eighteenth-Century Stratford', esp. pp. 129-34
[101] Romola Davenport, Leonard Schwarz, and Jeremy Boulton, 'The Decline of Adult Smallpox in Eighteenth-Century London', *Economic History Review* 64 (2011), 1289–314, p.1289.
[102] Lane, 'Poverty and Disease in Eighteenth-Century Stratford', pp. 132-4.
[103] There was a national smallpox epidemic in 1824-25; Charles Creighton, *A History of Epidemics in Britain*, 2 (Cambridge: Cambridge University Press, 1894) pp. 593-6



CAUTION.

SMALL-POX.

A case of SMALL-POX in a very severe form, having made its appearance in the Borough of STRATFORD-ON-AVON, the Medical Gentlemen of the Public Dispensary recommended that an immediate and General Vaccination should be promoted, which as far as respects the Poor of the Borough has been directed to be carried into effect, and no doubt the Heads of the Families will comply with so respectable a recommendation, but lest some should persist in SMALL-POX Inoculation,

Notice is hereby given,

That it is unlawful for any person who has the disorder of the Small-pox on them to pass, or any person to cause them to pass, through any of the Streets or Highways, so that the disorder may thereby be communicated to any of his Majesty's Subjects, and every person who may offend therein, will be prosecuted as the Law directs; the punishment for which offence in some recent cases has been very severe.

Stratford-upon-Avon, August 1, 1824.

R. Lapworth, Printer and Bookbinder, Stratford.

Figure 16: Measures to be taken to combat smallpox , 1 August 1824 (SCLA BRU15/18/133; broadside issued by Stratford Select Vestry)

The first patient, said to have a 'severe form' of the disease, was Ann Raison, a fifteen-year-old labourer's daughter of Windsor Street (her younger sisters, Hannah and Sarah, showing signs of the infection three weeks later).[104] The description 'severe' probably arose from the extent and degree of the child's eruption, which roughly corresponds with the likelihood of dangerous internal involvement. The first case led John Conolly and two of his colleagues to write to the mayor, their letter being passed to the parish select vestry.

[104] The thesis introduction started with an account of this outbreak. SCLA DR 253/1, Patient register, 1824.

Alongside somewhat alarming posters (fig 16), the vestry followed medical recommendations and offered vaccination for parish paupers.[105] There were two more cases in children in nearby villages during September and October but fortunately all five dispensary patients recovered. While the total of those affected is unknown, burial records record no deaths from smallpox in these months.

Although local practitioners promoted vaccination in infants, their parents did not present them at the dispensary, nor did parish paupers undergo the procedure.[106] Such apathy had stimulated Conolly to write a pamphlet promoting the practice and discouraging the riskier procedure of variolous inoculation; he notes the prevalence locally of 'considerable prejudices…against the cowpox [vaccination]'.[107] Despite the medical efforts at promoting vaccination, the local population, or at least its poor members, remained unpersuaded. By 1829 local feeling had evidently altered, and three pages in the dispensary register list vaccinated infants (122 in the period 1829-33).[108] In 1832-3 the Overseers of the Poor paid several local practitioners £21 for vaccinations (at five shillings a case, equivalent to eighty-four individuals).[109] The Birmingham and Coventry Dispensaries also encountered suspicion of vaccination among local populations, but by the 1830s this had evidently diminished (at least in Birmingham; 'vaccine hesitancy' continued in Coventry,

[105] Vaccination was the introduction into the skin of material from a cow with cowpox or *Vaccinia*, as popularised by Edward Jenner from 1796. Medical practitioners promoted this in preference to the riskier procedure of inoculation (using material from a smallpox pustule).

[106] SCLA DR 363 Overseers' accounts, 1824-25; the vestry made no payments to medical practitioners for the procedure during this financial year.

[107] His pamphlet was on similar lines to one written anonymously two years previously (in Chichester; see Richard Hunter and Ida Macalpine, 'An Anonymous Publication on Vaccination by John Conolly (1794--1866)', *Journal of the History of Medicine and Allied Sciences,* 14/3 (1959), 311-319.

[108] In 1829 nine children were vaccinated, four in 1831, 14 in 1832, and 95 in 1833. SCLA DR 253/1, Patient register, back pages, 1829-33.

[109] SCLA BRT 8/256/38-9, Abstract of the receipts and disbursements of …the Overseers of the Poor, 1832-32 and 1833-34).

as discussed near the end of Chapter 2). Brunton comments that poor people were 'less enthusiastic about vaccination' in the early nineteenth century, many continuing to prefer inoculation (often from unorthodox practitioners, one of Conolly's grumbles in his pamphlets).[110]

Smallpox, while feared, was to a large degree a familiar condition. When Asiatic cholera arrived on these shores late in 1831, this seemed to most people an unknown and frightening disorder (as considered in Chapter 2 for Birmingham and Coventry). Its mysterious features included the rapid, often fatal decline of victims, and patterns of spread between locations or individuals which seemed puzzling and unpredictable. Central government encouraged local action through parish vestries, which were required to appoint local boards of health.[111]

In November 1832 the Stratford corporation minutes noted the prevalence of cases at Shottery, one mile from the town, and started a charity collection to fund 'proper food and clothing' for the poor people of the parish. Meanwhile the local Board of Health (formed on government instructions by James Pritchard, the current mayor and both a Poor Law and a dispensary surgeon) was ordering the closing of open cesspits and whitewashing some working-class houses.[112] In general the reaction, both of local authorities and of the population, appears less intense than in Birmingham the same year (as discussed in Chapter 2).[113] The epidemic resulted in twenty local cases and seven deaths, but evidently none among dispensary patients.[114] The local boards of health were dissolved once the crisis had passed, and public authorities resumed their laissez-faire policies.

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[110] Deborah Brunton, The Politics of Vaccination: Practice and Policy in England, Wales, Ireland and Scotland, 1800–1874 (Rochester: University of Rochester Press, 2008) p.13.
[111] R. J. Morris, *Cholera 1832: The Social Response to an Epidemic* (London: Croom Helm, 1976); attitudes pp.16-17, official responses pp. 23-25.
[112] SCLA BRU 2/8, Corporation minutes, 15 November 1832.
[113] Ian Cawood and Chris Upton, '"Divine Providence': Birmingham and the Cholera Pandemic of 1832', *Journal of Urban History* 39 (2013), 1106-24.
[114] Tina Young Choi, 'Cholera Returns in Great Britain (1832)', in *Sanitary Reform in Victorian Britain,* 1*,* ed. by Michelle Allen-Emerson, Tina Young Choi , Christopher Hamlin (London, Pickering & Chatto, 2012), 45-69, p. 64.

As Stratford gained inhabitants in the early nineteenth century, workers' housing was added piecemeal to the ancient borough that had developed 'without any attention to drainage or cleanliness'.[115] Dwellings were squeezed into back alleys and yards, or rows of cottages were built behind others. The already narrow Scholars Lane offers a striking instance, Garden Row being added in 1815, where fourteen cottages shared one privy.[116] In 1832 John Conolly reflected on his earlier experience in the town; he noted the 'lack of space [in such cottages] for a back door…the manure heaps in front, and a surface never drained'. He observed that fever was commoner in such recently built dwellings than in older ones.[117] From the 1830s several terraced streets were built in the New Town close to the Birmingham canal, laid to the north of the town. Those closest to the canal suffered seepage from it, a factor worsened by the lack of surface drainage and the high clay content of the soil.

In most towns, both dispensary and poor law practitioners were active in documenting the high rates of fever found where living conditions were poor, but in Stratford it was Thomas Thomson, the Infirmary physician, whose voice was mainly heard. In 1848 national legislation was introduced that enabled (and to some extent required) local authorities to deal with urban sanitary failings. The Public Health Act was the work of Edwin Chadwick and his allies, who exploited general concern about insanitary conditions and fears of the approaching cholera epidemic (see discussion of cholera in Chapters 1 and 2).[118] At a large public meeting in October Dr Thomson reported the local statistics,

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[115] George T. Clark, *Report to the General Board of Health on a Preliminary Enquiry into the Sewerage, Drainage and Supply of Water, and the Sanitary Conditions of the Inhabitants of the Town of Stratford-on-Avon* (London: W Clowes for HMSO, 1849), p.5.
[116] Bearman, Stratford-Upon-Avon Streets and Buildings, p. 50.
[117] In his paper delivered to the inaugural meeting in 1832 of the Provincial Medical and Surgical Association (PMSA), Conolly drew on his experiences in Stratford during 1823-7; John Conolly, 'A Proposal to Establish County Natiural History Societies', *Trans PMSA*, 1 (1833), 180-218, pp. 188-9.
[118] Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800-1854* (Cambridge: Cambridge University Press, 1998), pp. 252-58.

speaking passionately in favour of an application under the Act. This was supported by a large majority of those present.[119]

In March 1849 an inspector appointed by the General Board of Health visited the town. He noted that in 1848 local inhabitants experienced an annual mortality of 23.5 per thousand, 21 per thousand for the borough and 26 for the rest of Old Stratford parish.[120] The latter rate, surprisingly high for a mainly semi-rural district, resulted from the amount of illness in the northern 'New Town'. In this suburb of small dwellings built after 1816, 27 per cent of the inhabitants in two streets were affected by zymotic disorders; likewise unhealthy (with 14 per cent affected) were Scholars Lane and Garden Row (discussed above).[121] As regards the second cholera epidemic in 1848-49, Stratford fared better than in 1832, not experiencing a single cholera death. The local Board of Health established in September 1850 therefore received only lukewarm support. Wealthier inhabitants supported the recommendations for drainage and water supply, their leaders on the council being Dr. Thomson, the surgeon David Rice, the miller Charles Lucy, and the brewer Edward Flower (who also experienced flooding from the canal into his adjoining house and brewery).[122] In opposition to the costly plans, several small tradesmen gained election to the Board as 'economisers'. After a fierce battle the proposals were eventually carried in 1853, but it was many years before their full implementation (for instance, the town's streets not being paved until 1868).[123]

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[119] The Act could be applied locally if there was either a petition of 10% of the inhabitants or a mortality rate exceeding 23 per thousand. Stratford qualified on both counts; 'Meeting at Stratford', *Warwick and Warwickshire Advertiser*, 4 November 1848.

[120] Clark, Sanitary *Report on…Stratford-upon-Avon*; in December 1848 the borough population was calculated as 3269 and the rest of Old Stratford parish as 2363 (total 5632). Dr Thomson supplied the mortality figures for 1841-7, quoted in Clark's report, p. 6 (he may also have used the figures of Poor Law doctors, who were generally on the Infirmary staff); in 1849 Thomson was serving his third term as mayor.

[121] The average incidence in all local streets was 9.3%; Clark, *Sanitary Report on Stratford-on-Avon*, p.11.

[122] Clark, *Sanitary Report on Stratford-on-Avon,* pp. 8-9; R.I. Penny, 'The Board of Health in Victorian Stratford-Upon-Avon: Aspects of Environmental Control', *Warwickshire History* 1 (1971), 1-19 , pp. 9-10.

[123] Penny, 'The Board of Health in Victorian Stratford', pp. 10-11.

Despite such delays, even the limited changes in drainage and attention to nuisances resulted in improvements in Stratford's total mortality. A decennial report by the Registrar-General revealed a mortality rate for 1851-60 of 19 per thousand (having fallen from 24 for the previous decade).[124] As the previous Chapter observed, the resistance of some ratepayers to sanitary 'improvements' can be seen as understandable. The technical solutions advocated by Chadwick, supported by much medical opinion, were costly, not self-evidently effective, and sometimes flawed.[125]

Later efforts are worth noticing, such as the renewed efforts to improve sanitary conditions in the 1870s. After a local Medical Officer of Health was appointed in 1873, he worked closely with Drs Henry Kingsley and John Nason, respectively physician and surgeon to the Infirmary.[126] They turned their attention to housing and gained support from Liberal businessmen such as the timber merchant James Cox and members of the Flowers brewing family. The owners of several growing family businesses were thus fostering local urban improvement, like sanitary reform earlier; while on a small scale, there are interesting parallels with the activities of Chamberlain and his allies in Birmingham (Ch. 1 & Ch. 6).[127] From 1875 the Stratford-on-Avon Labourers' Dwellings Society created some soundly built terraced dwellings. These were fully up to prevailing ('by-law') standards, charged modest rents, but still earned a small profit.[128]

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[124] Registrar-General, *35th Annual Report* (London: HMSO, 1861)

[125] These included small-bore sewage pipes and the use of untreated sewage as manure on farmland. Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800–1854* (Cambridge: Cambridge University Press, 1998), pp. 274-334; Christopher Hamlin, 'Muddling in Bumbledom: On the Enormity of Large Sanitary Improvements in Four British Towns, 1855-1885', *Victorian Studies,* 32 (1988), 55-83.

[126] Henry Kingsley (1818-85) MD Aberdeen 1854, FRCP Edin 1858, MRCP London 1859, was the infirmary physician from 1857; John J. Nason MB London 1856, LSA MRCS 1852, was elected a surgeon c.1857.

[127] Several generations of the Cox family operated the timber business from a wharf adjoining the river and canal basin, the premises, 'Cox's Yard', now being a restaurant and entertainment venue.

[128] Penny, 'The Board of Health in Victorian Stratford', pp.16-19; Nason was the current mayor and Kingsley was an ex-mayor.

During the nineteenth century, Stratford-on-Avon became much more recognisably the town of Shakespeare. Medical practitioners joined other citizens to celebrate the town's most famous son, through organisations like the Shakespeare Club.[129] It was principally younger tradesmen that formed this group in 1824, but local professional men and the urban gentry soon joined them. A prominent early member was John Conolly, well known for his love of the poet (as noted by his friend Sir James Clark in his memoir).[130] Later the committee that planned the 250th Anniversary celebrations (in 1866) included the local vicar, leading businessmen and Drs. Kingsley and Nason.[131] During this period, energetic campaigns sought to preserve various Shakespeare properties to ensure public access. In 1857 the Shakespeare Birthplace Trust purchased the house in Henley Street traditionally considered the dramatist's childhood home.[132] 'The myth of the building contributed to the "myth" of Shakespeare…its status as a burgeoning tourist site… provided proof or Shakespeare's universal (and imperial) appeal.'[133] Once 'restored' the birthplace became the key site in a tourist trail that took in the family's properties and other places traditionally linked with Shakespeare.[134] Such associations became a huge source of civic pride. Large industrial cities, like Birmingham, could demonstrate their cultural credentials with concert halls and art galleries, but Stratford, small as it was, could claim the home and shrine of the national bard.[135]

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[129] Susan Brock and Sylvia Morris, *The Story of the Shakespeare Club of Stratford-on-Avon 1824-2016: Long Life to the Club Call'd 'Shakspearean'* (Stratford-on-Avon: Shakespeare Club, 2016).
[130] Sir James Clark, *A Memoir of John Conolly, M.D., D.C.L., Comprising a Sketch of the Treatment of the Insane in Europe and America* (London: John Murray, 1869) pp. 6-7.
[131] Brock and Morris, *The Shakespeare Club of Stratford-on-Avon*; a photograph of the group appears on p.71.
[132] While resident in Stratford, John Conolly lived in a substantial Georgian house adjoining the birthplace (demolished when the latter was restored in the 1850s).
[133] Julia Thomas, *Shakespeare's Shrine: The Bard's Birthplace and the Invention of Stratford-Upon-Avon* (Philadelphia: University of Pennsylvania Press, 2012), p.5
[134] Thomas, *Shakespeare's Shrine*, pp. 122-55.
[135] For Birmingham, see Asa Briggs, *Victorian Cities* (London: Penguin, 1990 (orig. publn.1963)), pp. 231-3; Tristram Hunt, *Building Jerusalem: The Rise and Fall of the Victorian City* (London: Weidenfeld & Nicholson, 2004) pp. 230-4.

Conclusions

This Chapter has outlined the nineteenth-century development of an important strand of the medical services in a small but prosperous and steadily growing Midlands town. In a time of rapid social and medical change, a small dispensary developed into an infirmary and developed more comprehensive services. Its organisational evolution therefore differed from the principal dispensaries in Birmingham and Coventry, which continued as purely outpatient institutions alongside the general hospitals.

An account of services in a small town might appear simpler than its counterparts in larger places, but here one institution performed functions that in larger places might be the task of several. During the nineteenth century, the local welfare economy gained a provident medical institution, and later a lying-in charity, a nursing institute, and a convalescent home. By the late decades of the century, there were thus, in principle, several sources of help for the poorer citizens of Stratford. In terms of the social groups supporting the dispensary and the later infirmary, the landed gentry prominently supported the founding and headed later funding campaigns, but otherwise took little regular part. It was the medical officers, supported by committee members comprising professional people and the urban gentry, that controlled day-to-day institutional functioning. Stratford's experience thus seems closer to the interpretations of Morris and Loudon than Pickstone' view, in which the landed gentry are seen as having a more significant role.[136] In its change from a dispensary to an infirmary, the local institution followed a path broadly similar to those of institutions in Cheltenham and in Yorkshire's West Riding.[137] Analysis of the patient register indicates that the dispensary patients came from a broad swathe of the rural and small-town working class, from a wide age range and of both genders. From the late 1830s, the Provident Institution may have covered

[136] Pickstone, *Medicine and Industrial Society*, pp 7-70; 'The Professionalisation of Medicine in England and Europe' p. 40; Loudon, 'Origins and Growth', pp. 228-30; Morris, 'Voluntary Societies and British Urban Elites', pp. 96, 101-110.
[137] Daphne Doughton, 'The Beginnings of the Cheltenham Dispensary', *Gloucestershire History*, 5 (1991), 14-17; Marland, *Doncaster Dispensary*, pp. 71-2; *Medicine and Society in Wakefield and Huddersfield*, pp. 101-9, 133-5, 155-6.

more of the local artisan class, while labourers and their families could continue to seek the aid of the dispensary and the later infirmary. Local patterns of morbidity and mortality, judging from the limited evidence, show only subtle differences in comparison with larger towns. The dispensary minutes and register offer hints about the life of the local 'sick poor' and their experiences of medical care, but neither in these sources or others do we hear their voices.

The study reflects the close connection between the town's corporation and its medical charity. In the early days such links might reflect the position of both governors and medical men as members of the local oligarchy.[138] Later in the century (in a reformed system of local government) medical knowledge and experience influenced the local council in its endeavours to improve the health of citizens, especially through sanitation and housing conditions. Practitioners may have found that Stratford's small size made it feasible to combine professional practice with civic activities, but more generally, such a degree of medical involvement was unusual.[139] The individuals concerned presumably gained social capital from this work, as they also did with their honorary dispensary or infirmary appointments. Several medical practitioners were also active in the shared endeavours celebrating Shakespeare as a cultural icon, thereby helping their town to gain a national and even international significance. Such local efforts matched those in larger towns, like Birmingham, that sought to enhance their own cultural capital.[140] The campaigns at Stratford assisted its evolution from a purely market and agricultural centre into the largely residential, cultural, and leisure town that it has since become.

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[138] Rosemary Sweet, *The English Town 1680-1840: Government, Society and Culture* (Harlow: Longman, 1999), pp. 30-35.
[139] E. P. Hennock, *Fit and Proper Persons: Ideal and Reality in Nineteenth-Century Urban Government* (London: Edward Arnold, 1973), pp. 40-42, 44-45.
[140] Briggs, *Victorian Cities,* pp. 231-3; Hunt, *Building Jerusalem*, pp.230-34.

Chapter 4

Medicine, science, and journalism: the lives and writings of two Midland dispensary physicians: *c.*1820 - *c.*1840.

Introduction

John Darwall of Birmingham was 'a physician of great estimation among his provincial brethren'… because of…'his learning, experience and never-ceasing ardour for knowledge'. These were the words of John Conolly, his friend and student contemporary, when a few months following his death, he addressed two hundred fellow practitioners. These were the members of the recently formed Provincial Medical and Surgical Association, attending their annual meeting in Bristol.[1] Following their undergraduate days in Edinburgh, the two men had continued to collaborate, including in medical journalism, despite differences in temperament, political views, and, perhaps, of religious convictions. This chapter will explore the relationship of their writing to their medical work, in Warwickshire dispensaries and elsewhere, and hence their relevance to this study. Darwall passed ten years in in such a role in Birmingham (1821-31), while Conolly served at several dispensaries (mainly at Stratford-on-Avon in the 1820s and Warwick in the 1830s, but also briefly in Chichester, and for three years at the London University Dispensary). As nineteenth-century dispensary practitioners writing for publication, they appear to be in a minority, so their publications are worth examining both for reflections on their own clinical work and the influence of wider ideas.

[1.] John Conolly, 'Biographical Memoir of the late Dr John Darwall of Birmingham, *Trans. PMSA (Transactions of the Provincial Medical and Surgical Association)* 2 (1834), 489-546; quote p.489; the meeting was in Bristol in August 1834.

While Conolly's remarks on his late friend expressed conventional pieties, they probably did reflect genuine esteem by colleagues.[2] Despite this, John Darwall is relatively little-known today.[3] This contrasts with John Conolly, who gained contemporary fame through his work introducing more humane care for mental illness. This view has, however, been much qualified by later revisionist critiques, notably summarised by Scull.[4] This Chapter is devoted to exploring the significance of their lives and writings, and the relationship of these with the contexts in which they worked, especially in dispensaries. Both individuals' careers, including their work as authors and editors, suggest that they were influential figures rather than typical of their peers: their work, however, offers various clues to early nineteenth-century medical ideas, experiences, and preoccupations. After introducing certain key concepts, such as Inkster's adaptation of the 'marginal man' idea, the Chapter will outline the two biographies and discuss the two men's writings in detail. These sections will be followed by consideration of the general significance of medical associations and publications, and their connection with everyday medical practice, especially at dispensaries.[5]

The Chapter's time frame is determined by the start of their professional lives in 1821, and its termination, in Darwall's case by his premature death in 1833, and in Conolly's, by the start of a new phase as an alienist in 1839. As

[2] At the 1832 PMSA meeting, Darwall was named as the member to give the 'retrospective address' (in modern terms, a keynote lecture) at the meeting two years thence in Birmingham, *Trans. PMSA* 1 (1833), xxiii.

[3] Jonathan Reinarz, 'Darwall, John (1796–1833), physician ', in *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004, online edn, Jan 2013); last accessed 7 July 2021. https://0.www.oxforddnbcom.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-62849.

[4] Andrew Scull, 'Conolly, John (1794–1866), physician and alienist', *Oxford Dictionary of National Biography*. (Oxford: Oxford University Press, 2004, online edn, Jan 2013); Accessed 6 October 2021. https://0-www-oxforddnb-com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-6094.

[5] A general biographical article has appeared as John Wilmot, 'John Conolly: Nineteenth-century Physician and Reformer', *University of Edinburgh Journal*, 49.3 (2020), 189-93.

physicians, they chiefly treated internal disorders, and at dispensaries they served alongside other professionals including surgeons, apothecaries, druggists, and sometimes nurses or midwives. By the early nineteenth century, physicians, surgeon, and apothecaries differed more in their training and status than in the content of their everyday practice. However, as Loudon suggested, dispensaries and hospitals tended to preserve intra-professional distinctions, together with the associated prestige.[6] The physicians, as the only medical graduates, might seem to be more likely candidates for visibility through authorial and other public activity, but at least some surgeons gained attention in a similar way. The significance of their journalistic work is suggested by the way that authors and editors reflect their times and sometimes influence their peers. Such factors contribute to the potential relevance of a biographical component even to a study, like this one, whose principal focus is on institutions and their social contexts.

The Chapter's themes embrace both *knowledge* and *association*, the two axes proposed by Michael Brown for analysis of contemporary practitioners' social and intellectual world.[7] Another theme is suggested by early nineteenth-century shifts in the social role and function of medical men. Ian Inkster's concept of the 'marginal man' will be interrogated in relation to Conolly's and Darwall's lives, particularly regarding their wide-ranging medical, scientific, and cultural interests. Inkster adopted the term from the Chicago sociologist Robert Park, whose concern was with migrants, often members of ethnic or religious minorities, who 'lived in more than one social world' but were not completely at home in any. Inkster studied a group of practitioners of medicine and allied fields in the rapidly changing community of Sheffield during the Industrial

[6] Anne Digby, Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911 (Cambridge: Cambridge University Press, 1994), pp.28-30; see Irvine Loudon, Medical Care and the General Practitioner, 1750-1850 (Oxford: Clarendon, 1986), pp. 27-28.

[7] Michael Brown, Performing Medicine: Medical Culture and Identity in Provincial England, c.1760 – 1850 (Manchester: Manchester University Press, 2011), pp. 5-6.

Revolution (1790-1850).[8] Among many provincial 'new men', socially and geographically mobile, medical practitioners stood out in their striving for individual status and as members of a still emerging profession. Inkster's Sheffield practitioners involved themselves in an associative world that ranged from medical societies to more general cultural groupings, such as literary and philosophical societies, the 'Lit and Phil' found in many towns. Their political ideas generally leaned towards reform or radicalism, and most were dissenting in religion. Such individuals were also active, in Sheffield and elsewhere, in the urban mechanics' institutes that were founded from the 1820s.[9] These provided a forum for scientific discussions and (somewhat debatably) for the adult education of working men.[10]

Science in the early nineteenth century was increasingly concerned with analysis, on 'taking objects apart' to understand them better.[11] For medical men, the new clinical science developing in Paris was analogous in its close observation of living patients, which was coupled, in those who died, with the use of pathological anatomy in a search for the causative disease.[12] Conolly and Darwall would have become familiar with this clinico-pathological paradigm through their Edinburgh training, while their later careers revealed more general scientific and cultural interests. Ulrich Tröhler has argued that dispensary practitioners were well placed for extensive observations of the

[8] Robert E Park, 'Human Migration and the Marginal Man', *American Journal of Sociology*, 33 (1928), 881-93.
[9] Ian Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850', in John H Woodward and David Richards (eds), *Health Care and Popular Medicine in Nineteenth Century England* (London: Croom Helm, 1977), 128-63, pp. 128-9, 140-1, 148-9, 159-60.
[10] In 1851 there were over 700 such institutions with over 120,000 members. Ian Inkster, 'The Social Context of an Educational Movement: A Revisionist Approach to the English Mechanics' Institutes, 1820-1850', *Oxford Review of Education,* 2 (1976), 277-307, p.284.
[11] John V Pickstone, *Ways of Knowing: A New History of Science, Technology and Medicine* (Manchester: Manchester University Press, 2000), p. 73.
[12] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, (London: Routledge, 1989); Stephen Jacyna, 'Medicine in Transformation, 1800-1849', in W F Bynum et al (eds.), *The Western Medical Tradition, 1800-2000,* Cambridge: Cambridge University Press, 2006), 11-110, pp. 40-64.

'natural history of diseases', including their features, variations, and responses to treatment.[13] New ideas from France were in the 1820s and 1830s changing thinking, albeit in a contested manner, in medicine and its allied sciences. Reformers and radicals were also challenging the structure and functioning of medicine's governing institutions and sometimes of its underlying philosophy.[14]

The historiography of medical journals helps to illustrate the part played by printed material in wider debates. Early surveys by Bynum, the Loudons and others identified various publications and explained their role in informing practitioners, so offering context for the individual journalistic efforts considered here.[15] Other scholars, such as Desmond, Burney, and Brown, adopt a more explicitly political analysis of Thomas Wakley's *Lancet* and its rivals, in relation to currents of radicalism, reform and reaction. Desmond explored how bitter debates in the field of anatomy reflected wider social and political turbulence. [16] All these authors, but especially Brown, emphasise the importance of such publications in the formation of the modern medical profession.

In his comparative study of Birmingham and Sheffield, Dennis Smith challenged Inkster's thesis, contesting the relevance of the 'marginal man' to

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[13] Ulrich Tröhler, 'The doctor as naturalist: the idea and practice of clinical teaching and research in British policlinics 1770-1850'. *Clio Medica* 1987; 21(1-4):21-34, pp 22-3, 27.
[14] Ian Burney, 'Medicine in the Age of Reform', in Arthur Burns and Joanna Innes (eds.), *Rethinking the Age of Reform: Britain 1780-1850,* (Cambridge: Cambridge University Press, 2007), 163-85; Adrian Desmond, *The Politics of Evolution : Morphology, Medicine and Reform in Radical London* (Chicago: Chicago University Press, 1989), esp. pp. 3-5,9,21.
[15] W F Bynum and Janice C Wilson, 'Periodical Knowledge: Medical Journals and Their Editors in Nineteenth-Century Britain', 29-48; Jean Loudon and Irvine Loudon, 'Medicine, Politics and the Medical Periodical 1800-50', 49-69, both in William F. Bynum, Stephen Lock, and Roy Porter (eds.), *Medical Journals and Medical Knowledge: Historical Essays,* (London: Routledge, 1992).
[16] Ian Burney, 'The Politics of Particularism: Medicalisation and Medical Reform in Nineteenth-Century Britain ', in Roberta Bivins and John Pickstone(eds.), *Medicine, Madness and Social History: Essays in Honour of Roy Porter,* (London: Palgrave Macmillan, 2007), 46-57; Burney, 'Medicine in the Age of Reform', 163-85; Michael Brown, ''Bats, Rats and Barristers': the *Lancet*, Libel and the Radical Stylistics of Early Nineteenth-Century English Medicine', *Social History,* 39 (2014), 182-209; Michael Brown, 'Medicine, Reform and the 'End' of Charity in Early Nineteenth-Century England', *English Historical Review,* CXXIV (2009), 1354-88.

the Birmingham context. He points, for instance, to the prominence of Anglican-Tory medical men there in the 1820s and 1830s.[17] Relevant here is Inkster's later revision of his original thesis; he recognised that many practitioners were far from marginal or 'outsiders' in social and economic terms. He suggested that both medical men and savants (these groups of course often overlapping) relied on the above activities less for social mobility than to develop an identity distinct from both capitalist employers and from the labouring masses.[18]

The two individuals considered here, while close friends from student days, followed distinct paths. John Conolly's chequered career (a term he himself used) ranged from provincial medical practice in Sussex and Warwickshire to the first chair of medicine at London University.[19] He is however best known for his later post (initially as 'resident physician') in charge of the large pauper lunatic asylum at Hanwell to the west of the metropolis. He was widely praised by contemporaries for establishing a more humane regime for the mentally ill, especially in relation to the abolition of physical restraints. Nevertheless, controversy has surrounded his character and achievements from his own day: in recent decades this has often been allied to wider critiques of psychiatric concepts and practices. Conolly's friend James Clark presented the view of an admiring contemporary; Conolly's son-in-law Henry Maudsley recorded very mixed observations and opinions; two psychiatrist-historians, Richard Hunter and Ida Macalpine, regarded him as a humane and foundational

[17] Dennis Smith, Conflict and Compromise: Class Formation in English Society, 1830-1914 (London: Routledge, 1982), pp.154-60.
[18] Ian Inkster, 'Introduction: Aspects of the History of British Science and Science Culture, 1780-1850 and Beyond', in Ian Inkster and Jack Morrell, (eds)., *Metropolis and Province: Science in British Culture, 1780-1850* (London: Hutchinson, 1983), 11-54, pp. 40-41.
[19] Conolly himself used the term 'chequered' in a valedictory speech in Stratford; 'Dr Conolly's Farewell Dinner', *Warwick and Warwickshire Advertiser*, 6 June 1839.

figure; and these varying judgements are discussed by Andrew Scull both in an *ODNB* entry and in a lengthy critical revisionist analysis in *Masters of Bedlam*.[20]

Although, as already noted, John Darwall is not well known today, he has latterly been recognised as significant, in two fields where he was a pioneer, namely children's medicine and contributions to occupational diseases.[21] Conolly's own life is relatively well documented, but Darwall's is much less so, meaning that all recent accounts (including this one) have relied heavily on Conolly's vivid memoir of his friend.[22] The abundant biographical and other material concerning the pair's friends and collaborators (especially John Forbes and Charles Hastings) helps to place them in a web of acquaintanceship and ideas. In terms of sources, much contemporary journalism has become more accessible through digitisation projects, but the paper versions of journals remain invaluable in amplifying and contextualising material found online, through related or serendipitous documents. This is particularly true of the frequent controversies ventilated in the *Lancet.* [23]

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[20] Sir James Clark, A memoir of John Conolly, M.D., D.C.L.: comprising a sketch of the treatment of the insane in Europe and America (London: J. Murray, 1869); Henry Maudsley, 'Memoir of the late John Conolly, MD' Journal of Mental Science, XII, 58, (1866), 11-25, 151-74; Richard Hunter and Ida Macalpine, 'Editors' Introduction', in John Conolly, An Inquiry into the Indications of Insanity (London: Dawson, 1964 (orig. edn. 1830)); see also Scull, 'John Conolly', ODNB; Andrew Scull, Charlotte MacKenzie, and Nicholas Hervey, 'John Conolly: A Brilliant Career?', in Masters of Bedlam: The Transformation of the Mad-Doctoring Trade (Princeton, N.J.: Princeton University Press, 1996), 48-83.

[21] Jonathan Reinarz, 'Darwall, John (1796–1833), physician ', in *Oxford Dictionary of National Biography*. . 2013; Accessed 5 Oct. 2021. https://0-www-oxforddnb-com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-62849.

[22] John Conolly, 'the Late Dr John Darwall', pp. 489-500; Reinarz, 'John Darwall', *ODNB;* Jonathan Reinarz and Andrew N. Williams, 'John Darwall, MD (1796--1833): The Short yet Productive Life of a Birmingham Practitioner'*, Journal of Medical Biography,* 13 (2005), 150-54; A. N. Williams and J. Reinarz, 'John Darwall MD: Birmingham's Forgotten Children's Physician', *Archives of Disease in Childhood,* 90 (2005), 60-5, ; A Meiklejohn, 'John Darwall, M.D. (1796–1833) and "Diseases of Artisans"', *British Journal of Industrial Medicine,* 13 (1956), 142–51.

[23] Georgina Ferry, 'Medical Periodicals: Mining the Past', *Lancet,* 385 (2015), 2569-70.

Two medical biographies: John Darwall

John Darwall (figure 17) came from a family of Anglican divines and remained a committed churchman through his life. Born and schooled in Birmingham, he initially pursued surgical training, first as a pupil to George Freer locally, then under John Abernethy at St Bartholomew's Hospital, London, where he gained the MRCS in 1817. Even in youth he was serious and studious, according to Conolly being 'remarkable for the gravity of his deportment'.[24] He became more interested in medicine rather than surgery and believing that this was taught in London 'in a superficial manner' he elected to continue studies at Edinburgh University.[25] He enjoyed Edinburgh, largely for its intellectual rather than its social opportunities. His health, never robust, suffered from the intensity of his studies, and various symptoms continued to afflict him. While reputedly spurning the lighter diversions of student life, he appreciated the debates at the medical society, where he formed a close friendship with John Conolly.[26] His MD thesis in 1821 on the diseases of artisans appears to be the first British contribution to this field and demonstrated what was to be an enduring personal interest.[27] Back in Birmingham with his degree, John Darwall became a

[24] Reinarz, 'John Darwall', *ODNB;* Conolly, 'the late John Darwall,' p. 493.
[25] Conolly, 'the Late John Darwall', p. 495.
[26] Conolly, 'the Late John Darwall', pp. 496-501; health, pp. 539-40; the portrait of John Darwall (2012) was created by Bobby Nixon during a residency at the University of Birmingham in 2012 and is partly inspired by Conolly's memoir. (Birmingham University Arts and Science Festival 2013 –https://rcc-redmarley.tumblr.com/post/45185298732/arts-and-science-festival)
[27] Meiklejohn, 'Darwall and "Diseases of Artisans"', p.142.

physician to the General Dispensary and to the Institute for Bodily Deformity (later the Orthopaedic Hospital, founded by his old master Freer in 1817).

Figure 17: Portrait of John Darwall (2012), by Bobby Nixon, https://rcc-redmarley.tumblr.com/post/45185298732/arts-and-science-festival)

Like other physicians of the era, he regularly attended poor patients at his house for no charge, seeing one hundred through January 1824, and once attending eighty individuals in one morning. Despite his abilities, he found his private practice slow to grow, perhaps hampered by the social awkwardness implicit in Conolly's account.[28] Digby has demonstrated how many medical men struggled to establish their practices, gaining at best a precarious income. Writing for publication might help to fill idle hours and bring one's name before colleagues and the public.[29]

Darwall devoted much effort to collating details of diagnoses among those attending the Birmingham dispensary. His quarterly summaries, which

[28] Conolly, 'the Late John Darwall', pp. 506-7, 527-8.
[29] More so for physicians than general practitioners; Digby, *Making a Medical Living*, esp. pp. 162-65, 170-75; for altruistic practice, pp. 232-4.

formed an important source for the clinical details in Chapter 2, appeared as 'Diseases of Birmingham' from 1823 to 1825 in the widely read *Edinburgh Medical and Surgical Journal.*[30] He became one of five co-editors, with Charles Hastings, of the Worcester-based publication, the *Midland Medical and Surgical Reporter* (*…and Topographical and Statistical Journal*, to give its full title). This was associated with the county medical society, one of the oldest in the provinces; this carried his account of Birmingham medical topography and 'clinical observations' on different (mostly dispensary) cases. He later drew on both his private and institutional practice in his book aimed at a mixed audience, *Plain Instructions for the Management of Infants*.[31] In 1824 he accompanied Conolly on a brief visit to London to further a proposed medical association, at this stage an abortive project. However, their meetings there with George Birkbeck and others bore other fruit, such as their appointment as co-editors with James Copland of the monthly *London Medical Repository and Review*, to be described in more detail below (see also figs 19 & 20).[32]

He also wrote, for a strictly medical readership, sections in the multi-author *Cyclopaedia of Practical Medicine* (1833-35), a part-work largely aimed at students and young practitioners. Both will be discussed below. His characteristically serious-minded relaxations included reading the English classical dramatists and studying botany (often using a microscope). He applied his botanical interests to medical teaching, delivering lectures and taking students on botanising expeditions.[33] The Birmingham Botanical Gardens, which

[30] The editor was Andrew Duncan, junior (1773-1832), a physician and teacher at Edinburgh.
[31] John Darwall, Plain Instructions for the Management of Infants: With Practical Observations on the Disorders Incident to Children (London: Whittaker, Treacher and Arnot, 1830).
[32] The Scottish physician and prolific author, James Copland (1791–1870) was by then concentrating on a medical dictionary; Loudon and Loudon, 'the Medical Periodical 1800-50', p. 64.
[33] John Darwall, 'Introductory Lecture to a Course of Lectures on Botany, Delivered at the Birmingham school of Medicine and Surgery', *Midland Medical and Surgical Reporter*, 1, 1828-9, 118-20.

he co-founded in 1832, remains an important feature of local life. He was also active in the foundation of local general and medical libraries.[34]

Table 17: Publications of John Darwall, 1823-1833	
As author	**As co-editor**
Diseases of Birmingham', 1823-5, *Edinburgh Medical & Surgical Journal*	(with J. Copland & J. Conolly) *London Medical Repository and Review,* 1825-7
Plain Instructions for the management of infants, 1830	
Articles in *Midland Medical and Surgical Reporter,* 1828-31	(with C. Hastings and four others) *Midland Medical and Surgical Reporter*, 1828-32
Sections (5) in *Cyclopaedia of Practical Medicine,* 1833-5	
History of Medicine (Society for the Dissemination of Useful Knowledge), 1833	

His political views were conservative and pessimistic, Conolly finding 'painful' his gloom about the prospect of real social improvement. A lifelong Tory, he avoided the newspapers in 1831-32 because of the dissension associated with the Reform bill. In 1832 he was appointed physician to the leading local institution, the Birmingham General Hospital. He entered on his new post with his usual eagerness, commencing courses of clinical lectures for students attending the hospital. This period was cut short when in July 1833 he injured his hand during an autopsy on a gravely infected patient. Already overworked, he rapidly became ill; after ten days, he died from sepsis, leaving a widow and two daughters. Woods has shown how premature death, from infection or

[34] John Alfred Langford, *A Century of Birmingham Life*: Or, a *Chronicle of Local Events, from 1741-1841* (Birmingham: E.C. Osborne, 1868), p. 582.

otherwise, was a real hazard for nineteenth-century practitioners, especially the younger and less established among them.[35]

John Conolly: early life and career

John Conolly was born in middling circumstances in Lincolnshire, albeit with some connections among the landed gentry (see figure 17 for a portrait).[36] His first choice of career, aged eighteen, was as an officer in a militia regiment. A few months after its disbandment in 1816, and without any employment, he married Elizabeth Collins, the daughter of the late Sir John Collins, a distinguished but impecunious naval officer. This showed his tendency to take important decisions on impulse, as was later observed by his son-in-law Henry Maudsley.[37] After passing some months in France, the dwindling of his small inheritance and responsibility for a young daughter encouraged him to find a respectable means of living. Both his medical brother William and family medical friends may have influenced him in choosing to train in medicine. He decided to study in Edinburgh, attracted by its university, the highly regarded medical school, and the possibility of living very economically. He passed his first year largely in Glasgow, where he studied under Dr. Robert Cleghorn and observed his work among mentally afflicted patients at the Glasgow Royal Asylum. In Edinburgh he pursued interests in philosophy through attending Dugald Stewart's lectures as well as medical classes, while his dissertation of 1821 on lunacy and melancholia foreshadowed his later preoccupations.[38] Personal charm and facility with both writing and public speaking aided him during his time at Edinburgh, as they would throughout his life, and he became

[35] Robert Woods, 'Physician, Heal Thyself: The Health and Mortality of Victorian Doctors', *Social History of Medicine* 9 (1996), 1-30; in his memoir of Darwall, Conolly mentioned several student contemporaries who had died between 1821 and 1834; Conolly, 'the late John Darwall' pp. 502-3.

[36] His mother was a Tennyson, distantly related to the poet; his father was a younger son of the prominent Irish Conolly family. Scull, 'John Conolly', *ODNB.*

[37] Maudsley, 'the late John Conolly,' pp. 161-2.

[38] John Conolly, *An Inquiry Concerning the Indications of Insanity: With Suggestions for the Better Protection and Care of the Insane*....(Reprinted with Introduction by Richard Hunter & Ida Macalpine: London: Dawson, 1964 (orig. edn. 1830)); Hunter and Macalpine, 'Editors' Introduction', pp. 4-5, 10-11.

one of the four student presidents of the Royal Medical Society.[39] Soon after graduation, he spent several months in Paris studying under leading figures there. He practised briefly in Sussex, first at Lewes, and then at the larger town of Chichester. There he became friendly with another recent arrival, the young Scots physician John Forbes.[40] To quote Maudsley, 'Dr Conolly was the greater favourite in society [due to] courteous manners and vivacity of character...Dr Forbes was more reserved... but more consulted as a physician.'[41] As there seemed to be insufficient practice for both men, and perhaps also prompted by his lifelong fascination with Shakespeare, Conolly moved to Stratford-on-Avon in 1823.[42] In this market town of about five thousand people, he is described by Maudsley as showing himself 'a reformer by nature and a hearty liberal in politics [who] ardently devoted himself to… every measure of progress.'[43] His local activities included the foundation of both a charitable dispensary and a 'Society for Reading and Lectures' for working men. He also supported local initiatives that promoted the work and reputation of Shakespeare. In 1824 he was appointed 'visiting physician to Warwickshire asylums.' The sole duties of this impressive-sounding post were to accompany justices of the peace on their yearly inspections of small private mental institutions.[44] He was invited to join the borough council, later becoming alderman and mayor. In these ways his

[39] Comments on his social ease and 'polished manner' are cited by Scull *et al* in 'Conolly: A Brilliant Career?', pp. 50-51; the Society was an important element of student life, as agued by Lisa Rosner, *Medical Education in the Age of Improvement: Edinburgh Students and Apprentices 1760-1826*, (Edinburgh: Edinburgh University Press, 1991), pp. 119-34.

[40] Forbes (1787-1861) had been a naval surgeon 1807-16 before gaining an Edinburgh MD in 1817, then practising for five years in Penzance, where he also pursued his interests in geology; see R. A. L. Agnew, 'Forbes, Sir John (1787–1861), physician and medical journalist.' *Oxford Dictionary of National Biography.* 23 Sep. 2004; Accessed 5 Oct. 2021. https://0-www-oxforddnb-com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-9841.

[41] Maudsley, 'the late John Conolly,' p. 164.

[42] Hunter and Macalpine. 'Editors' Introduction', pp. 12-15.

[43] In Maudsley's words; Maudsley, 'the late John Conolly', p.164.

[44] Hunter and Macalpine. 'Editors' Introduction', pp. 15-16.

public roles echo those of Inkster's Sheffield figures.[45] Like Darwall, however, his income was slow to grow, and his best year at Stratford netted him the moderate sum of £400.[46]

Conolly's career: a wider sphere

In 1825 both Conolly and Darwall, joined the staff of the *London Medical Repository and Review* as assistant editors. This publication, launched in 1814 to bring 'theory and practice to country practitioners', comprised mainly reviews and summaries of varied British and foreign medical publications. This will be discussed in detail below, together with other journals (also see figures 19 & 20).[47] His next career move may have surprised many, when he was appointed in 1827 to the first chair in medicine at London University (later University College). The Quaker physician and educationist George Birkbeck was evidently impressed by Conolly at their earlier meeting (in 1824) and in turn influenced Henry Brougham, the Whig politician and lawyer who was the leading figure on the university council. Conolly may have been helped by his Edinburgh degree, known liberal views, and perhaps his religious principles, as a convert to Unitarian beliefs. [48]

The foundation of the new university, the first in England since the Middle Ages, was claimed by Brougham as 'a matter of infinite moment'. Its sponsors were Whigs and Radicals, many with Edinburgh connections, and generally followers of Jeremy Bentham. Its constitution was closely modelled on its Scots forerunner, investing much authority in the professors, and adopting a strictly non-denominational entry policy.[49]

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[45] Probably his medical colleagues proposed him for election to the council, as noted in Ch.3. For the other roles, see Inkster, 'Marginal men', pp. 140-1, 148-9.
[46] Conolly's involvement in the dispensary is explored in Chapter 3; see Scull et al, 'Conolly: A Brilliant career?' pp. 50-6; such a level of earnings would support (albeit not generously) the genteel existence expected of a physician with a family; Digby, *Making a Medical Living*, pp. 170-75.
[47] Loudon and Loudon, 'the Medical Periodical 1800-50', p. 61.
[48] As suggested by Hunter and Macalpine, plausibly enough, but without primary evidence. See Hunter and Macalpine. 'Editors' Introduction', pp. 10-11, 19.
[49] Desmond, *Politics of Anatomy*, pp. 25-31, quote from Brougham's 1825 letter to Sir Francis Burdett, the Radical MP, p.25.

Figure 18: John Conolly, c.1835. (lithograph by T.M. Bayes, after a painting by T. Kirkby: Wellcome images, London).

Alongside allied reforms planned for education, closed corporations, and national government, it was intended to deliver efficient professional training and to spread higher education more widely. Its secular and radical character aroused hostility from the ancient English universities and the established church, attracting jibes such as the 'godless institution'.[50] Nor did the existing

[50] While 'the godless institution in Gower Street' tends to be attributed to Dr Thomas Arnold of Rugby, a precise source is elusive.

London medical schools and the medical Royal Colleges welcome their new rival.

The infant institution also had abundant internal problems, with shortages of funds and disagreements about both policy direction and educational content. Scholars have interpreted the complex events during the institution's early years through their preferred interpretive lenses, and these will be considered further below. Desmond explored the academic battles between adherents of 'philosophical anatomy', often scientific materialists, who stressed the common features in human and animal structures; and more conservative figures basing their ideas on surgical experience (and often influenced by arguments from divine design).[51] Conolly, by preference adopting reformist rather than revolutionary views, leaned more towards the latter group. He also argued for broadening current medical courses, arguing that the study of mental disorders should be added to the curriculum, in part through observing affected patients. His proposal was rejected by the council as premature, but in fairness to them, the medical faculty then lacked facilities for any clinical instruction, only gaining a teaching hospital in 1834. Following that response from the council, Conolly wrote his *Indications of Insanity*, to provide students and practitioners with practical hints in dealing with mental illness.[52]

To improve practical instruction, in 1828 Conolly and several colleagues established the University dispensary, which survived until 1834, when it was absorbed into the new North London Hospital, later University College Hospital. The medical and surgical professors attended poor patients, as at any dispensary, and medical students could learn through observing these encounters.[53] An anonymous article praised the dispensary, remarking on the 'great pains taken in examining patients…and in rendering the symptoms of the cases obvious to the pupils.' The institution's house surgeon later reported that

[51] Desmond, *Politics of Anatomy,* pp. 8-9, 27, 94-9
[52] Conolly, *the Indications of Insanity*.
[53] Hunter and Macalpine, 'Editors' Introduction', pp. 28-31; twentieth-century research established the site of the dispensary, in Gower Street, north of the present Euston Road, see 'Hospital finds its roots: dispensary site located', *The Times*, 13 January 1961.

1597 individuals attended in 1829, 1009 of these attending the physicians, while the pattern of diseases resembled experience at other London dispensaries.[54]

The professors were also hindered in their work by personal antagonisms, often related to opposing positions in the anatomical debates. For instance, Granville Pattison was much criticised as professor of Anatomy, not least by a strong party among the students: Conolly may have tried both to support him and to act as peacemaker between rival factions, as Hunter and Macalpine argue. These authors also recall Conolly's loyalty to an old teacher, Pattison having taught him at Glasgow. Desmond explains that Pattison's failure to embrace the new anatomy prompted a hostile campaign among the more militant students.[55] Members of the council were wont to interfere in academic matters, with Leonard Horner, the able but abrasive Warden, being especially dictatorial in his relations with the professors. The lectures delivered by Conolly were found uninspiring, apparently largely due to his relative lack of medical experience, and student attendances declined.[56] Funding difficulties led in 1830 to a reduction in the professorial stipends from the original, hardly generous, £300 per annum (Conolly receiving £150 in 1830-31). Various slights culminated in his resignation in late 1830 and his return to Warwickshire early in 1831. Warwick, where he settled, he evidently found dull after London and less congenial than Stratford.[57] During 1832-35 he assisted his old Chichester friend Forbes with editing the *Cyclopaedia of Practical Medicine,* and from 1836 joined him as co-editor of the new quarterly *British & Foreign Medical Review (BFMR)*

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[54] 'On the Best Method of Prosecuting the Study of Medicine', *The London University Magazine*, 1, 61-68, quotation p. .66; John Hogg, *London As It Is* (London: Macrone, 1837), pp. 128-32, esp. p. 129

[55] Hunter and Macalpine, 'Editors' Introduction', pp. 26-27; Desmond, *Politics of Anatomy,* pp. 94-99.

[56] Maudsley, 'the late John Conolly', p.166.

[57] According to his letters, mainly to T. E. Coates, the secretary of the Society for the Dissemination of Useful Knowledge (SDUK; Coates replaced Horner as the university administrator in 1831); cited by Scull, 'Conolly: a brilliant career?' pp. 57, 63.

Table 18: **Selected Publications of John Conolly 1822-63** **(some later psychiatric papers are omitted)**	
As author	**As co-editor**
Pamphlets on smallpox vaccination, 1822 & 1824	(With J. Copland & J. Darwall) *London Medical Repository and Review,* 1825-7
Indications of Insanity, 1830	
Sections (5) in *Cyclopaedia of Practical Medicine*, 1832-35	(With J. Forbes & A. Tweedie) *Cyclopaedia of Practical Medicine,* 1832-35.
Papers in *Transactions of the Provincial Medical and Surgical Association*, 1833-6	
The Construction and Government of Lunatic Asylums and Hospitals for the Insane, 1847. *The Treatment of the Insane Without Mechanical Restraints*, 1856. *A Study of Hamlet,* 1863	(With J. Forbes) *British & Foreign Medical Review,* 1-9

Conolly's public roles in these years, as well as writing and editing, included lecturing to mechanics' institutes in Warwick and elsewhere, co-founding a phrenology society in 1834, and facilitating its transition into a county natural history society in 1836. His lectures to different groups were generally well received by local audiences, one instance being in Warwick in April 1832, when he spoke on 'structure and functions of the human body'. He accompanied his address with anatomical charts displayed on the meeting room's walls, the newspaper report also mentioning his 'crowded auditory' which responded with 'gratitude and delight'. Later that year Conolly spoke at the first meeting of the Leamington Literary and Scientific Society, and in February 1834 he delivered the inaugural lecture to an audience of over 400 ('including many ladies') at the

new hall of the Leicester Mechanics' Institute.[58] He was also active in the Shakespeare Club in Stratford, where he campaigned for restoration of the poet's memorial in the parish church (note the Shakespearean references in his portrait, figure 18).[59] In 1836 he was one of those appointed justice of the peace by the current Liberal government and was elected a Warwick borough alderman (although not previously a council member).[60] Local newspapers show him to have been active in local affairs during 1836-38, as he had been earlier in Stratford. Henry Maudsley waspishly summed up the wide-ranging pursuits of those years as the 'dissipation of energy in numerous straggling activities.'[61]

It is uncertain whether Conolly's private practice in Warwick thrived; possibly not, but then eighteen practitioners, including seven other physicians, practised in the two towns of Warwick and Leamington.[62] Repeated changes of address during the 1830s hint at financial pressures, as discussed by Elizabeth Burrows in her recent biographical study. Burrows also argues that the Conollys, then with four children, were then experiencing marital stresses.[63] The possibility that Elizabeth Conolly suffered from mental illness herself has been the subject of rumour and speculation but gains tentative support from

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[58] 'Warwick and Leamington Mechanics' Institute', *Warwick and Warwickshire Advertiser*, 21 April 1832; 'Leamington Literary and Scientific Institute', *Leamington Spa Courier*, 25 August 1832; 'Leicester Mechanics' Institute', *Leicester Chronicle*, 8 February 1834.

[59] *The Story of the Shakespeare Club of Stratford-Upon-Avon 1824-2016* (Stratford-on-Avon: Shakespeare Club, 2016), pp. 56-9; in Conolly's portrait by T. Kirkby (fig. 18), the medal, the rainbow ribbon and the document refer to activities celebrating Shakespeare.

[60] 'Commission of the Peace', *Warwick and Warwickshire Advertiser* 13 February 1836; 'Election as Alderman, Borough Council Meeting', *Warwick and Warwickshire Advertiser* 29 October 1836.

[61] Maudsley, 'Memoir of the late John Conolly', p.168.

[62] Pigot's *National Commercial Directory*, 1835; one of these was Henry Jephson, said to have one of the most lucrative practices in the country; Eric G Baxter , Joan Lane, and Robert Bearman, *Dr Jephson of Leamington Spa*, (Leamington Spa: Warwickshire Local History Society, 1980), pp. 13-34.

[63] Elizabeth Mary Burrows, 'Alienists' Wives: The Unusual Case of Mrs John Conolly ', *History of Psychiatry,* 35 (1998), 291-301 ; Elizabeth Mary Burrows, 'Enigmatic Icon: A Biographical Reappraisal of a Victorian Alienist --John Conolly M.D., D.C.L.1794-1866' (PhD Thesis, Oxford Brookes,1999), pp. 57-61.

research by Burrows.[64] While Conolly was always reticent about personal matters, the challenges for Elizabeth would have included her husband's mercurial nature, chronic money difficulties and frequent changes of abode. Her name was notably absent from newspaper lists of those attending social occasions, such as Stratford's first Dispensary Ball in 1823. After 1841 she was evidently not living at the family home, dying in lodgings of 'old age', aged 82, a few months after her husband. Burrows argues that these events cast an ironic light on Conolly's reputation as a humanitarian, but without more knowledge of the circumstances, it would seem better to reserve judgment.[65]

In 1838 Conolly moved, evidently without his family, to Birmingham, where he spent about one year. In May 1839 the appointment of Conolly as resident physician at the large Middlesex Asylum at Hanwell seemed suited to his talents and would in due course transform him into a medical celebrity. This new post closed his earlier phase as a journalist and generalist physician, while he continued to lecture and write on mental concerns.

Print culture and medical reform

Medical journals formed part of an early nineteenth-century explosion of printed material which were produced on new steam-powered printing presses. Novel periodicals dealing with health and disease slowly differentiated into titles for professional audiences and for lay readership, albeit often short-lived.[66] During 1800-50 168 new medical journals appeared, although 69 per cent failed to reach their second birthday.[67] The most widely read was undoubtedly the *Lancet,* published weekly from 1823. Its editor and proprietor, Thomas Wakley, was the foremost champion of the medical rank and file.[68] He used his weekly journal as a vehicle for radical arguments, expressed mainly

[64] Scull, 'John Conolly', *ODNB*; Scull makes both of these points.
[65] Burrows, 'The Case of Mrs John Conolly', pp. 296-99.
[66] Roy Porter, 'The Rise of Medical Journalism in Britain to 1800', in *Medical Journals and Medical Knowledge*, pp. 6-8.
[67] Loudon and Loudon, 'the Medical Periodical 1800-50', p. 4
[68] Wakley's nineteenth-century biographer suggested a circulation of 4000, Brown, 'Bats, Rats, and Barristers', p. 183, n4 (circulation) pp. 188-92; Brown 'Medicine, Reform and the 'End' of Charity,' pp.1380-2.

through attacks on instances of jobbery, nepotism and incompetence in the teaching hospitals and the London medical corporations (and indeed, London dispensaries). Brown has shown how the invective, the scurrilous stories, and some stylistic quirks were closely modelled on the *Political Register* of his friend Cobbett and on contemporary underground publications.[69] In following decades, Wakley was elected a coroner and then a Radical MP, meanwhile continuing with the *Lancet*, somewhat softening his journalistic tone. He helped to achieve reform in an impressive list of fields, ranging from public flogging to food adulteration and neglect in workhouses. Present-day historians seem (like this writer) divided between admiration of his iconoclastic stance and a view of his early abrasive style as counterproductive.[70] A rival weekly, the *London Medical Gazette (LMG),* was launched in 1827. This pointedly adopted a restrained, gentlemanly tone as well as a conservative editorial line. In Burney's words, the *Lancet* seemed to promote the 'universalising abstractions' developed in France, including a common training route for all medical men. The *LMG,* conversely, stood for robust English pragmatism, including the preservation of intra-professional distinctions. However, the *Lancet's* radicalism was heavily qualified, while the *LMG also* accepted the case for cautious reform.[71]

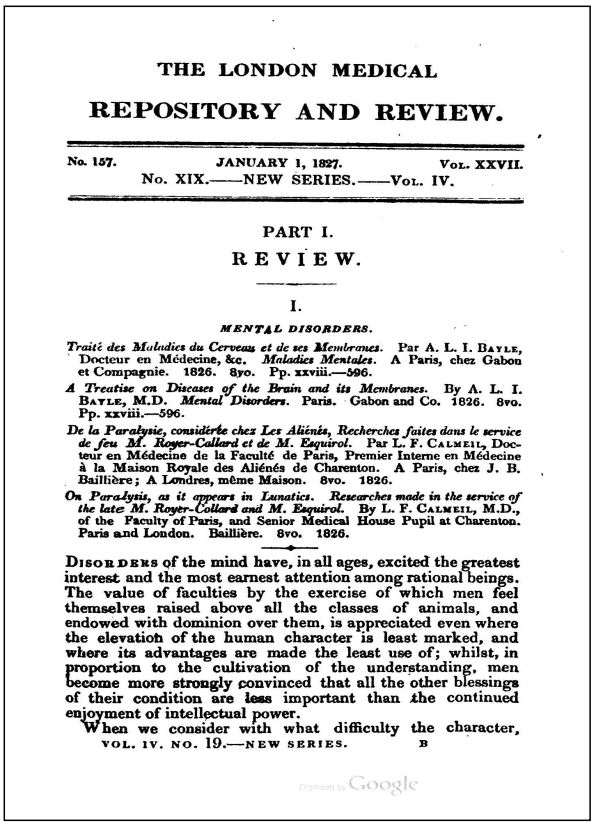
Most medical periodicals were published monthly or quarterly, and therefore were ill-placed to engage in much controversy. Most give only occasional hints of political leanings. In general their content followed similar lines to the four sections established in Edinburgh in the 1790s: abridgements of British and foreign publications; 'medical observations', chiefly case reports;

[69] Brown, 'Bats, Rats, and Barristers', pp. 188-92.
[70] Loudon and Loudon. 'The Medical Periodical 1800-50', pp. 61-2; Brown, 'Lancet, libel and stylistics', pp. 205-08; Burney. 'The Politics of Particularism', pp. 50-51; Jacyna, 'Medicine in Transformation, 1800-49', pp. 50-51. The Loudons express misgivings, and the other authors various degrees of approval.
[71] Burney showed how in the end both seemed to share many assumptions and values; Burney, 'the Politics of Particularism', pp. 49-51

news or 'medical intelligence'; and lists of new books.[72] Their habit of reprinting or summarising other journals' content, including those overseas, was seen as a compliment rather than plagiarism or breach of copyright.[73] They met a clear need among practitioners, often isolated, who would seize on the fresh information in their pages. As the Loudons comment, 'Today… it may be difficult to appreciate the hunger for medical knowledge in the early 1800s.' These publications are significant not only for the diffusion of new scientific and clinical ideas, but also through their role in fostering a sense of shared identity, of an 'imagined community' among scattered individuals, to use Benedict Anderson's phrase. This refers to the way that newspapers contributed to the process of constructing common identities, national and otherwise.[74]

One of the publications aimed at scattered practitioners was the monthly *London Medical Repository and Review (LMR*). When it was re-launched in 1825, both Conolly and Darwall contributed detailed review articles. Conolly's proficiency in French led Darwall to teach himself German so that he could concentrate on works in that language. Their two years' work on this journal Conolly later described as 'labour… particularly attractive to younger writers…[but] irksome to the middle-aged'.[75] Some articles in early issues suggest concerns then current. These include pieces on the diagnostic

[72] Andrew Duncan senior, a physician and medical teacher (1744-1828), established the new quarterly *Annals of Medicine* (that became in 1804 the *Edinburgh Medical and Surgical Journal);* Porter, 'the Rise of Medical Journalism', pp. 9, 16-17.
[73] Loudon and Loudon. 'The Medical Periodical 1800-50', p. 56.
[74] Loudon and Loudon 'The Medical Periodical 1800-50', p. 64; the latter term is taken from Brown (influenced by Benedict Anderson), 'Medicine, Reform and the 'End' of Charity,' pp.1380-82; Benedict R. O' G Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* 2nd edn (London: Verso, 1991), pp. 48-58.
[75] Conolly, 'the late John Darwall,' pp. 543-4; the new editors were introduced by Copland in his 'Preface', *London Medical Repository and Review,* 3, NS (1825), x-xvi, pp. xv-xvi.



THE LONDON MEDICAL

REPOSITORY AND REVIEW.

No. 157. JANUARY 1, 1827. Vol. XXVII.
No. XIX.——NEW SERIES.——Vol. IV.

PART I.

REVIEW.

I.

MENTAL DISORDERS.

Traité des Maladies du Cerveau et de ses Membranes. Par A. L. I. Bayle, Docteur en Médecine, &c. *Maladies Mentales.* A Paris, chez Gabon et Compagnie. 1826. 8vo. Pp. xxviii.—596.

A Treatise on Diseases of the Brain and its Membranes. By A. L. I. Bayle, M.D. *Mental Disorders.* Paris. Gabon and Co. 1826. 8vo. Pp. xxviii.—596.

De la Paralysie, considérée chez Les Aliénés, Recherches faites dans le service de feu M. Royer-Collard et de M. Esquirol. Par L. F. Calmeil, Docteur en Médecine de la Faculté de Paris, Premier Interne en Médecine à la Maison Royale des Aliénés de Charenton. A Paris, chez J. B. Baillière; A Londres, même Maison. 8vo. 1826.

On Paralysis, as it appears in Lunatics. Researches made in the service of the late M. Royer-Collard and M. Esquirol. By L. F. Calmeil, M.D., of the Faculty of Paris, and Senior Medical House Pupil at Charenton. Paris and London. Baillière. 8vo. 1826.

Disorders of the mind have, in all ages, excited the greatest interest and the most earnest attention among rational beings. The value of faculties by the exercise of which men feel themselves raised above all the classes of animals, and endowed with dominion over them, is appreciated even where the elevation of the human character is least marked, and where its advantages are made the least use of; whilst, in proportion to the cultivation of the understanding, men become more strongly convinced that all the other blessings of their condition are less important than the continued enjoyment of intellectual power.

When we consider with what difficulty the character,

VOL. IV. NO. 19.—NEW SERIES. B

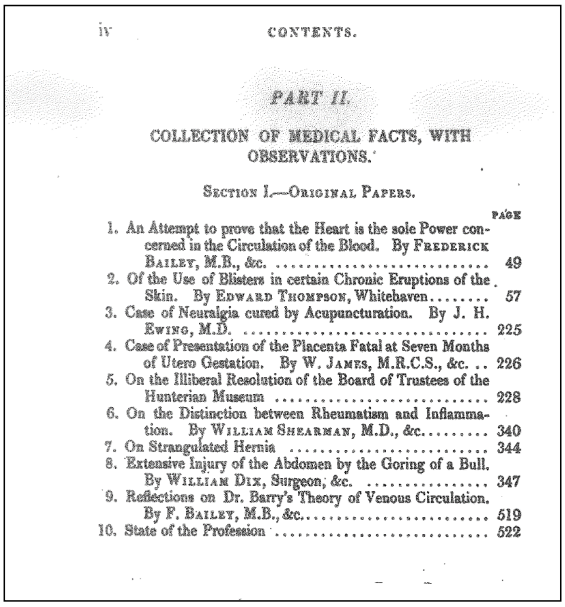
Figure 19: *London Medical Repository and Review*, 4, NS (January 1827) Initial page of review section

process, and finally on the 'state of the profession'.[76] Examination of the patient, they recommend, should include percussion and auscultation, then new techniques (and to be discussed later in this chapter).[77]

[77] The style of these pieces seems reminiscent of Darwall's, but the authorship is uncertain. 'The Art of Detecting Disease (Incorporating Reviews of Works by A. Buchan, M Hall, L Martinet , PJ Double, and M Harper)', *London Medical Repository and Review,* 2, NS (1826), 1-19, 97-117, 213-33, 313-31.

Two apparently new diseases appeared in the *LMR* in 1826-27, although the editors questioned whether these were indeed novel, or merely newly identified. In 1827 the journal reported an unpleasant disorder then emerging in Paris asylums (Figure 19). Accounts by Bayle and Calmeil described the early features, the muscle weakness and slurring of speech, and more strikingly, the later excitement and grandiose ideas. Affected patients, mostly veterans of Napoleon's campaigns, typically 'believed themselves directors of France, generals, kings'... In the next stage weakness increased, over months or years being succeeded by dementia, paralysis, coma, and death. 'General paralysis of the insane' (GPI), as this disorder came to be known around 1850, became increasingly prevalent in nineteenth-century asylums, and was in 1907 firmly identified as being caused by syphilis.[78] Bretonneau of Tours had written in 1826 on 'diphtheritis', a severe form of childhood croup, which had appeared in epidemic form in the city in 1818. Affected children developed a membrane that could obstruct breathing, with frequently fatal results.[79] John Conolly, covering French publications, probably wrote both these reviews. The 'cases and observations' in the *Repository* in January 1826 (figure 20) include: 'neuralgia cured by acupuncturation'; 'strangulated inguinal hernia'; and finally, the 'state of the profession'.[80] The modern reader can be surprised by the juxtapositions of commentary on topical affairs with descriptions of new techniques and interesting cases, just as when reading a newspaper of the era.

[78] 'Mental Disorders (Incorporating Reviews of Works by a L Bayle and L F Calmeil)', *London Medical Repository and Review,* 4, NS (1827), 1-24, pp.225, 344, 522; GPI is discussed in George Rosen, *Madness in Society: Chapters in the Historical Sociology of Mental Illness* (Chicago: University of Chicago Press, 1968), pp. 248-58.
[79] This disease later became known as diphtheria. The review also described the treatments used by Dr William Conolly (John's brother), then in medical practice in Tours; 'Diphtheritis', *London Medical Repository and Review,* 3, NS (1826), 483-508.



iv CONTENTS.

PART II.

COLLECTION OF MEDICAL FACTS, WITH OBSERVATIONS.

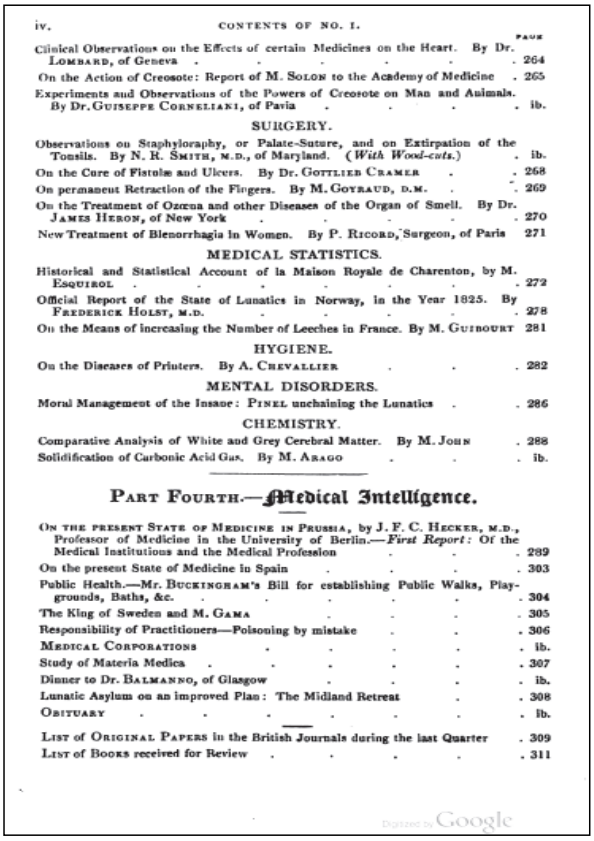
SECTION I.—ORIGINAL PAPERS.

Figure 20: ***London Medical Repository and Review*****, January 1827.**

Front of part II

Nearly a decade later, Conolly would return to similar work, as co-editor with Forbes of the *British and Foreign Medical Review* (1836-39; see figure 21). The serious-minded aims of the new quarterly were to continue the principles of the *Cyclopaedia*, printing 'critical and analytical reviews' of important medical works, especially those from abroad (see figure 20). Desmond saw the new review as supporting 'moderate reform [and] professional standards, and being relatively costly, aimed at prosperous Dissenting practitioners. [81]

[81] The cost was 6s per (quarterly) issue, compared with 6d for the weekly Lancet; Desmond, *Politics of Anatomy*, pp. 15-16.



iv. CONTENTS OF NO. I.

Part Fourth.—Medical Intelligence.

Figure 21: ***British and Foreign Medical Review*****: Contents of first issue (1836) Vol.1, No.1, iv**

To return to authorship, Darwall's five sections for the part-work *Cyclopaedia of Practical Medicine* included one on his great interest, diseases of artisans. In this he noted the damaging effects on the lungs of inhaling metal dust or mineral vapours, so common in Birmingham metalworking and jewellery trades. His dispensary practice probably included various such patients.[82] In 1830 both Conolly and Darwall published books evidently intended for both lay and medical readers. The latter's *Plain Instructions for the Management of Infants* was aimed at 'the profession' and at nurses (presumably children's nurses or

[82] John Darwall, 'Artisans, Diseases of', in *Cyclopædia of Practical Medicine*, 1, ed. by John Forbes, John Conolly and Alexander Tweedie (1833). In its 1829 annual report, the Birmingham General Dispensary staff documented the higher death rate from lung disease among those following certain trades.

nannies). The little book's accessible, direct style conveys much practical common-sense advice. Darwall emphasized the role of prevention, pointed out the high mortality from common diseases among poor children, and discouraged surgery or other heroic measures in the very young.[83]

Conolly's *Indications of Insanity* aimed to compensate for practitioners' prevailing lack of training or experience in mental disorders but was also responding to current public concerns about wrongful or fraudulent confinement of those so afflicted. Conolly briefly refers to his experience in 'country practice' but draws most case material from other authors, also proffering advice to medical men when approached for certificates required for committal to an asylum. They should, he argued, converse with the patient calmly and politely, without tricks or deception. They should also be wary of the motives of family members and not accept all their testimony at face value. Eccentric or odd individuals were especially at risk of unjustified committal, which was easily initiated and much harder to end. The defects of private asylums led him to urge a greater role for the state both in regulation and direct provision.[84]

In the early 1830s Conolly and Darwall also wrote for a lay readership on behalf of the Society for the Diffusion of Useful Knowledge (SDUK). This body produced factual, improving works aimed at working men, frequently circulated through mechanics' institutes. Those by these two authors concern scientific phenomena, medical ideas concerning cholera, and medical history.[85] There has been much historical debate regarding how far either the SDUK or the mechanics' institutes truly contributed to popular education. While historians

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[83] Darwall, *the Management of Infants;* intended readership, pp. 1-2.
[84] Conolly, *Indications of Insanity*, pp. 361-63, 368-72; his experience in 'country practice', probably among private at least as much as dispensary patients, is mentioned pp. 370-71.
[85] John Conolly, *The Workingman's Companion: Cottage Evenings* (London: C Knight, for SDUK (Society for the Diffusion of Useful Knowledge), 1831); John Conolly, *The Workingman's Companion: The Physician (I-the Cholera)* London: C. Knight, for SDUK, 1832), Darwall is said to have written at least one volume of a history of medicine (although this has not been traced). This was mentioned in an obituary, 'The Late Dr Darwall', *London Medical Gazette*, 12 (1833), 778-9.

have moved from regarding them as principally agents of social control, such initiatives clearly met middle-class social aspirations (for instance, through reduction of marginality) at least as much as the educational needs of manual workers.

'Knowledge and association' in a new professional society

In 1832 Conolly, Darwall, and Forbes were among the practitioners who joined the Worcester physician Charles Hastings (the latter mainly associated with the Worcester Infirmary) in founding a new association. All of them were active in early meetings of the new body, the Provincial Medical and Surgical Association (PMSA).[86] The new organisation aimed to represent all medical men outside London, and like the many new local medical societies, drew on in a growing sense of shared interests between different sorts of practitioners. The initial purposes of the new Association in Worcester were social and scientific although in later decades it developed a more political and union-like role as it evolved into the British Medical Association. Peter Bartrip, historian of the Association, argues that Hastings and his allies were comfortably established practitioners unwilling to upset the existing order. They also may have feared that allowing free rein to professional tensions might tear the new body apart.[87] Its focus on the *shared* interests of provincial medical men avoided the dissension and 'hostility between different branches of the profession' found in the metropolis.[88]

The restive London practitioners included Scottish-trained physicians and the numerous surgeon-apothecaries, who resented their limited voice in

[86] Peter Bartrip, 'Hastings, Sir Charles (1794–1866)', in *Oxford Dictionary of National Biography,* (Oxford: Oxford University Press, 2004, online edn, May 2014, last accessed 1 July 2021).
[87] Bartrip, *Themselves Writ Large,* pp. 4-6; Brown, 'Medicine, Reform and the 'End' of Charity,' pp. 1380-1.
[88] Charles Hastings, 'Address Delivered to the First Meeting of the Association', *Trans PMSA* 1 (1833), 3-28, pp. 5-6

the national colleges of physicians and surgeons.[89] Many reformist voices argued, often in new periodicals, that all practitioners should share common institutions and educational preparation. This seemed consistent with the wider movement for change in parliament and many other national institutions that aimed for them to become more open, meritocratic, and rationally organised.[90]

On its foundation in 1832 the new association (the PMSA) launched annual *Transactions*, in style and content closely resembling the earlier *Midland Medical and Surgical Reporter*.[91] Its aims, like those of its parent association, included investigating disease, disseminating medical information from practitioners, and exploring medical topography.[92] In his inaugural address at Worcester in July 1832, Charles Hastings praised the recent advances achieved by distinguished physicians and surgeons in the provinces, for instance the accounts by Darwall and Thackrah of Leeds of occupational diseases.[93] He added his view that provincial figures were ideally placed to study medical topography, which discipline could help to explain variations in disease patterns. Given that England trailed its continental neighbours in this field, their efforts could even advance enhance national prestige.[94] Among modern scholars, Numbers points out that in the earlier nineteenth century the field was the 'queen of the medical sciences'.[95]

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[89] Irvine Loudon, 'Medical Practitioners 1750–1850 and the Period of Medical Reform in Britain', in *Medicine in Society: Historical Essays,* ed. by Andrew Wear (Cambridge: Cambridge University Press, 1992), 219-48, pp.236-40. The more radical critics had little time for the London medical corporations, seen as remnants of 'old corruption'.

[90] 'Medicine in the Age of Reform', in Arthur Burns and Joanna Innes (eds.), *Rethinking the Age of Reform: Britain 1780-1850*(Cambridge: Cambridge University Press, 2007), pp. 163-85; Joanna Innes, 'Reform: the fortunes of a word', in *Rethinking the Age of Reform,* pp. 71-97

[91] The *Transactions of the PMSA (Trans PMSA)* were slightly misleadingly named, as the volumes always included papers that had not been delivered at the annual meeting.

[92];

[93] Hastings, 'Address to the First Meeting', p.12; Darwall, 'Artisans, Diseases of', pp. 149-60; Charles Turner Thackrah, *The Effects of the Principal Arts, Trades, and Professions on Health and Longevity* (London: Longman, 1831).

[94] Hastings, 'Address to First Meeting', p.10.

[95] Ronald Numbers, 'Medical Science before Scientific Medicine: Reflections on the History of Medical Geography', in Nicolaas A. Rupke (ed) *Medical Geography in Historical Perspective* (London: Wellcome Trust Centre for the History of Medicine at UCL, 2000), 217-20 p. 217.

In a separate paper, Conolly pointed out that, compared with those in large towns: 'The country practitioner possesses certain advantages… [including those] of becoming acquainted with the habits, characters, and *constitutions* of local people'.[96] In support, Conolly cited instances from his Warwickshire practice, evidently based largely on his dispensary work. He argued that such opportunities enabled the practitioner to ascertain how far the effects of soil, situation, climate, exposure, water, diet, and occupations influence 'the health of body or mind'. He argued that individual medical efforts could be augmented by county natural history societies, each with various sections covering most natural sciences, as well as statistics and epidemiology. Members could collect and collate various observations to clarify issues such as the contagiousness of fevers and many influences on health and disease.[97] Perhaps unsurprisingly, the county society founded by Conolly and others in 1836, did not match such ambitious aims. The Warwickshire Natural History and Archaeological Society provided lectures at quarterly meetings, often on antiquarian topics, and established a museum for various specimens The members included medical men, businessmen, clergy, and a few of the landed gentry [98]

Other near-contemporary topographical pieces include a study of Worcestershire, probably by Hastings, in the first issue of the *Midland Medical and Surgical Reporter* in 1828. This contrasted the much better health of the inhabitants of Malvern (elevated, while well-watered), compared with those in Worcester city (largely low-lying, prone to flooding, with crowded housing,). A paper by Darwall on Birmingham discussed local housing, differences between

[96] 'John Conolly, 'a Proposal to Establish County Natural History Societies, for Ascertaining the Circumstances in All Localities, Which Are Productive of Disease, or Conducive to Health', *Trans PMSA,* 1 (1833), 180-218, quotation pp.181-2 (emphasis in original); Conolly comments on the housing conditions of the Stratford poor, pp.188-90, and on fevers and meteorological conditions, pp. 190-205.
[97] Conolly, 'County Natural History Societies', pp. 204-6, 214-5.
[98] WCRO, Warwick (Warwickshire County Record Office), CR 924/4/1, Warwickshire Museum Papers, 'Warwickshire Natural History and Archaeology Society: Minutes 1836-41'; The Society's collections found a home in Warwick's market hall building, where the County Museum remains.

different localities, and the effects on health of different urban trades; he presumably based most of his observations on his work at the dispensary and in the homes of the poor.[99] In the later *Transactions* Forbes detailed Cornish geology, climate, and botany, before a later paper discussing local disease patterns, particularly as regards the plight of the tin miners. These 'interesting and intelligent men', patients of the Penzance Dispensary, typically experienced prolonged disabling chest symptoms before death in middle age.[100] Medical topography thus covered areas that presently would be considered more the province of epidemiology and social medicine.[101]

Clinical science and medical practice

Early nineteenth- century practitioners gained key scientific ideas and techniques from 'Paris medicine'. The clinical philosophy of the Paris school sought deep explanations for disease through close observation of physical signs among inpatients, coupled with study of post-mortem findings. One striking example from the 1820s lay in auscultation using the stethoscope. Especially when combined with percussion (tapping of the chest with fingers), alterations in heart and lung sounds could reveal signs of disease deep in the body. The stethoscope, introduced by René Théophile Laennec (1781-1826), was originally a simple hollow wooden cylinder about seven inches long (figure 6).[102] John Forbes was Laennec's translator and initially more interested in the

[99] The *Reporter* was a predecessor of the PMSA and its publications; 'Medical Topography, Essay 1: Worcestershire', *Midland Medical and Surgical Reporter,* 1 (1828), 1-15, ; John Darwall, 'Observations on the Medical Topography of Birmingham and the Health of the Inhabitants', *Midland Medical and Surgical Reporter,* 1 (1828), 106-12, 140-53.

[100] John Forbes, 'A Sketch of the Medical Topography of the Hundred of Penwith, Comprising the District of the Lands-End, in Cornwall (Part 1)', *Trans PMSA,* 2 (1834), 32-147; John Forbes, 'A Sketch of the Medical Topography of the Hundred of Penwith, Comprising the District of the Lands-End, in Cornwall (Part 2)', *Trans PMSA,* 4 (1836), 152-262, quotation p.156.

[101] Some Birmingham authors and their topographic interests are discussed by Jonathan Reinarz, 'Putting Medicine in its Place: The Importance of Historical Geography to the History of Health Care', in Erika Dyck and Christopher Fletcher (eds.), *Locating Health: Anthropological and Historical Investigations of Health and Place* (London: Pickering & Chatto, 2011), 29-40.

[102] Jacyna, 'Medicine in Transformation, 1800-1849', pp. 41-3.

latter's discussion of pathological anatomy. Teaching himself the demanding technique, he quickly saw its possibilities, not least among the Cornish tin miners who attended the Penzance Dispensary. He later published his observations among dispensary patients in Cornwall and Sussex, in most of them also incorporating pathological (post-mortem) findings.[103] His book thus not only applied Paris medicine in England but also demonstrated the scientific potential of dispensary practice.[104] Early experience in dispensaries, as pupils or assistants, helped to form clinicians who later became famous. Tröhler cites the Guy's Hospital figures, Thomas Addison and Richard Bright; to them could be added Thomas Hodgkin. Other instances of new knowledge derived largely from dispensary work would include the studies by Darwall and Thackrah of occupational diseases, and Darwall's observations concerning kidney disease [105] All these were Edinburgh graduates, who also figured largely among the 'early adopters' of the new methods of clinical examination after reading Laennec and Forbes.[106] Conolly quoted a neighbour of Darwall, a respected surgeon, as follows: 'By diligent attention he [Darwall] attained peculiar tact in distinguishing the various changes produced by disease in the chest and its

[103] In 1826 the Chichester dispensary was replaced by a new infirmary, Forbes having led fundraising efforts; Agnew, 'John Forbes', *ODNB.*

[104] John Forbes, A Treatise on Diseases of the Chest in Which They Are Described According to Their Anatomical Characters, and Therr Diagnosis Established on a New Principle by Means of Acoustic Instruments (London: T & G Underwood, 1821); John Forbes, Original Cases with Dissections and Observations Illustrating the Use of the Stethoscope and Percussion in the Diagnosis of Diseases of the Chest (London: T & G Underwood, 1824); three of the cases were from Cornwall and 36 from Chichester Dispensary.

[105] Darwall, 'Artisans, Diseases of', pp. 149-60; Thackrah, *Effects of … Trades on Health;* Pierre-François Olive Rayer, 'The history of albuminous nephritis', orig. publ. 1840. *Medical History (Supplement)*,2 4 (2005): 14-72, p. 47; Tröhler points to the importance of pathology and statistics alongside clinical observation.

[106] Including James P. Kay, the Manchester dispensary physician; James Phillips Kay, 'Use of the Stethoscope (Letter)', *Lancet,* 1 (1828), 754-7; a fictional example is George Eliot's Tertius Lydgate, who had studied in Paris and Edinburgh; George Eliot, *Middlemarch: A Study of Provincial Life*, 2003 edn (Harmondsworth: Penguin, 1874), e.g, Ch. 30; see Malcolm Nicolson, 'The Introduction of Percussion and Stethoscopy to Nineteenth-Century Edinburgh', in WF Bynum and Roy Porter(eds), *Medicine and the Five Senses,* (Cambridge: Cambridge University Press, 1993), 134-53.

contained organs, by means of the stethoscope and percussion.'[107] Another example, probably also self-taught, was Hastings, who discusses the use of the stethoscope in an 1828 article on lung disease.[108] Conolly may have come to know its use, for instance as a colleague of Forbes at the Chichester dispensary in 1822-23, but there is no direct evidence that he used it. Malcolm Nicolson has emphasised the key importance of practical, tacit knowledge in the take-up of auscultation and the allied practice of percussion.[109]

The Edinburgh teaching faculty propounded the new methods during the early and mid-1820s, but their use did not become firmly embedded in London hospitals until at least the 1840s. The reasons, Nicolson argues, include London's greater size and decentralised medical education, and a greater acceptance of French ideas in the Scots political and cultural climate.[110] In this instance, provincial and perhaps marginal individuals could distinguish themselves by their skill in a new technique, while more securely established figures might see little advantage in the daunting task of acquiring similar proficiency.

[107] Conolly, 'the late John Darwall', pp. 507-8 (Mr. Wickenden).
[108] Charles Hastings, 'The Signs of Pulmonary Tubercle, with Observations on the Use of the Stethoscope', *Midland Medical and Surgical Reporter*, 1 (1828), 153-69, 234-8.

[110] Nicolson, 'The Introduction of Percussion and Stethoscopy', pp. 140-5, 150-1.

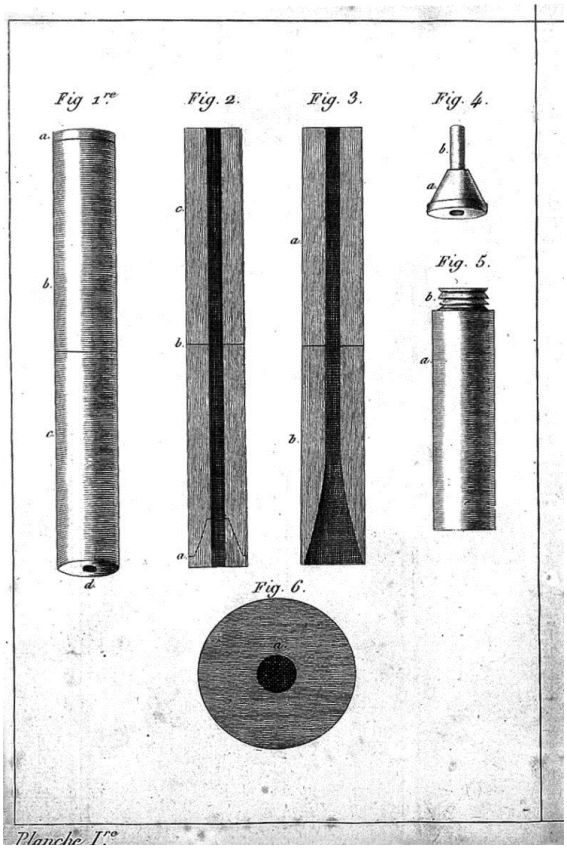

Figure 22: Illustrations of the early stethoscope. John Forbes was sent one of these from Paris. R.T. H. Laennec, Plate from *De l'auscultation médiate, ou traité du diagnostic des maladies des poumons et du cœur, fondé principalement sur ce nouveau moyen d'exploration*, 1819 (Wellcome Images).

Conclusions

As has been outlined in this Chapter, John Conolly and John Darwall covered a wide range of fields in their writings, including children's medicine, occupational diseases, medical topography, and more humane approaches to the mentally afflicted. Darwall followed a steady course in his career, while Conolly could be seen as restless in his different roles and locations before finding his niche concentrating on mental illness. Both adopted locally prominent responsibilities that combined science with popular, or at least public, education. This does suggest that they can be seen in terms of Inkster's 'marginal man', especially in this concept's revisionist form.[111] They seem, however, more decidedly marginal in their first few years of practice. This suggests possible limitations of the concept, in that it will appear less applicable to individuals well established in their careers. Digby's work helps to illustrate how typical their early struggles were, and how writing or editing might bring in a little income and help to establish a reputation.[112] Premature death (as in Darwall's case) was of course a more extreme form of jeopardy particularly applicable to medical life.[113] The common relationship of a period as journal editor with later professional eminence rather confirms the role of journalism in aiding personal recognition (together with other advantages, such as gaining familiarity with the medical literature and acquiring useful contacts).[114] For Conolly and Darwall, journalism seems to have been mainly a stage in their working lives, rather than a continuing (if generally part-time) occupation, as it was for Forbes, Hastings and, of course, Wakley.

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[111] This can be seen in the local initiatives in popular education, mechanics' institutes, and the like, undertaken by Conolly in particular, as well as efforts on behalf of the SDUK. Forbes and Hastings also supported local free libraries and museums, as well as the SDUK. Agnew, 'Sir John Forbes, *ODNB*; Bartrip, Sir Charles Hastings, *ODNB;* Inkster, 'History of British Science and Science Culture', pp. 40-1.

[112] Digby, *Making a Medical Living*, pp. 170-75.

[113] Woods, 'Physician, Heal Thyself'.

[114] Bynum and Wilson, 'Medical Journals and their Editors', pp. 41-3.

Most of Conolly and Darwall's fellow editors shared the background of MD qualifications from Edinburgh University. Beyond opportunities for 'networking', in modern terms, it seems appropriate to question the part played by cliquishness among graduates or by other factors. [115] The institution's alumni were prominent beyond journalism in various fields of reforming activity.[116] But did the northern capital form such people, or were those with specific inclinations attracted to study there? Edinburgh had advantages for the scientifically minded, for Dissenters, or those without means or family advantages, corresponding strikingly to key aspects of the marginal man.[117]

Considering Conolly and Darwall together with Forbes and Hastings, both their writings and aspects of their daily practice suggest the influence of ideas from Paris. This is particularly so as regards chest disease and the examination methods used. Darwall was evidently self-taught in the use of the stethoscope and percussion, in common with Forbes and Hastings (both of whom helped to publicise the techniques through their writings). Conolly's journalism reflects Parisian influences on managing mental disorders, including Pinel's unchaining of the lunatics and the new disorder associated with grandiose delusions (see figs 19 and 20).

The scientific concerns of all four individuals largely informed their public roles in popular education. As provincial practitioners they were well placed to contribute to medical topography, a field where medicine and natural science seem to intersect. Their relevant publications doubtless drew on their earlier or more general interests, such as Darwall's botany, Forbes' geology, and

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[115] Edinburgh apparently became well-known for cliquishness; Loudon and Loudon, 'The Medical Periodical 1800-50', p. 61.

[116] Those who studied at Edinburgh, often later involved in reform of different kinds, included George Birkbeck (MD Edin. 1799) and James Phillips Kay (later Kay-Shuttleworth, MD Edin. 1827); Whig politicians such as Brougham and Palmerston, and prominent civil servants; M. W. Flinn, 'Editors' Introduction', in *The Sanitary Condition of the Labouring Population of Great Britain*, ed. by M. W. Flinn (Edinburgh: Edinburgh University Press, 1965), 1- 48, esp. pp. 18-24.

[117] Edinburgh University was a scientific centre, open to dissenters, and living economically was very feasible there. Thomas Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945* (Oxford: Oxford University Press, 1995), pp. 64-5.

Hastings' natural history. The newer disciplines of the age, although concerned with analysing, identifying mechanisms by 'taking apart', yet coexisted with an older, often gentlemanly, tradition of descriptive natural history. Provincial forums such as county natural history societies might offer discussions of both strands, while in the metropolis these approaches were more often, as Desmond argues, in differing and often opposed forums. [118]

The practitioners of the early nineteenth century constructed identities in which science was prominent, while not excluding literary and more general cultural concerns. Other Chapters in this thesis (mainly 3, 5 and 6) explore the specifically professional activities of this generation and their successors. As Brown has expressed it, medical men of the era constructed a new culture, centred on their professional identities, and often concerned with the 'care of the social body.'[119] Dispensaries, in their aims and tasks of were prime examples of the social body in action. Chapters 1, 2, and 3 explore how dispensary practitioners were in the forefront of practitioners who broadened their focus to include all the inhabitants of a parish or district when they participated in local boards of health or contributed material to the various urban sanitary reports.

The individuals discussed in this Chapter worked largely from dispensaries but do not seem typical of most practitioners doing such work. Their rank-and-file colleagues would be unlikely to write for publication, beyond an occasional brief letter to an editor. However, many (or most) dispensary medical officers seem likely to have been readers of medical journals, and some would attend the annual meetings of the PMSA and of regional medical societies. The latter include the Worcestershire Medical and Surgical Society, founded 1817 (as noted earlier in this Chapter), the Coventry Medical Society (in existence in 1831-2 – Ch. 3) or the Leamington Medical Society after its foundation in 1847. The records of the meetings of these societies reveal the attendance of a wide range of local practitioners. Their attendance at the

[118] Pickstone, *Ways of Knowing*, p. 73; Desmond, *Politics of Anatomy*, pp. 8-12, 17-21.
[119] Brown, *Performing Medicine*, p. 9

meetings would provide opportunities for learning about new medical ideas, and for discussion with their colleagues; what would nowadays be categorised as 'continuing medical education' or 'continued professional development'.[120]

[120] e.g. Opening remarks in *Trans PMSA,* 1-3 (1833-35); WCRO,CR 3038, Leamington Medical Society collection.

Chapter 5

Dispensaries Reformed? The Origins and Growth of Provident Dispensaries *c.*1820 -*c.*1860

> Self-supporting dispensaries…may be regarded as the best…and most economical means of supplying prompt and efficient medical assistance to the working classes.[1]

Introduction

During the two decades following the end of the Napoleonic Wars in 1815, the plight of the poor provoked increasing public alarm. As numbers of paupers grew, so did financial demands on ratepayers. Anxieties about possible unrest were mingled with feelings of humane concern for the poor, especially the sick poor.[2] In a small market town in Warwickshire, a local medical practitioner appeared to have found a solution to many such problems when he originated 'self-supporting' dispensaries. Henry Lilley Smith (1788-1859) founded the first of these in 1823, the Southam Dispensary, in a town of about 1000 inhabitants. Thereafter he tirelessly campaigned for the benefits of his new system and its quasi-mutual elements, in which small contributions from potential users were added to charitable support from the prosperous. During the next decade medical and lay supporters aided him in establishing similar institutions in neighbouring towns and villages, and then more widely. Later in the nineteenth century, self-supporting or 'provident' dispensaries (as they came to be called) were formed in many towns, including some of the largest conurbations.

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[1] Thomas Hodgkin, 'Selecting and Remunerating Medical Men for Professional Attendance on the Poor of a Parish or District', *London Medical and Surgical Journal*, 10 (1836), 389-92; quote p.389.

[2] Derek Fraser, *The Evolution of the British Welfare State: A History of Social Policy since the Industrial Revolution* (4th ed, Basingstoke: Palgrave Macmillan, 2009), pp. 44-49.

Dispensary Debates and Themes

The overall themes of the Chapter relate to differing, and sometimes contradictory, early nineteenth-century concerns. One was the relief of the poor, especially the sick poor. Besides the statutory provisions of the poor law, both paternalism and self-help seemed to have a role in supporting poor people. Another issue, or theme, concerns changes in the roles and social relationships of medical practitioners, often subsumed under the term professionalisation. The most general theme concerns the ideas and processes of reform, which had a bearing on all the above areas. The poor laws, the organisation of the medical profession, and the processes of government, could all be seen as calling for some sort of reformation.[3]

This Chapter will start by exploring the debates on the medical care of the poor that influenced the rise of self-supporting dispensaries. Ideas for new forms of care were canvassed in pamphlets and periodical articles, including Henry Lilley Smith's proposals for self-supporting institutions (in embryonic form).[4] Once the early foundations were in place, a lively debate continued in print. Their advocates claimed that they shared the strengths of true collective self-help organisations, the friendly societies and benefit clubs; they argued that their quasi-mutual elements should encourage thrift and provident habits.[5] Other voices, notably that of the influential *Lancet*, vigorously contested such arguments. Critics pointed to financial and managerial flaws in the newer institutions, and, commonly, strong local professional opposition.[6] While the evidence is rather fragmentary, sufficient primary sources survive in Warwickshire to make at least tentative judgements regarding institutional strengths and weaknesses of the new style of dispensary.

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[3] Joanna Innes, ''Reform' in English Public Life: The Fortunes of a Word', in Arthur Burns and Joanna Innes (eds.), *Rethinking the Age of Reform : Britain 1780-1850* (Cambridge: Cambridge University Press, 2003), 71-97.

[4] Derek Fraser, *Evolution of the British Welfare State*, pp.109-10.

[5] e.g. Henry Lilley Smith, *Self-Supporting Charitable and Parochial Dispensaries* (London: Gaulter, 1831); John Storer, *Hints on the Constitution of Dispensaries* (London: J. Hatchard, 1832).

[6] e.g.,'Bloomsbury Dispensary, *Lancet* 2 (12), 1 August 1829, 309.

Therefore, it seems appropriate to consider, briefly, the associated wide-ranging critique of the contemporary medical world, where analogies were commonly drawn between defects in professional governance and an outdated national constitution. The *Lancet*'s radicalism combined the two elements; in its support for a wider parliamentary franchise, and opposition to inherited privilege or corruption; in medicine, it sought to end abuses of charity and to develop a more meritocratic system, with less nepotism in appointment processes.[7] The Chapter will go on to consider the altered landscape of publicly funded medical provision after enactment of the new Poor Law in 1834. Dispensaries appeared to have a potentially relevant role, at least until the new structures solidified around the end of the 1830s.

The crises and innovations in dispensary organisation were relevant to wider changes in the nineteenth-century medical profession, especially accompanying debates about reform during 1820-50.[8] Emerging professional attitudes influenced institutional fortunes, locally and more widely. Ambitious physicians and surgeons could acquire social capital (and therefore lucrative practice) through serving at charitable dispensaries, but the associated abuses aroused resentment among their rank-and-file colleagues.[9] In their turn the self-supporting dispensaries offered new openings for general practitioners

[7] Roger French and Andrew Wear(eds), *British Medicine in an Age of Reform* (London: Routledge, 1991), esp. pp. 7-8; Burney, 'Medicine in the Age of Reform', pp.163, 168-71.

[8] Irvine Loudon, 'Medical Practitioners 1750–1850 and the Period of Medical Reform in Britain', in Andrew Wear (ed), *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), pp. 219-48; Ivan Waddington, *The Medical Profession in the Industrial Revolution* (Dublin: Gill & Macmillan, 1984). Some issues were eventually resolved by the Medical Act of 1858 that created the General Medical Council and made the first moves towards a common system of initial medical education.

[9] Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon, 1986), pp. 224-7; Irvine S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine* 55: (1981), 322-42.

although many initially saw them embodying threats rather than opportunities.[10]

Michael Brown identified the early 1830s as a period when a new sense of shared medical professionalism became evident. This became evident at certain dispensaries, highlighted by quarrels between the medical staff and the lay governors. The medical protagonists in these disagreements appealed to common attitudes, evidently widely shared, and gained strong support from their colleagues. This common professional ethos was to differing degrees linked with increased support for meritocratic appointment processes and a questioning attitude towards medical charity.[11] Such ideas echo an earlier interpretation: 'So, in Britain, science was largely associated with medicine…it was meritocratic and democratic…. [and] implied state support for training'.[12]

The wider context for these developments was the early nineteenth-century 'age of reform', when many aspects of national life came to be questioned, including the organisation of medical care, and as noted above, public aid to the indigent.[13] Such issues received close attention in medical journals, above all in the *Lancet*. This was a prominent reformist, indeed radical, voice from its launch in 1823.[14] The new journal shared with its peers a concern to share clinical knowledge, but more significantly turned a sardonic, questioning eye on major medical institutions. Leading hospitals, the medical corporations, and after 1829, metropolitan dispensaries came under the *Lancet*'s critical eye.[15] Their flaws included, so it was claimed, poor professional

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[10] Loudon, *Medical Care and the General Practitioner*, pp .252-5; Joan Lane, A Social History of Medicine: Health, Healing and Disease in England, 1750-1950 (London: Routledge, 2001), p. 92.
[11] Michael Brown, 'Medicine, Reform and the ' End ' of Charity in Early Nineteenth-Century England', *English Historical Review* CXXIV (2009), 1354-88.
[12] French and Wear, 'British Medicine in an Age of Reform: Introduction, p.7
[13] Burns and Innes, 'Rethinking the Age of Reform: Britain 1780-1850'; Innes and Burns, 'Introduction', in *Rethinking the Age of Reform: Britain 1780-1850,* e1-71.
[14] The implications of 'radical' in this context will be discussed below; Jean Loudon and Irvine Loudon, 'Medicine, Politics and the Medical Periodical 1800-50', in William F. Bynum, Stephen Lock, and Roy Porter (eds.), *Medical Journals and Medical Knowledge: Historical Essays,* (London: Routledge, 1992), 49-69.
[15] Ian Burney, 'Medicine in the Age of Reform', in *Rethinking the Age of Reform: Britain 1780-1850,* ed. by Burns and Innes, 163-85.

care, mis-applied charity, and dubious appointment processes. The purpose, funding and conduct of dispensaries thus became significant issues in contemporary debates.

In the provinces in the 1820s and 1830s, the crises and dilemmas surrounding the relief of the poor may have seemed more pressing than ideas for the remaking of national institutions. Henry Lilley Smith, a provincial practitioner whose ideas became influential, adopted elements of philanthropic schemes that aimed to prevent the working poor from sinking into pauperism. These include the paternalistic initiatives promoted by the 'Society for Bettering the Condition and Increasing the Comforts of the Poor'.[16] Among poor people more generally, informal networks of mutual support were evidently both common and important source of aid. Weinbren sees friendly societies as developing from such informal networks of mutual aid, which shared porous boundaries with small-scale charity. [17] Such 'clubs', as benefit or friendly societies were often called, gained support among working people but also much criticism from middle-class commentators. This was partly because of common financial and actuarial weaknesses: their tendency to meet in taverns was also claimed to foster insubordinate talk or dissipated habits. Penelope Ismay argues that, influenced by such considerations, some social reformers favoured savings banks as vehicles for self-help.[18]

From the 1820s the savings banks seem to have influenced the so-called 'new friendly societies', favoured by parish clergymen and some others. These societies calculated contributions and benefits on actuarial principles, so were

[16] Sir Thomas Bernard, Bart, founded the society in 1796; see, e.g., *Reports of Society for Bettering the Condition and Increasing the Comforts of the Poor*, Vol 1, 5th Ed (London: Hatchard, 1811); individual schemes ranged from charity schools to clothing clubs. Lilley Smith quoted Bernard (Report for1811, p.6) on p.2 of his 1819 pamphlet.
[17] Daniel Weinbren, 'Supporting Self-help: Charity, Mutuality and Reciprocity in Nineteenth-Century Britain' in Bernard Harris and Paul Bridgen, (eds)., *Charity and Mutual Aid: in Europe and North America since 1800* (London: Routledge, 2007), 67-88, esp. pp. 67-68, 70-72.
[18] See Penelope Ismay, *Trust among Strangers: Friendly Societies in Modern Britain* (Cambridge: Cambridge University Press, 2018), esp. 'The Battle between Savings Banks and Friendly Societies', pp. 85-118.

more stable. As members could withdraw contributions when leaving, they offered a form of individual savings; also, perhaps crucially, they were intended to include wealthy 'honorary members' who would guide them, as well as providing additional finance. The best-known clerical exponent of the new friendly societies was J.T Becher of Southwell in Nottinghamshire.[19] Later instances in Warwickshire include Richard Seymour, the vicar of Kinwarton near Alcester (mentioned in Ch. 3) and Henry Sitwell of Leamington Hastings, between Rugby and Southam.[20] The activity of the established clergy in these initiatives could be seen as growing out of their traditional duties towards the sick and needy. Most could combine compassion for the unfortunate with an acceptance of great inequalities in wealth and status, while the established church commonly encouraged higher social ranks to use their wealth for social benefit. Meanwhile the poor were expected to be dutiful, sober, and humble.[21]

Henry Lilley Smith, as noted above, was among the medical practitioners who proposed schemes for improving the care of the sick poor, both parish paupers and the larger mass of labouring people.[22] His pamphlets proposed rural dispensaries, the first example being launched in the small market town of Southam in 1823.[23] As these 'self-supporting' dispensaries incorporated small payments by their users, they drew on the mutual traditions of benefit clubs and friendly societies. In their original form they sought to unite this quasi-mutual element both with charitable aid and with publicly funded provision for

[19] Becher's pamphlet first appeared in 1824; later editions contained actuarial tables, such as those based on the calculations of Tidd Pratt and Morgan in e.g., John Thomas Becher, *Constitution of Friendly Societies Upon Legal and Scientific Principles*, 5th Ed (London: Simpkins and Marshall, 1828).
[20] Richard Seymour, *Old and New Friendly Societies: A Comparison Between Them*, (2nd ed, London: Rivington, 1839); Canon Seymour described the benefit societies established in 1839 in Stratford and Alcester (see Ch.3). A 'Victoria Club' existed at Leamington Hastings, near Rugby. As this required smaller contributions (albeit with less generous benefits, i.e., not graduated with age) its provisions were considered better suited to older labourers.
[21] David Roberts, *Paternalism in Early Victorian England* (London: Croom Helm), pp. 151-2.
[22] Fraser, *Evolution of the British Welfare State*, pp.44-9.
[23] Lane, *Social History of Medicine*, pp. 91-2

the sick poor, thus combining the three major strands of the 'mixed economy of welfare'.[24]

Lilley Smith, aided by his allies, achieved some striking early successes with the new hybrid system, while his single-mindedness may also have contributed to later difficulties, for instance during a divisive local controversy in 1858.[25] Despite earlier studies of his life and achievements, neither Smith nor the early institutions he inspired have, arguably, received the attention they warrant.[26] Therefore this study of dispensaries in Warwickshire needs to consider his life, work and influence. This Chapter will focus on the factors shaping the creation and the practices of self-supporting dispensaries, including the attitudes of local practitioners; the patronage of figures among the aristocracy, clergy, and gentry; what can be gauged of the support from the patients who were their potential subscribers, and the basis for the contestation they also experienced.

The Old Poor Law and Dispensaries

From their eighteenth-century beginnings, dispensaries aimed to relieve the 'sick poor' but which poor? Needy people in the early nineteenth century were affected by the 'mischievous ambiguity' of the term, applied as it was to both to labouring people in general and those who could not work.27 The latter were served by a poor law system that came under great pressure following the French wars. Economic depression and dislocation, especially during 1815-20,

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[24] Geoffrey Finlayson, *Citizen, State, and Social Welfare in Britain, 1830–1990* (Oxford: Clarendon Press, 1994), pp. 15-18; Fraser, *Evolution of the British Welfare State*, pp.12-13.

[25] To be discussed below; also mentioned by Lane, *Social History of Medicine*, p.13.

[26] R J Cyriax, 'Henry Lilley Smith MRCS: Founder of Self-Supporting Dispensaries', *Br Med J* 2 (1936), 141-2; Simon Wheeler, 'Henry Lilley Smith (1788-1859): Surgeon, Philanthropist and Originator of Provident Dispensaries : A Study of the Career, Ideas and Achievements of a Nineteenth Century Country Doctor' (Unpublished MA Thesis, Warwick, 1996); Simon Wheeler, 'Dr. Henry Lilley Smith and the Invention of Self-Supporting Dispensaries', *Warwickshire History* XIII (2007), 180-96

[27] The Poor Law Report of 1834 used this phrase, objecting to the conflation of the needy with the labouring poor; H.M. Commissioners, *Report of the Royal Commissioners for Enquiring into the Administration and Practical Operation of the Poor Laws* (London: HMSO 1834), p. 156; this was discussed by Gertrude Himmelfarb, *The Idea of Poverty: England in the Early Industrial Age* (London: Faber, 1984) p.253.

caused widespread distress and unrest, with increasing numbers seeking parochial aid and consequently increasing costs for ratepayers.[28] During this period, there was some support for abolishing the Poor Laws altogether, often encouraged by the writings of Thomas Malthus. At the risk of over-simplifying, the arguments of Malthus included the idea that food production could only increase in an 'arithmetic' ratio, while population tended to increase 'geometrically'. He also claimed that the availability of public relief enabled the poor to embark on early marriage and parenthood, and therefore fostered unsustainable population increases. David Ricardo, the early economist, argued that there was an essentially fixed sum for wages and public relief, so payments to paupers would depress the wages of industrious workers.[29] While such views were influential, most taxpayers and voters supported reform rather than abolition of the Poor Law system, and hoped for a less costly system of public support which encouraged self-help rather than dependence.

As noted above, medical men were among the many authors offering solutions for the problems of poverty, which, unsurprisingly, focused on the role of illness and its treatment. This had broader significance, as ill-health was such an important reason for people in working age groups to seek parish assistance.[30] In the early decades of the new century, systems of payment for pauper health care changed, with annual contracts increasingly replacing fees for parish surgeons covering individual services.[31] Medical opinion generally opposed such arrangements, often referred to as 'farming' the care of paupers. The parish overseers would seek tenders from practitioners, typically selecting the lowest offer. In the worst cases this might amount to only five guineas per annum, to include the cost of medicines. Medical and lay critics argued that

[28] Fraser, *Evolution of the British Welfare State*, pp. 46-50.
[29] Fraser, *Evolution of the British Welfare State*, pp. 47-49; Malthus first published his *Essay on the Principles of Population* in 1798, while Ricardo published *Principles of Political Economy* in 1817.
[30] The abundant writings on the theme of poor relief in general are discussed by Himmelfarb, *The Idea of Poverty*, pp. 135-6, and Fraser, *Evolution of the British Welfare State*, p. 46.
[31] Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), pp. 224-9.

parish surgeons willing to accept such terms would all too likely be inexperienced, incompetent, or callous. Both humane feelings and self-interest doubtless contributed to the professional critique of prevailing poor-law practice (the poor pay arguably resulting in shoddy medical treatment).[32] Nevertheless, many provincial practitioners continued their conscientious attendance on the poor alongside wealthier patients.

The Somerset practitioner, John C Yeatman, was an opponent of prevailing arrangements.[33] In a pamphlet of 1818 he expressed qualified acceptance of annual contracts, albeit only in populous parishes and when decently paid; for instance, at the levels paid by the military (when travelling without their medical officers) or by the more generous benefit clubs. His objections were thus to inadequate rates of payment rather than to contracts as such.[34] He also suggested the establishment of small infirmaries in medium-sized towns (those with five to twelve thousand inhabitants). Shortly afterwards, Ideas emerging from Warwickshire seemed to have some echoes of Yeatman's proposals. These were the proposals advanced by Henry Lilley Smith, who aimed to improve medical care, not only for parish paupers, but for all poor people.

At this point, Henry Lilley Smith had spent several years as the parish surgeon in the town of his birth. Following an apprenticeship, he attended Guy's Hospital and was briefly an assistant army surgeon before gaining the MRCS qualification in 1810. His family were by then minor landowners, while his forebears had been prosperous Coventry tradesmen (his grandfather a

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[32] Loudon, *Medical Care and the General Practitioner,* pp. 234-5; Michael E Rose, 'The Doctor in the Industrial Revolution', *British Journal of Industrial Medicine* 28 (1971), 22-26.

[33] John C. Yeatman, *Remarks on the Medical Care of the Parochial Poor* (London: Longmans, 1818), pp. 6-7. John Carleton Yeatman (1790-c.1841, MRCS 1809) was a general practitioner and parish surgeon in the textile town of Frome in Somerset, where the local woollen trade was suffering from competition elsewhere. At the time of his pamphlet, 4000 of the town's population (of about 11000) were claiming parish relief.

[34] The contractual arrangements Yeatman recommended both paid about five shillings per head *p.a.;* Yeatman, *Care of the Parochial Poor,* pp. 15-17; infirmaries, pp. 33-4.

grocer.)[35] He criticised the prevailing farming system, as 'repugnant to sound judgement and enlightened policy.'[36] His first pamphlet envisaged the working poor making modest regular contributions to a fund, also supported (and governed) by prosperous inhabitants. Parishes would provide funding for the care of paupers. The combined income from the three sources would set up and support the running costs of small infirmaries or dispensaries (he also refers to a 'parish medicine chest'). Each institution would deal with people living up to seven miles distant, so covering several parishes.[37] The district dispensary that he and others established along these lines in 1823 was to become (often in amended form) the model for various other institutions. The promotion of such 'self-supporting' dispensaries became the great cause of Lilley Smith's life, and he spoke and wrote energetically regarding their benefits.

The Southam Dispensary: The Birth of a Pioneer Institution

Henry Lilley Smith collaborated with prominent local figures in October 1823 to establish first self-supporting dispensary in Southam, Warwickshire. This was a market town of about one thousand people, located at the junction of the Coventry-Oxford and the Warwick-London turnpikes. The town possessed many inns that served the stagecoaches, as well as the foot traffic on the Welsh cattle drovers' route leading to the south Midlands and the capital.[38]

[35] Wheeler, 'Dr. Henry Lilley Smith', p. 180

[36] Henry Lilley Smith, *Observations on the Prevailing Practice of Supplying Medical Assistance to the Poor, Commonly Called the Farming of Parishes* (London: Philanthropic Society, 1819), p.8.

[37] Lilley Smith, *Observations on the Prevailing Practice of Medical Assistance*, esp. pp 12-16.

[38] Located thirteen miles south of Coventry and eight miles east of Leamington; *West's Warwickshire* (in 1830) regarded the town as rather sleepy, p. 745; See also John H. Drew, 'The Welsh Road and the Drovers', *Transactions & Proceedings, Birmingham Archaeological Society*, 82 (1967), 38–43.

Figure 23: Southam Dispensary (left of picture) and the Eye and Ear Infirmary (centre right), 1823, reprinted c.1858 (Southam Heritage Collection)

The new institution was based in a rented cottage adjacent to the Eye and Ear Infirmary, founded by Lilley Smith five years previously (see figure 1).[39]

A prospectus explained its philosophy and the intended regulations.[40] A preamble approvingly noted certain welfare schemes 'for the prudent and industrious of the labouring class'. These included 'savings banks, clothing societies, etc.', which could such people 'to raise themselves into independence'. The new dispensary, the document argued, would similarly support provident habits, and therefore assist such individuals. Indeed, it would provide medical help so economically that the need to resort to parish assistance would be lessened, with benefits for public expenditure and consequent savings for ratepayers. Its services would be open to those in the vicinity 'unable to defray the expenses of medical attendance… [who were mainly] servants, mechanics and labourers, with their families'. The annual subscription would be 3s 6d for an adult and 2s for each child under 15 (respectively about 1d and ½d weekly, and to be paid quarterly).

[39] The infirmary later became a hotel.
[40] 'Prospectus of the Dispensary of Southam' (Southam Heritage Collection).

Prospective members would need recommendations from either the clergyman of their parish or 'two respectable inhabitants.'[41] The institution's surgeon, Henry Lilley Smith, would attend three mornings weekly, for at least three hours. An assistant surgeon and dispenser would also be in 'constant attendance' (Edward Bicknell -- Smith's brother-in-law and apprentice -- in early years occupied these roles, also acting as secretary to the dispensary).[42] Patients living outside the town who were visited at home by the surgeon would need to pay 2s 6d for a journey of up to three miles and an additional 1s for each further mile (Smith added that expansion of the institution would allow these costs to be absorbed).

The original committee comprised Sir Gray Skipwith, Bart, of Alveston, near Stratford, as president; four other country gentlemen; seven clergymen; and a banker, a solicitor, and Dr John Conolly of Stratford-on-Avon. Skipwith held similar positions with other local medical charities, including the Stratford Dispensary, which was established the same year. Conolly, a co-founder and physician of the latter institution, became one of Smith's principal medical allies in the campaign to establish self-supporting or provident dispensaries. A pamphlet in 1830 describes the three classes of patients treated at the dispensary (probably reprinting a document dating to the start of the institution):

> Firstly, the free members, 'labourers who were able and willing to subscribe, who were issued with a blue ticket; secondly charity patients, recommended by the honorary subscribers, carrying a white ticket; thirdly parish patients (paupers) with yellow tickets. [43]

When patients waited at the dispensary the surgeon would see them in the corresponding order. 'A Classification of Manual Labourers' (Figure 22), a

[41] Apparently this was intended as evidence that applicants were 'needy', and unable to pay medical fees.
[42] Edward Bicknell (1806-81), MRCS & LSA 1830, was later medical officer to the Coventry Dispensary 1831-71
[43] Henry Lilley Smith et al., *Abstract of a Plan for the Formation of Self-supporting Charitable and Parochial Dispensaries,* London 1830; this pamphlet became more widely known through its second edition in 1831.

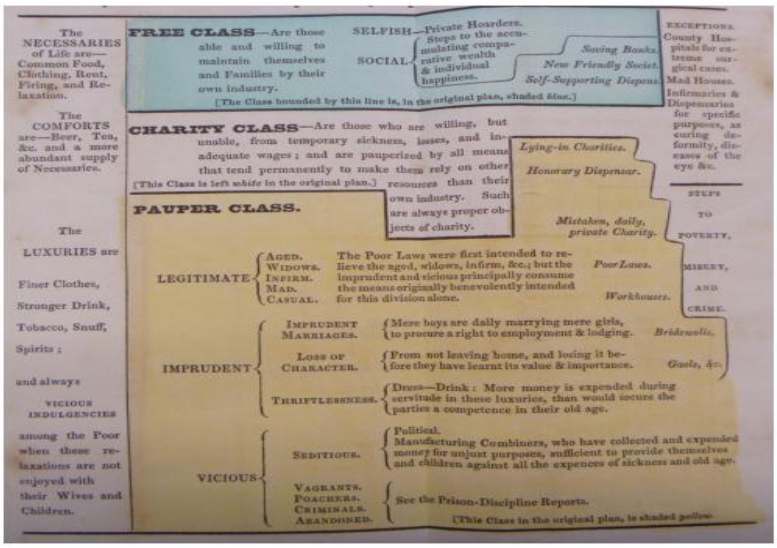

Figure 24: 'Classification of Manual Labourers', by Henry Lilley Smith (Wellcome Library EPB/P/48645).

document later appended to the *Abstract of a Plan* in 1830 (see below), expanded the attributes of the three groups.[44] The highly coloured terms reveal Smith's thinking on the merits of frugal habits and the dire consequences of improvidence. The dispensary's second annual report is one of the few original documents that contains institutional statistics for Southam. At that point (October 1825) the dispensary had 336 members, 270 (80 per cent) of them receiving treatment during the year. The subscriptions amounted to £44 11s 11d, and payments for journeys £26 0s 6d. The expenses included drugs, subscriptions to hospitals, wages and rent; the balance after such payments was £7 5s 7½d. Donations totalling £22 18s 6d had been applied to the costs of initial outfitting, but the chairman, John Shuckburgh, appealed for additional funds to complete the task.[45]

In additional notes to this report, Lilley Smith reflected on his experience.[46] Of the 336 members at Southam 215 were adults and 121 were

[44] Henry Lilley Smith, 'A Classification of Manual Labourers' (Southam, 1823).
[45] Southam Dispensary, 'Second Annual Report', (1825). p.1.
[46] He suggested 'district' or 'centripetal' dispensaries as suitable working names for the new style of institution; Southam Dispensary, Second Annual Report, p.2

children. As there were no obstacles to their seeking medical aid, their diseases were 'generally slight' (hence the attendance to 80 per cent of the members).[47] However, eight had died, six from phthisis (tuberculosis), and the existence of the dispensary permitted the latter to receive palliative medicines, which were not usually provided by parish surgeons.

In his notes Lilley Smith also considered the relevance of the dispensary's services for the local population. Southam had 1161 inhabitants, 335 of them sufficiently prosperous to live without manual labour and 'independent of assistance'. The subscribers were those with earnings inadequate to 'defray the expenses of medical attendance'; they would therefore either incur debt or seek parish aid (or possibly have foregone medical treatment altogether). Of the 270 individuals treated in the year, 48 would otherwise have sought the help of the parish. Before the dispensary, 145 individuals received 'parish pay', while 400 others occasionally sought the help of the parish surgeon. There were thus 250 people 'floating between independence and pauperism' that the dispensary treated, but who might otherwise find themselves sliding towards pauperism. There were also 30 'casual poor' belonging to other parishes (whom the dispensary was able to treat, but who otherwise found difficulty in obtaining aid). Two marginal groups could now readily gain access to medical care, those belonging to other parishes, and those 'floating' on the margins of long-term parish relief. The occupation of the members is not described but most appear likely to have been mostly agricultural labourers, with smaller numbers of servants and small-scale artisans.[48]

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[47] This perhaps accounts for the 80% who sought treatment in the first year.

[48] Occupational statistics are not available for this period, but those for the much larger Southam Poor Law Union (Registration District) for 1861 showed that for adults over 20, 1998 were engaged in farming; 362, mostly female, were servants and 997 were engaged in various trades. *GB Historical GIS / University of Portsmouth*, Southam PLU/RegD through time | Population Statistics | Age and Sex Structure data in 5-year bands to age 100, *A Vision of Britain through Time*.
URL: http://www.visionofbritain.org.uk/unit/10005553/cube/AGESEX_100UP

In July 1826, Henry Lilley Smith communicated his ideas to a wider audience when he addressed a meeting at Southam of local clergy, gentry, and medical men.[49] Then and later, Smith vividly expounded the prevailing flaws in the care of the poor, coupled with forthright claims for his new initiative.[50] After the meeting his supporters formed a committee (called the 'Warwick Committee' from its meeting place) to investigate the national state of the sick poor. Its 26 members included Warwickshire medical practitioners, clergy, and gentry; most were committee members at the Southam Dispensary or Eye and Ear Infirmary. Its secretary, Dr John Conolly, circulated a questionnaire to clergymen, justices, and medical practitioners across the country. Conolly reported the following year on the results; the returns revealed that annual contracts predominated in 23 counties and were known to be usual in five others (although the original sample size and the response rates are unknown).[51] Most respondents (the majority medical practitioners) believed that the farming system encouraged neglect of the sick poor. They considered sickness the principal cause of pauperism itself; those located in manufacturing districts, however, attributed this largely to the 'improvidence of the poor' themselves. There was general support for district dispensaries on the Lilley Smith model, albeit with heavy qualifications. These concerned their practicability, and in some very poor agricultural districts, the ability of labourers to make the required regular contributions.[52] Echoing certain of the Warwick report's findings, a pamphlet by the surgeon John Hulbert, of

[49] Meeting on 8 July at Southam, *Warwick and Warwickshire Advertiser*, 6 August 1826.
[50] Wheeler, 'Dr. Henry Lilley Smith', pp. 188
[51] Henry Lilley Smith, *Report of a Committee for Enquiring into the State of the Sick Poor* (Stratford-on-Avon: R Lapworth, 1827). This is the 'Warwick Committee'.
[52] Smith, *Report of 'Warwick Committee'*; for contracts, pp. 9-10; disapproval of farming system, pp.10-11; responses from manufacturing districts, p.12; practicability of self-supporting dispensaries, p.16.

Melksham in Wiltshire, collated various instances of parsimonious or callous behaviour on the part of parish authorities.[53]

Lilley Smith and his supporters also founded a national society that publicised his ideas, whose committee's membership overlapped with the Warwick body, and whose 1831 report was discussed by the *Lancet* and the *London Medical Gazette*.[54] The document urged the foundation of self-supporting dispensaries in every market town or large village, claiming that they preserved 'industrious labourers… from pauperism', while also extending coverage to their wives and children.[55] Each institution would treat several categories of patients: the largest group would be 'free members' subscribing small sums (normally one penny per week for an adult), any surplus, after deduction of expenses, being duly shared between the dispensary's medical officers. 'Honorary subscribers' were prosperous people whose support would fund both general expenses and treatment of a second group, the charity patients.[56] The treatment of parish paupers would be covered by a contract with the overseers.[57] Importantly, all local practitioners could (and ideally should) become medical officers so that the poor had a choice of medical attendant.[58]

In the next few years various medical writers argued the benefits of self-supporting dispensaries for patients, practitioners, and society generally. For Dr John Storer of Nottingham, they would both foster working-class independence and reduce the economic threat to young surgeons (compared with purely charitable dispensaries). Storer, now retired at 85 years, regretted that the new

[53] John F Hulbert, *Farming the Sick Poor: Observations, on the Necessity of Establishing a Different System of Affording Medical Relief to the Sick Poor, than by the Practice of Contracting with Medical Men, or the Farming of Parishes* (Shrewsbury: C.Hulbert, 1827)
[54] Lilley Smith, *Self-Supporting Charitable and Parochial Dispensaries*.
[55] Lilley Smith, *Self-Supporting Charitable and Parochial Dispensaries*, pp. 3-4.
[56] Both the term 'honorary subscribers' (or members) and their role were adopted from the 'patronised' friendly societies; P. H. J. H. Gosden, *The Friendly Societies in England, 1815-1875* (Aldershot: Gregg Revivals, 1993 (orig. pbn.1961)), pp.13-15.
[57] Smith, *Self-Supporting Charitable and Parochial Dispensaries*, pp. 7-8.
[58] Smith, *Self-Supporting Charitable and Parochial Dispensaries*, pp. 10-11.

Nottingham dispensary initiated in 1830 was not self-supporting.[59] In the same county, John Bigsby argued that they were less open to abuse by those who were not genuinely needy.[60] The *London Medical Gazette (LMG),* a conservative or (probably more accurately) cautiously reformist medical journal, warmly welcomed Lilley Smith's innovations.[61] In September 1832 the *LMG* noted that nine years' experience at Southam had inspired similar dispensaries in sixteen different towns and villages. These provided welcome aid to working people, with some recompense (albeit inadequate) to medical men. Politicians should heed the decline in pauperism that was experienced in places with self-supporting dispensaries and the consequent reductions in local poor rates.[62]

The Lancet was much more sceptical towards the innovations, given its radical viewpoint and critical stance towards dispensaries in general. In January 1833 it ridiculed the 'self-supporting' label for the new institutions, given their significant charitable element, and was doubtful that the arrangements for the parish poor would improve on existing provision.[63] On 30 March Wakley offered a lengthier critique, referring to one hundred readers' letters and most of the earlier publications.[64] He conceded that Lilley Smith was evidently humane and sincere, but claimed that his ideas lacked originality, merely echoing those advocated by J.C. Yeatman (a charge that Smith contested and indeed appeared to refute).[65] Wakley regarded as implausible the prospect of reasonable earnings for medical officers of self-supporting dispensaries. He pointed to Derby, where the seven surgeons had dealt with 1434 cases of illness but

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[59] John Storer, *Hints on the Constitution of Dispensaries* (London: J. Hatchard, 1832), comments on new Nottingham dispensary, pp. 13-15; implications for young surgeons, pp. 24-6.
[60] John Bigsby, *A Brief Exposition of Those Benevolent Institutions Often Denominated Provident Dispensaries* (Newark: Ridge, 1832), p. 35
[61] The *London Medical Gazette* was founded in 1827 by some leading London consultants as a counter to the *Lancet*. Burney described its policy as 'reforming to preserve' Burney, 'Medicine in the Age of Reform', p.165; Adrian Desmond, *The Politics of Evolution: Morphology, Medicine and Reform in Radical London* (Chicago & London: University of Chicago Press, 1989), p.16.
[62] 'Self-Supporting Dispensaries', *London Medical Gazette* X (1832), 807-8
[63] 'Mr Smith's Dispensaries, Mis-Called Self-Supporting', *Lancet* 19 (1833), 566-7
[64] Such as the pamphlets by Bigsby, Storer and Yeatman; see above.
[65] Yeatman, *Medical Care of the Parochial Poor*, pp. 19-20.

shared only £78. He also observed that where overseers contracted for the care of the parish poor, the amounts paid were still paltry.[66]

The Early Self-Supporting Dispensaries: Warwickshire and beyond

Henry Lilley Smith was able to recruit distinguished figures, especially in his own county, to help promote his ideas.[67] Both his origins within the minor gentry and his natural persuasiveness may have helped him to gain support. The leading figures on his committees were Whigs, such as Viscount Althorp and Sir Gray Skipwith, but other members had varied political allegiances.[68] In April 1829 he delivered a lecture (twice in one day) in Coventry on 'self-supporting, charitable and parochial dispensaries', a cumbersome title expressing the threefold funding sources.[69] Some leading local citizens formed a committee to implement suitable plans, although medical and allied opposition impeded its foundation for two years.[70] Lectures by Lilley Smith in smaller Warwickshire towns stimulated discussion but little direct action. In August 1828 Lilley Smith addressed a public meeting at the Stratford Tradesmen's Library; in Warwick in 1830 he 'repeated his lecture…to a very crowded auditory', his audience in

[66] 'Mr Smith's Dispensaries', *Lancet* 19, 500 (1833); Derby surgeons' earnings, pp. 21-2; Poor Law contracts, pp. 22-3; H. Lilley Smith's detailed rebuttal of the Lancet's plagiarism charge distinguished his proposals from Yeatman's; HL Smith, 'Origins of the Self-supporting Dispensaries, *Lancet* 19, 504 (1833), 160-1.

[67] They included Lords Althorp and Vernon; several members of parliament, Dr Thomas Arnold, several other clergymen; and the medical men Calvert, Conolly and Hope. These were members of the London committee, and most were also on the Warwick Committee, Smith, *Self-Supporting Charitable and Parochial Dispensaries,* p. 3.

[68] John Spencer, 1782-1834, who became 3rd Earl Spencer in 1834, was previously known as Viscount Althorp, and was Chancellor of the Exchequer 1830-34; Lord Vernon was another Whig; Sir Gray Skipwith (1771-1852) was a Whig MP for Warwickshire 1831-5. Peter Mandler, *Aristocratic Government in the Age of Reform: Whigs and Liberals 1830-1852* (Oxford: Clarendon, 1990), pp. 66, 88, 112.

[69] Meeting reports, *Coventry Herald,* 24 April 1829; two papers describe the institution from 1831, Robert Arrowsmith, 'An Account of the Coventry Self-Supporting Dispensary', *London Medical Gazette* XII (1833), 426-29 ; Robert Arrowsmith, 'Progress of the Coventry Self-Supporting Dispensary', *London Medical Gazette* XIII (1834), 234-7.

[70] As discussed in Ch 3. of this study.

February 1833 proposing the launch of a self-supporting dispensary, but evidently failing to implement this. [71]

In 1834 a London physician, Dr John Calvert, highlighted the risks for the sick poor of sliding into pauperism, in lengthy evidence to the Royal Commission on the Poor Laws.[72] He also suggested that appropriate support and economical medical help could avert such an outcome. John M. Calvert is an intriguing but somewhat obscure figure. Despite being a fashionable Mayfair physician, he invested much time and energy in investigating medical provision for the poor, while his house in Sackville Street evidently housed the London Society promoting self-supporting dispensaries.[73] He described various 'dispensary associations', his own preferred term for self-supporting dispensaries (most instances he quoted being summarised in Table 19). His paper identified their features and indeed summarised 'best practice'. He commended Henry Lilley Smith's new type of institution for its different advantages. Without such aid, the independent labourer (he argued) could suffer a fateful sequence of events. When attacked by illness, he might seek the help of an itinerant quack in return for ready money. If the illness persisted, the attentions of a regular practitioner might result in heavy bills. By now in debt to tradesmen, he might resume work too soon and then relapse. Disheartened and burdened by debt, he was all too likely to seek parish relief and sink into a demoralised state.[74] Such a progression was a common trope among contemporary medical men, versions being found in the writings of Lilley Smith and others.[75]

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[71] August 1828 meeting in Stratford, *Leamington Spa Courier* 23 August 1828; meeting in Warwick, 1830, and February 1833, *Leamington Spa Courier* 18 December 1830, 2 February 1833. The proposals in 1829 and 1832 in Leamington, in relation to the hospital there, will be dealt with below.

[72] John Calvert, 'Dispensary Associations' (Evidence to Royal Commission on the Poor Laws), pp. 23-38, Appendix C.

[73] John M. Calvert (1802 --?1841), attended Merton College, Oxford; BM (1828) DM (1831), FRCP (1832).

[74] Calvert, 'Dispensary Associations', p.23

[75] e.g. Smith's 'Classification of Manual Labourers' (fig 23 and discussion in text above).

Table 19: Self-supporting/Provident Dispensaries founded 1823 --c. 1834 (from Dr J Calvert's Evidence to the Royal Commission on the Poor Laws, 1834)

	Warwickshire						**Other Counties**		
			3	4	5	6	7	8	9
Place	Southa m	Athers-tone	Chilvers Coton, nr. Nun-eaton	Welles-bourne	Rugby	Coven-try	Burton-on-Trent, Staffs	Derby	Lymington Hants
Date Founded	1823	1827	1828	1828	1830	1831	?1830	1830	1830
Date Closed	?1860	1837		?1836		1948	existing in 1887	existing in 1887	existing in 1878
Promin-ent Founder/ Supporter	H. Lilley Smith MRCS	CH Brace-bridge	Francis New-digate	W Brace-bridge, Revd. Lord C Paulett	Revd. T Arnold	Revd. W Hook	Robert Thorne-well	JT Jones MRCS	Revd. Peyton Blakiston
Pop. of Borough/ Parish 1831	1161	3870	2494	1357	2501	27,060	6,797	23,627	3361
Members	36	1828 -- 878 1834 – 452	500	1832 – 225	450	2500	1027	450	300
Charity patients	Yes	Yes	Yes	Yes	NK	No	No	300	Y 'restricted'
Paupers treated	Yes	Yes		Yes	Yes	No	No	Yes	Yes
Staffing	1 S, 1 Asst.surg/ disp.	1 P, 3 S, Disp., MW	2 S	2 S	4 S	2 S, I P, Disp.		1 P, 7S, Disp.	6 S, Dispenser
Sources	Calvert, Lilley Smith	Calvert, Wheeler	Calvert	Calvert	Calvert	Calvert		Calvert, Jones	Blakiston

Sources: R. Arrowsmith,' An Account ..and 'Progress of the Coventry Self-Supporting Dispensary', *LMG*, XII (1833), 426-29, *LMG*, XIII (1834)'; P Blakiston, Hints for the Improvement of the Labouring Classes (London: Longman, 1831); J. Jones, Observations on Self-Supporting Dispensaries (London: 1844).

Calvert summarised the essentials of Lilley Smith's scheme: small regular payments by working people (typically one penny per week for an adult), the payment of the dispensary's surgeons from the annual surplus of the membership contributions, and the contribution of wealthy inhabitants both financially and in manning a committee.[76] Among the important functions of the committee was to monitor applications for membership, excluding those who could afford to fund their own treatment; another, Calvert argued, was to ensure that about two-thirds of the members' subscriptions were paid to the

[76] Calvert, 'Dispensary Associations', p.23

surgeons. While the resident medical men of a town usually opposed a new dispensary, he pointed out that they should understand the greater security for their (admittedly modest) payments compared with the prevailing situation. The duties of the committee included supervising the members' contributions, which were paid when well (and in work). As he put it, the surgeons' earnings were probably better than many clubs, without the trouble and expense of supplying medicines (as these would come from the dispensary).[77]

As Calvert explained, the appointment of surgeons was a difficult matter. Appointing everyone in a town might lessen jealousy, but all were unlikely to be equally committed. To select two or three individuals was probably preferable. Other committee responsibilities included the funding of initial set-up costs, varying from £36 to £80.[78] They should also carefully plan how to reimburse the surgeons' travelling expenses (the above subscription calculations were only appropriate for members living within one mile). In practice varying solutions had been found for scattered populations; at Southam outlying patients paid sums for travelling expenses, while elsewhere these became a charge on the honorary fund. At Lymington, on the edge of the New Forest, where some members lived up to seven miles distant, subscriptions were graded according to distance.[79] At Rugby more distant parishes paid at a higher rate.[80]

The coverage of charity patients presented various problems, and Calvert urged that this category should only be included when there was no local charitable dispensary. Indeed, the most successful dispensaries had none. At Derby, alongside 500 free members, there existed (an excessive) 300 charity patients; at Lymington charity tickets were 'restricted'; at Wellesbourne only

[77] Calvert, 'Dispensary Associations', pp. 24-6
[78] Calvert, 'Dispensary Associations', pp. 30-1
[79] The Revd. Peyton Blakiston (who later trained in medicine) founded the Lymington dispensary and described it both in evidence to the Royal Commission and in a pamphlet; Peyton Blakiston, *Hints for the Improvement of the Condition of the Labouring Classes* (London: Longman, 1831).
[80] Calvert, 'Dispensary Associations', p.27

three such tickets were issued, as against 1200 members paying subscriptions.[81] For such reasons, the Derby Dispensary was by 1844 considering removing the charity class.[82] Arrangements for paupers were also difficult, including appropriate charging rates and the reluctance of some overseers to pay (as originally at Wellesbourne and Derby.)[83]

The division of labour at self-supporting dispensaries reflects a significant development. Local general practitioners generally served them as 'surgeons', while a minority (three of nine in Table 19) also appointed physicians. At Atherstone the latter was to be called in 'when thought necessary by one of the surgeons', in 1829 being paid £2 2s for two cases.[84] This is similar to the policy at Southam: 'In difficult cases [with the sanction of a committee member] the surgeon may call in the aid of a physician'.[85] At Coventry, Dr Robert Arrowsmith, the honorary physician, was clearly closely involved in the institution and did much to publicise its principles and practice.[86] The limited role for these practitioners marks a break with the eighteenth-century charitable dispensary tradition, where physicians were responsible for most patients attended.[87] This was the case at the Stratford Dispensary, founded in 1823 (although the dispenser there, usually a junior local practitioner, performed mch day-to-day care; see Ch. 3). Four dispensaries employed a phamacist as dispenser; at the larger instiutions in Coventry and Burton he acted as clerk and received the subscriptions.[88] All the dispensaries provided vaccinations and offered midwifery, the latter a contrast with most charitable dispensaries. Calvert cited a normal confinement fee of 10s 6d paid by the

[81] Later views on Wellesbourne (e.g. as quoted By Jones, n82 below) suggested that the institution became lax; Calvert, 'Dispensary Associations', p. 32
[82] John Jones, *Observations on Self-Supporting Dispensaries* (London, 1844), pp.13-14.
[83] Calvert, 'Dispensary Associations', p. 34
[84] This was at the lower end of physicians' fee scales. Digby, *Making a Medical Living,* pp.185-8
[85] Atherstone Dispensary Minutes, p.26; Southam Prospectus p.1, 1823
[86] Arrowsmith, 'An Account…' and 'Progess of the Coventry Self-Supporting Dispensary', *LMG* 1833 and 1834
[87] Loudon, 'Origins and Growth', p.358.
[88] Calvert, 'Dispensary Associations', p. 23

patient (about half that normally paid in private practice). At this point only Atherstone employed a midwife, probably part-time.

The self-supporting dispensaries founded in the first decade (see Table 19) seem appropriate to consider individually, so far as available evidence permits.* Southam is considered above. **Atherstone**, a small manufacturing town in the far north of Warwickshire, became the home of the first self-supporting dispensary outside Southam (and whose original institutional minutes have survived). Its main founder was a prominent Lilley Smith supporter, Charles Holte Bracebridge, of Atherstone Hall. Bracebridge (1799-1872), the descendant of local master hatters, was a supporter of various charitable and liberal causes at home and abroad[89] Most inhabitants lived and worked in notably cramped dwellings, located in courts opening off a long main street.[90] The principal local trade was hat-making, but some inhabitants pursued ribbon weaving or production of other textiles. The inaugural meeting, in December 1827, stated its purpose:

> The benefits of this establishment shall extend only to poor Mechanics, Labourers, Servants (excepting Gentlemen's Servants), and other poor persons, not receiving parish relief, and not being able to afford medical assistance in the ordinary way. [91]

Those present appointed three surgeons to attend the dispensary in rotation, a physician for occasional consultations, a midwife, and a dispenser. As well as the members subscribing 1d per head weekly when in health, the dispensary would admit those already ill if two healthy individuals joined with them and paid full subscriptions.[92]

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[89] Charles Bracebridge has been identified (perhaps unkindly) with Mr Brooke in *Middlemarch*, as suggested by Judy Vero, *'A Concern in Trade': Hatting and the Bracebridges of Atherstone, 1612-1872* (Warwick: Warwickshire, 1995), pp. 94-95.
[90] N. W. Alcock, 'Housing the Urban Poor in 1800: Courts in Atherstone and Coventry, Warwickshire', *Vernacular Architecture* 36 (2005), 49-60
[91] Warwickshire County Record Office (WCRO) Bracebridge Papers, Atherstone Dispensary Minutes CR258/483, 31 December 1827, 'Rules'.
[92] CR258/483, Rule III; a similar rule was also later adopted at Coventry.

In its first year the Atherstone dispensary seemed to thrive, gaining 856 members, the committee therefore deciding in 1828 to extend its benefits to people in neighbouring parishes. The consequent need to reimburse surgeons' travelling expenses placed pressure on the finances, not eased by dissension about the appropriate division of payments.[93] From 1833 numbers of members also decreased, and by 1835 the membership at 452, was only about half that in the first year. The dispensary was affected by local economic problems including a decline in the hatting trade; besides, many members evidently elected to join their peers in the town's clubs and friendly societies. Bracebridge later stated that he had been 'beaten by the clubs'.[94] When the dispensary closed in 1837 after nearly ten years, its failure could therefore be attributed to an adverse economic climate and competition from rival providers.[95] **Chilvers Coton** was an agricultural, coalmining and weaving village located one mile south of Nuneaton (of which it is now a suburb). Its surgeons were William Bucknill and Edward Nason, practice partners in Nuneaton and members of significant local medical dynasties.[96] The rules resembled those at Atherstone and other institutions.[97] **Wellesbourne** was a large, purely agricultural village, equidistant from Warwick and Stratford-on-Avon. Three years after its foundation, at mid-1831, free members had increased from 140 to 225, and 1233 individuals had been treated in total. By the latter date most of the funds received from honorary members were being spent on 'broth, gruel, meat, wine …[and] linen, also on nursing'. In the latest 6 months these amounted to over

[93] Self-supporting dispensaries soon adopted a practice of allocating salary payments to surgeons in proportion to the numbers of patients that elected to register with them.
[94] Wheeler, 'Dr Henry Lilley Smith', pp. 186-8; 'Victoria Provident Dispensaries' (meeting report; comments of Mr Bracebridge), *Leamington Spa Courier*, 14 July 1858.
[95] Wheeler, 'Dr Henry Lilley Smith', pp. 184-7; WCRO CR 258/483, Atherstone Dispensary Minutes. 31 December 1827, 'Rules'. It appears that 'gentlemen' were expected to pay for their personal servants' medical attention directly.
[96] Their 1830 court appearance was to sue a recently arrived practitioner for slander (they won), 'Warwickshire Lent Assizes', *Leamington Spa Courier,* 3 April 1830.
[97] 'Address by H.L. Smith to the Derby Medical and Surgical Society'; letter to Editor, *Derby Mercury* 21 April 1830.

£31.[98] The only medical officer known is the 79-year-old Thomas Foster, whose attendance was recalled at a court hearing in August 1837 by witnesses who had visited the dispensary.[99] **Barford,** with 675 inhabitants in 1831, was four miles south of Warwick and four from Wellesbourne. Bigsby and Calvert mention a dispensary here, but no details have been found. **Rugby** was then a small market town, dominated by its famous school. Its reforming headmaster, Thomas Arnold, was one of those responsible for the establishment of a local dispensary in 1830, but again few details are known. **Coventry** was from 1831 the home of both a self-supporting and a purely charitable dispensary. The first of these had proved very popular, the number of members being limited to 2500 (by agreement with the rival institution). It treated only free members, having no charity or pauper patients. Robert Arrowsmith, physician to the institution, described its workings comprehensively (as discussed in Chapter 2).

Birmingham, unlike other midland towns, had a limited and somewhat disappointing experience with self-supporting dispensaries (albeit a picture obscured by conflicting evidence). In 1828 the Birmingham Self-Supporting Dispensary had been founded by a Mr Sanders, jointly with three other surgeons. This adapted Lilley Smith's principles considerably, in that entitlement to treatment depended on pre-purchased tickets rather than continuing membership; the surgeons also used their own premises rather than a dispensary building to attend and supply medicines to patients. The civic leaders who supported the new initiative included both Anglican and Dissenting clergy, and the political figures Thomas Attwood and Joshua Scholefield (this dispensary was discussed in Chapter 2).[100] By the first annual meeting, the dispensary had treated 338 independent patients and 100 charity patients. The

[98] Half-year Report for Midsummer 1831, extract in 'Self-Supporting Dispensaries' *British Magazine* IX, Jan 1836, 74-77.
[99] This evidence would suggest that the dispensary still existed at this point. The court evidence related to a suit against a Mr Lea, a local surgeon-apothecary, by the London Society of Apothecaries, for practising without an apothecary's licence; Warwickshire Summer Assizes, *Leamington Spa Courier,* 12 August 1837.
[100] They were leaders of the Birmingham Political Union and later Birmingham's first MPs; 1st Annual Report of the Birmingham Self-Supporting Dispensary, March 1829 (appended to Lilley Smith, *Abstract of a Plan*).

meeting expressed appreciation both towards Mr Smith, for originating the self-supporting principle, and to Mr Sanders for adapting it to local circumstances. According to Aaron, a local colleague, in 1830 Sanders failed to gain support in 'placing the institution on a sufficiently liberal footing', and accordingly left to found a rival establishment; in 1833 the latter became the 'Birmingham and Deritend General Self-Supporting Dispensary'. Aaron differentiated the later institution from the original Lilley Smith dispensaries, alleging much current bias. and misinformation. He also noted the recent failure of one dispensary closely following Lilley Smith's original principles, founded in 1830 by C.H. Bracebridge in Aston. There was an institution in Walsall conducted similarly to the Birmingham examples, but Calvert observed that considering the size of the respective towns, these distinctive dispensaries had failed to attract many patients (by 1834 the leading Birmingham dispensary was treating 850 annually and Walsall 76).[101]

Leamington Priors (often known from 1838 as Royal Leamington Spa) evidently did not establish a successful self-supporting dispensary despite local efforts. In contrast with most towns mentioned here, it experienced rapid early nineteenth-century growth into a resort and leisure town for wealthy people, soon followed by the 'sick and infirm poor'.[102] Medical men settled there in some numbers and supported several medical charities, such as the 'Charitable Bathing Institution', from 1806 funding therapeutic baths for the sick poor. The Royal Pump Rooms, opening in 1814, soon provided medical and surgical consultations as well as spa treatment for the needy. Dr Amos Middleton, the doyen of early spa physicians, was also a substantial investor in Leamington's developing New Town.[103] Adjacent to his large house, in its acre of grounds, he

[101] J Aaron, 'Self-Supporting Dispensaries (Letter to Editor)', *London Medical and Surgical Journal* 5 (1834), 727-9.
[102] Phyllis Hembry, Leonard W. Cowie, and Evelyn E. Cowie, *British Spas from 1815 to the Present: A Social History* (Cambridge: Cambridge University Press, I999), p.28.
[103] Thomas B. Dudley, *A Complete History of Royal Leamington Spa*: From the Earliest Times to the Charter of Incorporation, with Chronology of All the Principal Public Events Down to Date (Leamington Spa: P. & W. E. Linaker, 1901), pp. 227-30; Lyndon F. Cave, *Royal Leamington Spa: Its History and Development* (Chichester: Phillimore, 1988), pp. 96-98.

established a charitable dispensary in 1816; nine years later this became the Leamington Hospital and Dispensary.[104] The scale of the institution's activity is unclear, but it seems unlikely to have had more than twelve inpatient beds. In the late 1820s the Leamington hospital struggled financially, regularly spending more than its income.[105] In 1829 two committee members, Dr Charles Loudon and W.H. Bracebridge, a country gentleman living near Wellesbourne, proposed a self-supporting dispensary to ease the financial pressures.[106] While subscribers were interested in the plan, it was evidently not implemented at that point. Objections included the inappropriateness of using working people's contributions to rescue a failing institution rather than to fund their own medical care.[107]

In April 1832 Loudon revived the self-supporting proposal on a larger scale, and it was implemented, although a new channel of funding rendered the change redundant. As increasing numbers sought medical aid, the available accommodation (in a small house) was found 'inconvenient'. By this stage the Reverend Samuel Warneford had promised very generous funding, which encouraged other donations and enabled the construction of a larger general hospital on a new site.[108] The above events did not end Leamington's interest in self-supporting dispensaries. In 1836 the 'Victoria Self-supporting Dispensary' was announced, with a physician, surgeons and a dispensary house. Despite the

[104] This seems to have operated in parallel with the Bathing Institution. The combined institution occupied two small houses in Bedford Street, close to the junction with Regent Street.
[105] In 1827 the deficit was £140, largely arising from the cost of fitting-out the hospital the previous year. WRCO CR 1564/1, Leamington Hospital and Dispensary Minutes, I May 1828
[106] Walter Holte Bracebridge was first cousin and brother-in-law to C.H. Bracebridge of Atherstone; Charles Loudon was a Scots physician and author (1801-44, MRCS 1826, MD Glasgow 1827). He was later a Factory Commissioner.
[107] Such views were expressed by the local surgeon, Egerton Jennings; letter, *Leamington Spa Courier*, 30 May 1829.
[108] Dr Warneford gave three thousand pounds initially (and later much more); Craig D. Stephenson, *The Warneford: A Hospital's Story* (Warwick: South Warwickshire General Hospitals NHS Trust, 1993), pp. 8-10, 15-17.

royal patronage (from Princess Victoria) the institution received no further mention in the press, suggesting that it failed to attract potential members.[109]

While Calvert was reporting to the Royal Commission, the Manchester physician James Phillips Kay, a co-founder of the Ardwick and Ancoats Dispensary in 1828, was recording reflections on his six years' practice there.[110] As in other industrial towns, the numbers attending had grown much more rapidly than the local population. Kay argued that gratuitous treatment discouraged the urban working classes from providing for life's hazards and urged dispensaries to adopt self-supporting or provident policies (such as the Coventry Provident Dispensary). To do so would be economical, and more importantly morally beneficial for those seeking treatment. His recommendations were endorsed by another Manchester medical man, P.H. Holland. In 1838 Holland visited Coventry to seek local views of the Provident Dispensary (a strikingly early social inquiry). Of 100 people who had received treatment there, sixty-nine preferred the new system (see Ch. 2).[111]

The 'first wave' of institutions in Table 19 includes several that evidently closed within a few years (Atherstone, Chilvers Coton, and Wellesbourne, as well as Barford, near Warwick).[112] All those launched in villages were short-lived, and not accidentally, each incorporated a 'charity class'. Lilley Smith later advised against including such a group, writing in 1844, 'I was soon forced to abandon the charity class, for the simple fact, that the poor would not pay for themselves as long as anyone would pay for them'. [113] Lilley Smith suggested that local shopkeepers, having received dispensary recommendation tickets,

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[109] This was in Newbold Street (close to the site of the later Leamington Provident Dispensary founded in 1869). Notice, *Leamington Spa Courier,* 18 June 1836. In 1838 Victoria (now Queen) showed her favour by naming the town 'Royal Leamington Spa'.
[110] In 1834 Kay became an assistant Poor Law commissioner (see above). James Phillips Kay, *Defects in the Constitution of Dispensaries and Suggestions for Their Improvement* (London: Ridgway, 1834).
[111] P. H. Holland, *An Essay on Dispensaries* (Manchester: Love & Barton, 1838), p.20.
[112] Although opening dates are more easily traced than those of closing; Barford is mentioned by both Bigsby and Calvert, but no other details are known.
[113] Jones, *Self-Supporting Dispensaries;* quoting letter from H.L. Smith, p.22.

were handing these out indiscriminately.[114] A successful launch, as with a traditional dispensary, seemed to require a strong-minded local individual who could foster and then champion the new institution: possibly a medical man, but more likely a member of the clergy or gentry. By the late 1830s the examples of Coventry, Derby and Burton-on-Trent, soon to be joined by Northampton, suggested that provident dispensaries might thrive best in larger towns with substantial numbers of artisans.[115]

As well as self-supporting dispensaries, Henry Lilley Smith initiated various measures of social welfare with a distinctly paternalist flavour. These included local allotment schemes and small friendly societies called 'Alfred Societies'. [116] Through patronage of the Southam 'Maypole Holiday', he encouraged a sedate version of the previous carnivalesque and disorderly spring celebration. This was an example of a rural celebration tamed and rendered more acceptable by the middle classes [117] Later in life he developed highly eccentric religious views. Lane suggests that he may have lost credibility through his writing on such themes as Solomon's temple and the Old Testament patriarchs.[118]

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[114] As occurred in relation to charitable dispensaries in London; 'The Evil of Dispensaries and How it may be Checked', *LMG* XV, 311-15, esp. p. 312.

[115] Northampton founded its Victoria Provident Dispensary in 1845; see Charles H. Bracebridge, 'Notes on Self-Supporting Dispensaries, with Some Statistics of the Coventry Provident Dispensary', *Journal of the Royal Statistical Society,* 21 (1858), 460-63, esp. pp. 462-63.

[116] Henry Lilley Smith, *Alfred Societies; or a Plan for Very Small Sick Clubs, Etc.* (Southam: F. Smith, 1837); John Hull, *The Philanthropic Repertory of Plans and Suggestions for Improving the Condition of the Labouring Poor* (5th ed, London: Ridgways, 1835), pp. 20-21

117 Wheeler, 'Henry Lilley Smith', pp. 183-4; various similar examples are cited in Robert Malcolmson, *Popular Recreations in English Society 1700—1850* (Cambridge: Cambridge University Press, 1973), esp. pp. 118-19, 150-52.

118 Lane, *Social History of Medicine*, p.93. The titles include 'A Diagram to Define the Lives of the Patriarchs'…, 1842, and 'Lithographs representing … the Church of the First Born', 1857.

Figure 25: Henry Lilley Smith, date unknown, but probably 1850s (J.E. Duggins, photomechanical print, Wellcome Images, CC—BY—4.0)

In 1858 his final campaign, in Warwickshire and elsewhere, sought to re-launch provident dispensaries. He proposed that a royal visit to the county that year should be marked by establishing a series of 'Victoria Dispensaries'. His speeches and letters aimed at achieving change in Warwick divided local opinion, but on this occasion his persuasiveness was of no avail. The committee of the Warwick Dispensary declined to change its policy.[119] This bitter dispute darkened Lilley Smith's last months, before he died, aged seventy-one, in April 1859. Neither of the Southam institutions that he founded, the Dispensary and the Eye and Ear Infirmary., survived him for long. Without de facto subsidy (Lilley Smith

[119] The Warwick Dispensary was to become a provident dispensary in 1871, when the existing general dispensary merged with a provident dispensary association. This was two years after Leamington founded its own institution; John F. Wilmot, '"Advice and Medicine for the Working Classes": The Leamington and Warwick Provident Dispensaries 1869-1913', *Warwickshire History* XV (2014), 26-42, pp. 28-29.

having taken no salary payments from either institution) they did not appear viable and by the early 1860s had ceased to function.

The local poor 'wept at his funeral' and a local newspaper praised his work, noting his respectful attitudes towards agricultural labourers. According to the obituary, farmers objected to such ideas, one of them being suspected of having sabotaged the allotments that Henry Lilley Smith had established (by letting in cows who trampled the growing plants). Nor did he receive much assistance from the local clergy, only a few of whom supported him. Most were alarmed by his 'intense earnestness' in religious matters, as well as his independence of thought and action in philanthropy.[120]

Dispensaries and the New Poor Law

While the old Poor Law, in its later stages, played a part in stimulating innovations in dispensaries, the new structures developing after 1834 had an uncertain relationship with the institutions. Sometimes their role seemed to be mainly to reduce the financial demands on the new boards of guardians. A gap emerged in national policy, as the architects of the new system were preoccupied with the workless able-bodied. They appear to have ignored, almost wilfully, the evidence of impaired health as a leading cause of destitution.[121] However, in practice, the assistant commissioners who implemented the new system in different counties implemented medical arrangements. They encouraged the appointment of district medical officers, each responsible for several rural or semirural parishes or some part of a larger town. Each union was centred on a workhouse, usually newly constructed, and almost always including wards for the sick. These two provisions soon became de facto national policy.[122]

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[120] One clergyman who did offer consistent support was the philanthropic Henry Sitwell of Leamington Hastings: 'Mr Henry L. Smith' (obituary), *Leamington Spa Courier*, 23 April 1859.

[121] Flinn, 'Medical Services under the New Poor Law', pp. 47-8; Alan J. Kidd, *State, Society and the Poor in Nineteenth-Century England* (Andover: Palgrave Macmillan, 1999) pp. 40-41.

[122] The key documents being the *Report of the Royal Commission on the Poor Laws* and the Poor Law Amendment Act, both in 1834; Flinn, 'Medical Services under the New Poor Law', pp. 48-9.

Medical practitioners may have hoped for sensible reform of the flawed old Poor Law medical arrangements but instead were frustrated by the 'contemptuous' attitudes of those responsible for the new system.[123] The national medical associations repeatedly argued the profession's case to parliamentary committees and the Poor Law Commission, but adjustments were slowly and grudgingly introduced.[124] Doctors' complaints included the tendering process, still being widely used in the 1830s for appointing medical officers; also the meagre rates of pay, most newly appointed district medical officers receiving salaries similar to those of the former parish surgeons for larger areas and populations. The sanction of the relieving officer was needed for attendance on pauper patients, even in emergencies.[125] In 1842 the Poor Law Commission prohibited tendering in its General Medical Order, but without establishing concomitant improvements in medical pay. The Commission's new policy arose because of scandals such as the well-publicised incidents at the workhouse in Bridgwater in Somerset. In 1836-37 enteric infections, compounded by poor care, resulted in the death of one-third of the Bridgwater workhouse population There was inadequate cover by medical practitioners, largely arising from the parsimonious practices of local guardians.[126] The wider significance of the new policies that General Medical Order introduced in 1842 lay both in the recognition of the system's medical responsibilities and the creation of legally binding provisions. Despite the scandals and the new policies, improvements were implemented only slowly.[127] For their part, guardians

[123] M. Anne Crowther, 'Health Care and Poor Relief in Provincial England', in Ole Peter Grell, Andrew Cunningham, and Robert Jütte (eds.), *Health Care and Poor Relief in 18th and 19th Century Northern Europe* (Aldershot: Ashgate, 2002), 203-20, p.214.
[124] Rather confusingly, the professional bodies included the Provincial Medical and Surgical Association and the original, London-based, British Medical Association (the PMSA became known as the British Medical Association or BMA in 1856).
[125] Flinn, 'Medical Services under the New Poor Law', pp. 48-50.
[126] Samantha Shave, *Pauper Policies: Poor Law Practice in England 1780-1850* (Manchester: Manchester University Press, 2017), pp.26, 199, 202-05
[127] Flinn, 'Medical Services under the New Poor Law', pp. 46-50, 59-61; Shave, *Pauper Policies*, pp. 202-12.

complained that some medical officers neglected their duties.[128] The persistence of many flaws seemed inevitable, given the tensions between humane impulses towards the sick poor and the overwhelmingly deterrent intention of the new law.[129]

In Warwickshire, Richard Earle was the assistant commissioner who organised the thirteen unions in the county. While varying greatly in area and population, each was centred on a town, however small. There were some anomalies, such as the union based on Foleshill, an Industrial village near Coventry, which covered Bedworth and nearby areas. In Birmingham, the large suburb of Edgbaston became the responsibility of the King's Norton union in Worcestershire.[130] The two great towns of Birmingham and Coventry retained some independence of the central authorities through existing local Acts, dating respectively to 1783 and 1801.[131] This is more striking in Birmingham, which possessed one of the earliest provincial Poor Law infirmaries (dating from 1766, with a separate building in 1797; it contained 160 beds). In the 1830s and 40s its staff included four visiting surgeons, a house surgeon, and an apothecary.[132] Large numbers of people received outdoor medical relief funded by the Guardians; in 1829-43 the numbers treated (mainly as outpatients at the Town Infirmary (the Poor Law dispensary) ranged from 7073 to 14260, numbers which

[128] Stuart Wildman, *'He's Only a Poor Pauper Whom Nobody Owns': Caring for the Sick in the Warwickshire Poor Law Unions, 1834-1914* (Stratford-on-Avon: The Dugdale Society/Shakespeare Birthplace Trust, 2016), pp. 24-8; evidence of Dr James Philips Kay to Select Committee on Poor law Amendment Act, 1838, p.132.
[129] Flinn, 'Medical Services under the New Poor Law', p. 57.
[130] Both places were engulfed by urban sprawl, Foleshill becoming an inner-city locality; the Kings Norton infirmary later became Selly Oak Hospital, whose catchment area covered much of south Birmingham.
[131] Wildman, 'He's Only a Poor Pauper', pp. 8-9.
[132] Ruth G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871* (London: Wellcome Historical Medical Library, 1967) pp. 190-1; Alistair E. S. Ritch, 'Medical Care in the Workhouses in Birmingham and Wolverhampton, 1834-1914' (Unpublished PhD Thesis, University of Birmingham, 2015), pp. 54, 161-2.

were comparable to those attending as outpatients at the General Hospital, and indeed at the General Dispensary (as discussed in Ch.2).[133]

Coventry evidently did not gain a separate infirmary until 1871 (and initially only a fever hospital); the three district medical officers instead operated a monthly rotation for the care of workhouse inmates.[134] This nineteenth-century workhouse is said to have played 'a significant role in health care', with admissions for accidents, illness, and pregnancy.[135]

In 1835, Edward Gulson, assistant commissioner for Oxfordshire, claimed that in rural areas of England, 'medical clubs are starting up in all directions'.[136] The authorities encouraged both dispensaries and medical clubs (local benefit associations and friendly societies), hoping to contain the costs of treating paupers.[137] Some guardians used the threat of withholding relief to force poor people to join clubs and dispensaries, as evidently happened in the Brackley Union in Northamptonshire.[138] At the 1838 Select Committee, Edward Gulson urged Coventry's self-supporting dispensary as a model for other towns, combining self-help for the poor with acceptable fees for medical officers.[139] However questions by Thomas Wakley and others revealed that the institution served the class just above the poor (so was unlikely to have much impact on pauperism) and was strongly opposed by most local practitioners.[140]

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[133] Alistair Ritch, 'New Poor Law Medical Care in the Local Health Economy', *Local Population Studies*, 99.1(2017), 42-55, esp. pp.48-49

[134] Hodgkinson, *Origins of the National Health Service,* p.187.

[135] Rosemary Hall, 'Distressed Weavers, Deserted Wives and Fever Cases: An Analysis of Admissions to the Coventry Workhouse', *Warwickshire History* 13 (2007/8), 226-39; the paper covers 1859-61, but the 1830s situation may have been similar, especially in the absence of a general hospital (which opened in 1840).

[136] This may have been most true of the south Midlands counties that the writer knew best; Edward Gulson, assistant commissioner, Evidence (for Oxfordshire) to Poor Law Commissioners, 1st Annual Report, 1835, p.55.

[137] Hodgkinson, *Origins of the National Health Service,* pp. 205-14

[138] Hodgkinson, *Origins of the National Health Service*, p. 220; evidence of H. W. Rumsey (for PMSA) to Select Committee on Poor Law Amendment Act, 1838, p. 46.

[139] Gulson had been a reforming Director of the Poor in Coventry and a co-founder of the self-supporting Dispensary there; the institution was also commended by Richard Earle. Gulson, Select Committee on Poor Law Amendment Act 1837-8, 'Minutes of evidence', p.19.

Contemporary sick clubs are less well documented, but three 1830s Warwickshire examples include clubs in Stratford-on-Avon, Alcester, and Leamington Hastings near Rugby (mentioned early in this Chapter).[141] Notwithstanding such provisions, poor people increasingly distrusted the clubs established or favoured by the guardians (especially as their own small contributions were intended to reduce local rates). The medical organisations, the BMA and the PMSA, were also increasingly opposed and the assistant commissioner Dr. James Phillips Kay came to question their effectiveness.[142] Overall dispensaries and sick clubs are seen as making only a 'marginal' contribution to Poor Law services.[143] Indeed the increasing separation of charitable and state medical care rendered impossible a potential role for self-supporting dispensaries in the provision of pauper medical care (as opposed to a preventive or pre-emptive function). Henry Lilley Smith's vision of an integrated medical service for all poor people had evidently faded. [144] The next section will discuss the role of the *Lancet*, which included self-supporting dispensaries among its targets.

The *Lancet* and Dispensary Reform

Since the *Lancet* had been founded in 1823 as a new sort of medical journal, it had turned a critical eye on the working of medical institutions. Its articles criticised widespread incompetence and nepotism among elite practitioners, the self-serving exclusiveness of the royal colleges, and various abuses of

[141] *Second Annual Report on the Poor Laws*, Appendix B, Reports from Assistant Commissioners, No. 15, pp. 419-20; Seymour, *Old and New Friendly Societies*, esp. pp. 6-20.
[142] Hodgkinson, *Origins of the National Health Service*, pp. 220-22. Kay was responsible for Norfolk and Suffolk. A former dispensary physician, he was relatively sympathetic to medical views and appeared in some ways to be the doctors' 'friend at court'
[143] This was Flinn's view; Flinn, 'Medical Services under the New Poor Law', p. 50
[144] Crowther, 'Health Care and Poor Relief', p. 216.

charity.[145] Dispensaries became a target from June 1829, following an inquest on a child who died when under the care of the Kent Dispensary in Deptford. This small boy had been treated for a cough with high doses of two risky but widely used medicines (antimony and calomel or mercurous chloride).[146] The dispensary had failed to monitor his condition, leading the *Lancet's* editor, Thomas Wakley, to castigate the medical man concerned for his callous neglect. Correspondents to the journal confirmed that such cavalier prescription of powerful drugs was indeed common, and other criticisms followed. Various alleged flaws were then ventilated in the *Lancet*. These included abuses of charity, including the imposition of charges on charitable patients for their treatment, for instance for midwifery. Others deprecated the use by dispensary subscribers of institutional treatment for household servants.[147]

One long anonymous piece criticised the reliance of voluntary institutions on gratuitous medical services.[148] As such posts were seen as valuable 'stepping-stones', they were sought with 'avidity', candidates for posts often resorting to 'expensive contests.' The writer claimed that candidates might give hundreds of pounds to encourage subscribers' votes, in turn hoping to earn 'enormous fees from apprentices.' Once appointed, inexperienced medical officers might neglect their duties, and delegate the care of patients to

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[145] Michael Brown, ''Bats, Rats and Barristers': The Lancet, Libel and the Radical Stylistics of Early Nineteenth-Century English Medicine', *Social History* 39 (2014), 182-209 ; Ian Burney, 'The Politics of Particularism: Medicalisation and Medical Reform in Nineteenth-Century Britain', in Roberta Bivins and John V Pickstone (eds.), *Medicine, Madness and Social History: Essays in Honour of Roy Porter* (London: Palgrave Macmillan, 2007), 46-57; Loudon and Loudon, 'Medicine, Politics and the Medical Periodical 1800-50', pp. 65--68.

[146] 'Non-Medical Coroners', *Lancet*, 12, 304, 27 June 1829, 401-3; the appointment of medically qualified coroners was another *Lancet* campaign; Wakley was elected coroner for West Middlesex in 1839.

[147] At one obstetric dispensary considered by the *Lancet*, most women were attended gratis by students, and the director/proprietor would only attend women in difficulties for a fee; 'NR', letter, 'Bill supplied to dispensary patient', *Lancet* 13 (1830), 352, 337-8; 'Scrutator', 'Bill supplied to dispensary patient', *Lancet* 13 (1830), 353, 396; 'Charges Made to Charity Patients', 13 (1830), 577. Restrictions on charitable treatment for one's household were customary; Veritas', 'Professional Puff-Shops', *Lancet* 12 (1830), 645

[148] X.X.X, 'Injurious Tendencies of the Hospital and Dispensary System', *Lancet* 12 (1829), 375-7.

the institution's apothecary or to their pupils. The writer urged that charities should appoint experienced men and to pay them an appropriate salary.

In addition to his critiques of prominent individuals and institutions, Thomas Wakley also acted as the mouthpiece of surgeon-apothecaries, or general practitioners as they were increasingly being called. Such men, especially in London, struggled to make a living in an overcrowded medical marketplace. Many were sensitive to social and professional slights and were particularly unhappy about the unwarranted credit that some physicians and surgeons gained with the public through gratuitous service with dispensaries and other medical charities. A dispensary located close to a practitioner's premises might attract not only the truly poor but also those of modest means, who in truth could afford private fees.[149]

Wakley evidently considered many flaws to be inherent in the constitution and funding of charitable institutions.[150] He claimed that dispensary medical officers were often incapable, probably appointed through the influence of family and friends, and were 'only remarkable for their ignorance, impudence and cunning'.[151] Such remarks reflect Wakley's typical invective and ridicule, weapons used to powerful effect in the journal's critique of leading medical institutions, but now aimed at more modest targets, the charitable dispensaries of the metropolis.

Some critics, as noted above, urged dispensaries to pay fees to medical officers.[152] Such a salaried, professionalised service was consistent both with Benthamite ideas and also more radical views derived from post-revolutionary France, that emphasised meritocracy a and a greater role for the state.[153] In July 1830 Wakley commended the use of examinations as a requirement for

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[149] Loudon, *Medical Care and the General Practitioner*, pp. 202-5
[150] J. Bainbridge, 'Dubs, Pures and Charity-Mongers', *Lancet*, 12, 311, 1 August 1829, 565-6; H. W. Dewhurst, 'Dispensary Abuses', *Lancet*, 12, 311, 1 August 1829, 618.
[151] These were his remarks in response to the above Kent Dispensary case; 'Non-Medical Coroners', *Lancet*, p. 402.
[152] X.X.X, 'Injurious Tendencies', p.377
[153] Harold Perkin, *The Origins of Modern English Society 1780-1880* (London: Routledge, 1972), pp. 258-61; French and Wear, *Medicine in an Age of Reform*, p.7; Burney, 'Medicine in the Age of Reform', pp.163-70.

appointment to medical posts, along the lines of the contests conducted in France, the 'concours général'. The Quaker physician Thomas Hodgkin advanced similar arguments in advocating examinations as the soundest basis for medical appointments to dispensaries or to Poor Law posts.[154] Unsurprisingly, these were never widely implemented.

Two important dispensary disputes: Aldersgate and Sheffield

In the early 1830s, at least some medical practitioners were influenced by a new mood of questioning aimed at medical charities. In this connection, Michael Brown has recounted events in 1833 at two prominent dispensaries in London and Sheffield. His analysis highlighted the sceptical attitude to charity apparent among the medical men concerned, and explored the wider professional responses that their actions stimulated.[155] The General Dispensary in Aldersgate Street, London, co-founded by John Coaksey Lettsom in 1770, was the oldest metropolitan general dispensary, and acted as an organisational model for others.[156] In June 1833 the subscribers decided to ease existing restrictions on new subscribers voting for prospective medical officers, prompting the resignation of all six medical officers. The implications were that candidates for posts could drum up support by recruiting new subscribers, perhaps using financial inducements (as mentioned earlier by the *Lancet*'s correspondents).

The resulting publicity, in medical and general publications, stimulated public meetings in support of the Aldersgate medical officers.[157] One of these was in London on 12 October, when 'five hundred physicians and surgeons' were addressed by John Elliotson, professor of medicine at London University, and a political radical. He argued that 'it is the duty of all the profession to come forward in support of their brethren'.[158] In his address, Elliotson referred

[154] ''Concours Général'', *Lancet* 13 (1830), 551-4; Hodgkin, 'Selecting and Remunerating Medical Men for Professional Attendance of the Poor,' pp. 395-97. Thomas Hodgkin, of Guy's Hospital, was a keen social reformer as well as a clinician and reseracher (originally describing the eponymous lymphoma).
[155] Brown, 'Medicine, Reform and the 'End' of Charity'.
[156] Loudon, 'Origins and Growth', pp. 323-4.
[157] The implication was that candidates for posts would pay the subscriptions of supporters in return for their votes.
[158] Brown, 'Medicine, Reform and the ' End ' of Charity', p.1355

to other large gatherings, for instance at Ipswich and Northampton, that had endorsed the Aldersgate practitioners' stand.

Another dispensary dispute in 1833 differed in detail but also excited wide interest, stimulated by a disagreement between the medical officers of the Sheffield Public Dispensary and the institution's lay governors.[159] The practitioners here had criticised the lax procedures of the institution, especially in permitting the gratuitous treatment of people who were not genuinely needy. On 31 July a 'memorial' appeared, signed by thirty-three Sheffield medical men.[160] The governors, allegedly, failed to scrutinise the circumstances of those seeking treatment. For instance, they commonly permitted domestic servants to receive dispensary treatment (considered their employers' responsibility, as earlier noted by the *Lancet's* correspondents). The authors of the document referred to the 'notorious improvidence of the lower orders', but they argued that this was surely encouraged by 'the lavish extension of gratuitous relief'. The medical officers resigned, the case was thoroughly publicised, and as with Aldersgate, there were expressions of support from other practitioners across the country.[161] As noted above, James Phillips Kay made similar arguments to the practitioners at Sheffield, referring to his experience at a Manchester dispensary during 1828--34.[162] Kay argued that the working classes commonly lacked forethought and provident habits, but could be encouraged in developing such attributes by joining self-supporting dispensaries, as many had done at Coventry.[163]

Brown linked the above occurrences at Aldersgate and Sheffield not only with a new critical spirit directed towards charity, but also a newly crystallised 'imagined community' of medical men, as discussed in Chapter 4 in relation to

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[159] Brown, 'Medicine, Reform and the 'End ' of Charity' pp.1371-2

[160] Corden Thompson *et al*, 'Memorial against the Indiscriminate Relief of Applicants at the Sheffield Dispensary', *The Lancet* 19 (1833), 628-31 (10 August 1833); this letter also appeared in the *LMG* and other journals.

[162] Kay, *Defects in the Constitution of Dispensaries.* In 1834 Kay became an assistant Poor Law commissioner (as mentioned earlier in the Chapter).

[163] Note accounts of Coventry above, and in Ch.2.

new societies and publications.[164] Benedict Anderson, the originator of the concept, had argued that 'technologies of imagination', especially newspapers, fostered the nineteenth-century emergence of national and other collective identities. [165] Medical journals, professional societies, and provincial clinical schools had all encouraged a sense among practitioners of a shared ethos and interests.

In both the above well-publicised episodes, flaws in governance stimulated the expression of reformist views among medical men. These applied to the proper function of charities like dispensaries, which were widely seen as extending their benefits too far beyond the truly needy (for instance, among more highly paid artisans). The *Lancet* and some of its correspondents favoured salaried rather than gratuitous service in public (charitable) posts, and perhaps also appointment through open meritocratic selection rather than informal influence, with all the potential for corruption.[166] There are clear parallels with the contemporary campaigns for reform of parliament and municipal corporations, with identical rhetoric frequently used. Philosophically, some of the medical and the general reformers were influenced by the utilitarian views of Bentham and his supporters. Others, like Wakley himself, drew on the universalising ideas of the French revolution, albeit with an admixture of native English radicalism.[167]

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[164] Brown, 'Medicine, Reform and the 'End ' of Charity' pp. 1357-8.
[165] Benedict R. O' G Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* 2nd edn (London: Verso, 1991); Brown also draws on Mary Poovey's concepts of social formation. Mary Poovey, *Making a Social Body: British Cultural Formation, 1830-1864* (Chicago: University of Chicago Press, 1995).
[166] Brown, 'Medicine, Reform and the 'End ' of Charity' pp.1357-8
[167] It should be noted that Wakley was strongly opposed to Benthamite ideas, which he saw as heartless; Brown, 'Medicine, Reform and the 'End' of Charity' pp.1370-2; Burney, 'Medicine in the Age of Reform', pp.163, 169-72, 175-9.

Conclusions

This Chapter aimed to explore disparate elements of the 'age of reform' during the early and mid-nineteenth century, including endeavours to reform medicine and its institutions, especially as reflected in the columns of the *Lancet*. Its historiography hitherto has tended to concentrate on its critiques of major hospitals and the medical corporations, and few scholars, other than Michael Brown, have paid much attention to the focus on dispensaries.[168] Dispensaries, just like other medical institutions, were attacked for laxity or outright abuses, in their administration of charity; for appointment processes vitiated by undue personal influence or venality; and for many instances of callous or negligent care. In the eyes of the *Lancet* and others, they had become tainted by 'old corruption', just like the organs of national and local government.

The other strand in the Chapter commenced with the plight of the poor, especially the sick poor, in the post-war decades. Henry Lilley Smith developed ideas aimed at improving the medical care of both parish paupers and labouring people more generally. Supported by other practitioners and concerned lay people, he developed a new style of dispensary in rural Warwickshire that aimed to provide accessible and affordable medical care. Such institutions were intended to avoid the flaws that the *Lancet* and its readers identified in current medical charity. Like other mutual organisations, they were intended by their founders to encourage provident habits.

While Smith and his early allies envisaged self-supporting dispensaries as being best suited to larger villages or small market towns, this is not where they thrived best. The early instances in such settings tended to fail, for reasons that cannot be clearly defined, given weaknesses in the primary sources). However relevant factors seem to have included erosion of the provident element by injudicious charity, competition from other providers, or simply questionable viability. The dispensaries founded in moderately large towns, such as Coventry, Burton, and Derby, were more successful. Their larger membership made for

[168] Brown, 'Medicine, Reform and the 'End ' of Charity'

easier coverage of the expenses of a building, dispenser and so on. They tended to avoid a class of 'charity patients' (except Derby, at least in its early years).

The crises in some leading dispensaries, as discussed in the *Lancet* and elsewhere, seems to have had the unintended consequence of encouraging some degree of unity among medical practitioners. In the terms that Brown adapted from Anderson, the early 1830s saw the birth of an 'imagined community' among members of the profession.[169] However Brown may overstate the amount of common ground, given the continuing tensions between medical men of different sorts.

For general practitioners, there were new opportunities in staffing the new provident dispensaries (although, ironically, they often opposed their foundation). This break from previous arrangements, where physicians were predominant, may simply have recognised the de facto role in most communities of surgeon-apothecaries in dealing with a wide range of complaints.[170]

Henry Lilley Smith, persistent and persuasive, was a key figure in establishing and fostering provident dispensaries. In doing so he was aided by certain medical colleagues and by leading figures in regional society. In winning their support he may have been helped by his Warwickshire roots and a degree of gentility. In contrast, other practitioners (including John Conolly), could be seen in Ian Inkster's terms as 'marginal men'. As discussed in Chapter 4, Inkster applied the concept to practitioners in Sheffield, seen as socially and geographically mobile individuals, whose interests in science and culture helped them to develop a distinctive social identity.[171] To sum up, dispensaries were an important element of the early nineteenth-century medical world. They were criticised for abuses and suffered crises of legitimacy, although the self-supporting or provident dispensaries seemed to offer some solutions. The new

[169] Brown, 'Medicine, Reform and the ' End ' of Charity', esp. pp. 1355-8
[170] Loudon, *Medical Care and the General Practitioner*, pp. 191-5

form grew up in Warwickshire, firstly in semi-rural settings and later in larger towns. They aimed to eradicate prevailing flaws and offer a more comprehensive and dependable medical service for the working classes in both town and countryside, but as they developed, they appeared to be more suited to urban than rural conditions

Chapter 6

Growth, change, and conflict: the dispensaries of Birmingham and Coventry, *c.*1860 – *c.*1880

Introduction

This chapter explores the dispensaries of Birmingham and Coventry during the two decades following 1860, a period of considerable economic and political change. The dispensaries continued their important role in providing medical care to a growing, and perhaps more assertive, working class. They faced increasing numbers seeking their help, and partly as a result, relations between different institutional participants were affected by tensions. During the last decades of the century established institutions were joined by other providers serving working people, forming part of an increasingly diverse local medical economy.

The chapter's aims and research questions begin with contexts, both local and national. On a local scale, how did the social, economic, and political backdrop change in the two industrial cities? More general questions concern the influence on dispensaries of national debates about charity and welfare. Inside the institutions, we need to assess how and why dispensaries changed during the period – what renegotiation took place between different participants, and why? There is a need to explore the amount and sources of the support dispensaries received, both financial and practical. Next follow the demands on dispensaries, assessing any changes, for example in illness patterns; were these related to local living and working conditions? A final question concerns the overall place of dispensaries in the medical world, including their relevance to medical careers.

Later nineteenth-century developments in medical services can be seen in terms of Keir Waddington's view of the interaction between a changing society and economy and 'diseases, ideas [and] practices'. He contrasts this with an older historiography that tended to 'over-privilege ideas of progress, great

men and women, technology or institutions'. [1] While this thesis considers individuals, and their relationship to evolving institutions, these are necessarily explored within local social and political contexts. In their exploration of later nineteenth-century medical services, Waddington and Cherry emphasise the expansion of hospitals (including an increasing contribution from specialist institutions).[2] Dispensaries, however, receive little attention from either author; this thesis will nuance their analyses by arguing for the significance of dispensaries in the medical landscape. Martin Gorsky and his colleagues have explored the governance and financing of health institutions in the period, performing quantitative research into trends in morbidity and the usage, management, and financing of health services.[3] They include an account of pioneering efforts in Birmingham to cover hospital costs through industrial workers' contributory schemes, and in this Chapter, the relevance of such arrangements to dispensaries will be considered.[4] Gorsky's studies of friendly societies and their medical services have explored common ground between mutualism and health care, again to be explored in terms of their local application. [5] Friendly societies were increasingly active in health care provision, largely through employing local practitioners as 'club doctors.' However, one

[1] Keir Waddington, *An Introduction to the Social History of Medicine: Europe since 1500* (Basingstoke: Palgrave Macmillan, 2011); quotes pp. 14, 340.
[2] Keir Waddington, *Charity and the London Hospitals, 1850-1898* (Woodbridge: Boydell Press, in association with the RHS, 2000); Steven Cherry, *Medical Services and the Hospital in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), pp. 45-48.
[3] e.g., Martin Gorsky, 'The Growth and Distribution of English Friendly Societies in the Early Nineteenth Century', *Economic History Review*, NS, 51.3 (1998), 489-511; Martin Gorsky and Sally Sheard (eds), *Financing Medicine: The British Experience since 1750* (Abingdon: Routledge, 2006), 147-63; Martin Gorsky, John Mohan, and Martin Powell. 'British Voluntary Hospitals, 1871–1938: the Geography of Provision and Utilization' *Journal of Historical Geography,* 25.4 (1999): 463–482.
[4] Martin Gorsky, John Mohan, and Tim Willis, 'A 'splendid spirit of cooperation': hospital contributory schemes in Birmingham before the National Health Service',in Jonathan Reinarz (ed), *Medicine and Society in the Midlands 1750 -1950* (Birmingham: Midland History Occasional Publications, 2007), 167-19.
[5] Steven Cherry, *Medical Services and the Hospital in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996); Martin Gorsky, 'Friendly Society Health Insurance in Nineteeth-Century England', in Martin Gorsky and Sally Sheard (eds.), *Financing Medicine: The British Experience since 1750* (Abingdon: Routledge, 2006), 147-63.

can challenge Gorsky (mildly) for an apparently over-optimistic view of medical attitudes to friendly society work. Within the West Midlands, this thesis draws on a body of recent research on local and regional medical provision, mainly by Birmingham-based researchers. Prominent among these is a historical overview of Birmingham hospitals by Jonathan Reinarz, with its wealth of empirical data.[6] Finally there exist a few authors who have researched dispensaries, not least Irvine Loudon, whose survey of early institutions only extends to c.1850; his research on outpatients, however, is highly relevant and will receive attention here. Chamard's painstaking thesis on dispensaries in contemporary London offered a narrative or rise and decline, which may be to some degree applicable to Warwickshire urban settings.[7]

The chapter will deal with events in both Birmingham and Coventry, but as will be explained, inevitably rather unevenly. There are intriguing opportunities for comparison between the two cities, each with a single large dispensary providing much of the out-patient medical care to local inhabitants but which, by the late nineteenth century, were operating alongside other providers. Their different organisational and funding models, as between Birmingham's purely charitable status and Coventry's 'provident', quasi-mutual basis, offer obvious aspects for evaluation. To gain a clear view of local societies and economies is more difficult. Late nineteenth-century Birmingham has stimulated a rich historiography, much of which explores the social and political role of Joseph Chamberlain and his associates. His faction is generally credited with ambitious reforms and redevelopments launched under the so-called 'civic gospel'. Scholars have studied Coventry less in the period; most attention has been focused on the city's severe crisis in 1858-60, due to a

[6] Jonathan Reinarz, *Healthcare in Birmingham: A History of the Birmingham Teaching Hospitals, 1779-1939* Rochester,NY: Boydell & Brewer, 2009); Jonathan Reinarz (ed), *Medicine and Society in the Midlands 1750-1950* (Birmingham: Midland History Occasional Publications, 2007); Alistair Ritch and Jonathan Reinarz, 'Exploring Medical Care in the Nineteenth-Century Provincial Workhouse: A View from Birmingham', in Jonathan Reinarz and Leonard Schwarz (eds.) *Medicine and the Workhouse* (Rochester,NY: Boydell & Brewer, 2013), 140-63.

[7] Mary J. Chamard, 'Medicine and the Working Class: The Dispensary Movement in London, 1867-1911' (unpublished PhD thesis, Toronto, 1984).

lengthy strike and the near-complete collapse of the silk ribbon trade (to be explored in more detail later in the Chapter).[8] In Coventry as well as Birmingham, an older historiography suggested an uneasy harmony and paternalism up to the 1830s, modified through the early and mid-Victorian era. Later revisionist accounts have challenged this view, noting the many tensions between the urban elite and local artisans.[9] It remains appropriate to note such differing interpretations, while neither time nor space permits their close exploration here.

There also exist useful primary and secondary sources for Birmingham's health institutions, but researchers are relatively disadvantaged (as briefly noted above) when dealing with contemporary Coventry. Hitherto much scholarship on the nineteenth-century city has concentrated on local industry and society up to c.1860. Nor have primary sources for health institutions survived such as minute books, or even many annual reports. However, thriving local newspapers compensate somewhat for these weaknesses. Despite such deficiencies in primary and secondary sources, Coventry's Provident Dispensary was a nationally prominent (and at times controversial) institution, and certainly warrants consideration.

An important focus of this chapter is the dispute of 1868 at the Birmingham General Dispensary, an unusual episode that illustrates both the tensions that could develop and the possible outcomes. The dispensary was the second oldest of Birmingham's medical charities and by some measures its richest. By the 1860s its staff, both honorary and paid, were treating about 6000 patients each year on the dispensary premises or in their own homes.[10] In February 1868 the six senior medical staff members drafted a document for the governors, complaining of their rising workload and suggesting organisational

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[8] Peter Searby, *Coventry in Crisis, 1858-1863: Ribbon Factory, Free Trade, and Strike* (Coventry: University of Warwick, for Historical Association 1977), pp. 5-7, 10-12.

10 Birmingham University Special Collections (BUSC), R988.B5 Birmingham General Dispensary Annual Report, various years; 'Scrutator', *The Medical Charities of Birmingham: Being Letters on Hospital Management and Administration* (2nd ed., Birmingham: Sackett, 1863).

changes.[11] The management committee welcomed some of their proposals but strongly resisted another request – that such (honorary) staff members be paid small honoraria. Despite extensive discussions, the two sides could not resolve their differences, and the medical officers therefore resigned in May 1868.[12] Clearly there was a sharp renegotiation of relationships, and the dispute will be explored in more detail in the chapter.

Birmingham in the 1860s: a Changing Scene

The general social and economic development of the two West Midlands cities may have influenced some aspects of medical provision, for instance in dealing with the ill health arising from poor living and working conditions. However, in this period the policies of medical charities appear only loosely related to health care needs. Nevertheless, industrial leaders, and later also (some) ordinary workers, helped to fund and organise responses by medical charities to disease and injury.

In Birmingham's industrial scene of the 1860s, small and medium workshops still predominated, with artisans using craft skills to manufacture such items as guns, jewellery, and small tools. Amongst these small units, some larger factories were emerging, whose products included, screws, steel pens, and varied brass items.[13] Workers enjoyed improved conditions in newer workplaces but at the cost of considerably increased management control.[14] Asa Briggs and other scholars, drawing partly on traditional local accounts, portray a cohesive local culture where able and fortunate small masters could become wealthy. However, Behagg and Smith have challenged such analyses in their

[11] Birmingham Archives and Heritage (BAH), MS 1759/1/4/1) 'Report by Honorary Medical Officers to the Management Committee', January 1868
[12] BAH, MS 1759/1/2/2 Birmingham General Dispensary, Minutes, May 1869.
[13] Malcolm Dick, 'The City of a Thousand Trades, 1700-1945' in Carl Chinn and Malcolm Dick, (eds.), *Birmingham: The Workshop of the World* (Liverpool: Liverpool University Press, 2016), 125-58, pp. 141-3.
[14] W. B. Stephens, 'City of Birmingham: Economic and Social History: Social History since 1815', in *VCH Warwickshire 7: City of Birmingham,* pp.196-97; Eric Hopkins, *The Rise of the Manufacturing Town: Birmingham and the Industrial revolution,* (rev. ed., Stroud: Sutton, 1998), pp. 85-9.

view of Birmingham as a society riven by hostility between classes, with much less social mobility than earlier authors had suggested.[15] Similarly there may have been tensions between manufacturing elites acting as governors of medical charities and the professionals who did most of the work.

In the later 1860s Birmingham's civic and parliamentary politics changed considerably, largely due to the influence of industrial figures. These aspects were explored in detail in Chapter 1, so will merely be summarised here. Around 1867-8 the manufacturer Joseph Chamberlain became actively involved in politics, his years as a successful entrepreneur always influencing his political approach. From 1854 he had worked in the new screw manufacturing firm founded by his maternal uncle, John Sutton Nettlefold. In early years Joe Chamberlain concentrated on finance and marketing, where his canny approach facilitated the mergers and takeovers that enabling the firm to grow. Chamberlain's cousin, Joseph Nettlefold, took charge of engineering production in a large new factory in Smethwick.[16] The firm of Nettlefold and Chamberlain soon came to dominate screw manufacture in Birmingham and in several international markets.[17]

Different scholars have underlined the influence of the charismatic preachers George Dawson and Richard Dale on wealthy Unitarians like Chamberlain and his associates. They inspired them to plan ambitious

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[15] William Hutton*, An History of Birmingham*, (Birmingham: W. Hutton, 1783), pp. 49-50, 61-3, 81, 111; Asa Briggs, *Victorian Cities*, (London: Odhams, 1963); Harry Smith, 'William Hutton and the Myths of Birmingham', *Midland History,* 40 (2015), 53-73, esp. pp. 53-4; Clive Behagg, 'Myths of Cohesion: Capital and Compromise in the Historiography of Nineteenth-Century Birmingham', *Social History,* 11 (1986), 375-84; Clive Behagg, *Politics and Production in the Early Nineteenth Century* (London & New York: Routledge, 1990).

[16] In early years the elder Joseph Chamberlain also worked in the firm with his brother-in-law; see Peter Marsh, *Joseph Chamberlain*, pp.10-17, 21-23; also Peter T. Marsh, 'Chamberlain, Joseph [Joe] (1836–1914), industrialist and politician.' *Oxford Dictionary of National Biography*. 23 Sep. 2004; last accessed 12 July 2021. https://0-www-oxforddnb.com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-32350

[17] Jules P. Gehrke, 'A Radical Endeavor: Joseph Chamberlain and the Emergence of Municipal Socialism in Birmingham', *American Journal of Economics and Sociology* 75 (2016), 23-57 p. 24.

programmes of municipal social improvement, extending well beyond the palliative work of charities. [18] The Chamberlain faction therefore campaigned in elections to the new school boards in 1867 and later to the borough council. Joseph Chamberlain continues to dominate scholarly attention, but his local achievements also owed much to his relatives and political allies. His leading supporters were his brothers, his cousin, and families such as the Kenricks and the Martineaus.[19] The close Unitarian networks were based on ties of both belief and kinship, cemented through intermarriage and business partnerships.[20]

In the late 1860s and 1870s, Chamberlain led the newly invigorated Liberal group on the council in designing a school building programme and grand designs for slum clearance and redevelopment. The early municipal activities were financed by council-controlled local utilities, commonly dubbed 'gas and water socialism'. Birmingham's 'central improvement scheme' cleared many of the worst slums, replacing them with the new Corporation Street as the core of new commercial redevelopment.

These ambitious policies were pursued alongside the traditional philanthropy seen by Dissenters (together with other Christians) as a religious duty. Birmingham Unitarians had an established pattern of support of medical charities, notably the General Dispensary. Influential figures there during *c.*1860-80 include Joseph Nettlefold, who became chairman; Joseph Chamberlain as a dispensary subscriber; and his younger brother Richard Chamberlain (1840-1899, committee member in the 1870s and president during

[19] Lesley Rosenthal, 'Joseph Chamberlain and the Birmingham Town Council, 1865-80', *Midland History*, 41, 1 (2016), 71-95, pp. 74, 78

[20] John Seed, Theologies of Power: Unitarianism and the Social Relations of Religious Discourse, 1800–50', in R. J Morris (ed), *Class, Power and Social Structure in Nineteenth-century British Towns* (Leicester: Leicester University Press, 1986), pp. 130-31; while Seed concentrates here on the first half of the century, such relationships seem to have been at least as important later.

his mayoralty in 1880).[21] Arthur Chamberlain, the middle brother, was closely involved with the Women's Hospital from its foundation in 1871. [22]

Medical services, needs and demand

'Faith in charity', in Waddington's words, underpinned nineteenth-century institutional provision. The charitable effort in support of hospitals (and also by inference, dispensaries) helped to unite old and new elites, cemented civic pride, and offered routes to resolving both disease and underlying social issues.[23] This summary echoes both Porter's remarks on early provincial infirmaries and the analysis by Morris of nineteenth-century voluntary societies.[24] In the later nineteenth century, the requirements of technological innovations (such as asepsis and laboratory investigation) became important and increasingly costly drivers of change in hospitals.[25] These were developments that almost entirely by-passed dispensaries, as they had no inpatients and performed little surgery. Nevertheless, their lack of involvement in medical advances may have contributed to their later marginalisation, especially around the turn of the twentieth century.

Later pages will explore the increases in numbers of patients attending the dispensaries in both Birmingham and in Coventry in the later nineteenth-century. This was a local instance of a much wider phenomenon, as from about mid-century, increasing numbers of people sought outpatient treatment from

[21] Joseph Nettlefold (1827-81) was chairman of the dispensary 1868-81; Richard Chamberlain (1840-1899) was a committee member in the 1870s and president (when mayor) in 1880. In 1885 he followed his brother into Parliament as a Liberal, later also becoming a Liberal Unionist.

[22] Arthur and Richard Chamberlain, Joseph's younger brothers, had joined the brass founding firm of Smith and Chamberlain. Arthur Chamberlain (1842-1913) was a major supporter of the Women's Hospital from its beginnings in 1871; Judith Lockhart, 'Women, health and hospitals in Birmingham: the Birmingham and Midland Hospital for Women, 1871-1948' (Unpublished PhD Thesis, Warwick, 2008), pp 84-5.

[23] Waddington, Social History of Medicine, p.150

[24] Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in Lindsay Granshaw and Roy Porter (eds.) *The Hospital in History*, (London: Routledge, 1990), 149-78; R. J. Morris, 'Voluntary Societies and British Urban Elites, 1780–1850: An Analysis', *The Historical Journa,l* 26 (1983), 95–118.

[25] Waddington, Charity and the London Hospitals.

medical charities. The increased numbers aroused most comment in relation to London hospitals (where annual numbers typically doubled between the 1840s and the 1860s) but certain provincial towns experienced similar changes (shown in Table 20).[26] For dispensaries, data are scantier (and perhaps less reliable), but some relevant figures are summarised in Table 21. The latter table uses, firstly, data derived from Loudon's survey of early dispensaries.[27] Contemporary data relate to 1843, when the London dispensary practitioner John Chippendale reported the statistics of metropolitan dispensaries, albeit with caveats arising from their inconsistent methods for recording attendances.[28] In January 1869 the *Times* expressed alarm that in one year, over half the population of London (four out of seven people, or 1,800,000 individuals) had received attention from hospitals and dispensaries. The newspaper's main source was the *Medical Directory*, using the section where institutions listed numbers attending. The journalist concerned did, not apparently consider issues such as double counting; patients might make repeat attendances or go to separate institutions (perhaps perfectly appropriately).[29]

[26] Irvine Loudon, 'Historical Importance of Outpatients', *BMJ* 1 (1978), 974-7 for a vivid account of conditions for patients, see Francis Barrymore Smith, *The People's Health, 1830-1910* (London: Croom Helm, 1979), pp. 252-6.
[27] Irvine S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine* 55: (1981), 322-42; Table 2 uses his count of foundations up to 1800, p.325.
[28] John Chippendale, 'A Statistical Account of the Metropolitan Dispensaries', *The Lancet,* i (1843), 325-7; the statistics reported by dispensaries might denote numbers of patients, attendances, or episodes of illness, making comparison difficult.
[29] Anonymous, 'London Hospitals and Dispensaries', *The Times*, 30 January 1869, p.4.

Table 20: Hospital Outpatient Numbers 1840 --c.1870					
Date	**Name of Hospital**	**Number of institutions**	**Annual Outpatient numbers**	**Increase %**	**Sources**
1840s	London Hospital		11913		Loudon, 'Outpatients' 1978
1860s	London Hospital		25906	117	
1840s	Royal Free Hospital		27567		
1860s	Royal Free Hospital		66662	142	
1840s	Radcliffe, Oxford		1348		
1860s	Radcliffe, Oxford		4663	246	
1840s	Gloucester Infirmary		583		
1860s	Gloucester Infirmary		1119	92	
1869	'Great' London hospitals	11	610,918		*The Times* survey, 1869 (& *Medical Directory*)
1869	'Small' London hospitals	64	705,735		

Table 21: London and Provincial Dispensaries with changes in patient numbers, c.1800 -- c.1875

	Charitable Dispensaries			**Provident Dispensaries**		
Date	**No. Institutions**	**Patient numbers**	**Increase %**	**No. Institutions**	**Patients (members)**	**Sources**
1800	*London* 16	50,000				Loudon, 'Origins and Growth'' 1981
	Provinces 22					
1843	*London* 27	101362	102	*London* 3	2209	Chippendale, 'Dispensaries of London'
1869	*London* 50	413,400	309	*London* 7	23,947	*The Times*, 30 Jan 1869 (& *Medical Directory*)
1875	*London* 55	122, 932		*London* 14	10,636	Whitfield 2010 (after *Medical Directory*)
1875	*Provinces* 175	134,037		*Provinces* 25	22,548	

Note: Entries for 20 dispensaries in 1875 (seven of them provident) were affected by missing data

Why were more people seeking help from official medical channels rather than using domestic or traditional remedies, or consulting irregular practitioners (or doing both)? Among possible explanations, the long-standing rhetoric about medicine and its scientific basis may, in the century's third

quarter, have gained some public traction.[30] It seems likelier, however that potential patients were influenced by the gentler therapeutic approach that developed around this time among much of the profession, and which relied less on bleeding, purging and heroic doses of toxic substances. In response to patients' preferences, mainstream medical practice may even have been influenced by the principles of homoeopathy.[31] Some of those seeking institutional help would be workers in large towns who lacked support systems when ill. Waddington noted the uneven changes across the metropolis, with attendance figures increasing more sharply in certain London localities, principally those experiencing the largest increases in inhabitants, such as Southwark and in the East End close to the London Hospital.[32]

Overall metropolitan hospital beds did not increase in numbers sufficiently to keep pace with rising population numbers, as was also the case in several provincial towns. In the latter, Cherry suggested that increasing pressures on bed space led later nineteenth-century hospitals to discharge in-patients early, perhaps inadvisably, and thereafter treating them as outpatients.[33] At hospitals, the consequences of increased numbers included uncomfortable waiting for patients, exhausting working conditions for doctors, mostly relatively junior, and cursory clinical assessments.[34] Some London dispensaries were affected by the same overcrowding, resulting in brief encounters with overworked practitioners. Among the reports are the single

[30] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), pp. 119-20, 180-1
[31] Anne Hardy, *Health and Medicine in Britain since 1860* (Basingstoke: Palgrave, 2001), pp. 28-9; see, e.g., Roberta Bivins, *Alternative Medicine? A History* (Oxford: Oxford University Press, 2007), pp. 99-103.
[32] Keir Waddington, ''Unsuitable Cases': The Debate over Outpatient Admissions, the Medical Profession and Late Victorian London Hospitals', *Medical History* 42 (1998), 26-46, pp. 29-30; Waddington, *Charity and the London Hospitals*, p.161.
[33] S. Cherry, 'The Hospitals and Population Growth: Part 2, the Voluntary General Hospitals, Mortality and Local Populations in the English Provinces in the Eighteenth and Nineteenth Centuries', *Population Studies* 34 (1980), 251-65, pp. 261-2.
[34] 'St Bartholomew's Hospital', the *Lancet,* 2 (1869) p. 240.

practitioners mentioned, who saw between seventy and one hundred patients daily.[35]

General practitioners objected to the hospital situation on both professional and financial grounds, as potential patients by-passed them, with the consequent loss of private fees; many also questioned how many truly needed the assistance of charities.[36] In discussion of its survey in 1869, *The Times* also doubted how many applicants to London medical charities were truly so poor as to be unable to meet professional charges. The newspaper suggested the automatic levy by institutions of a small fee (one shilling), with exemptions for the truly indigent. The newspaper was also critical of the number of small special hospitals, such as the seven established for women and children. Their proliferation surely wasted charitable funds and duplicated effort.[37] Such observations formed part of a more widespread critique of charity, or at least of the multiplicity of well-meaning bodies with chaotic, overlapping, or ill-coordinated policies.

From 1869 a new organisation in London, the Charity Organisation Society (COS), acted as a forum and a pressure group for such arguments. This organisation aimed to counter dependence and 'demoralisation' among the poor. The body developed innovative methods such as detailed family casework, but Fraser and others have seen it as limited by a reactionary philosophy that attributed poverty to individual failings.[38] In medical journals references to 'hospital abuse' abounded, with common tropes concerning well-

[35] As Chamard recounts, at the Surrey Dispensary In 1861, Dr D. Hooper saw at least one hundred patients daily; at the Farringdon Dispensary in 1872, Dr J Chapman attended 72 patients daily. Each patient had between 60 and 100 seconds with the doctors. See letter of 29 January 1861 from Dr Hooper in the Surrey Dispensary minute book 1858-69; Dr Chapman's account, *Pall Mall Gazette*, 4 June 1873, cited by Chamard, 'Medicine and the Working Class,' pp. 82 --83, 103, 106, 117, 144.
[36] 'Abuse of Hospitals and Dispensaries—a Monster Evil of the Day', *BMJ* 1 (1853), 76-77 ; here the *BMJ* was speaking clearly for the general practitioners. Many similar articles and letters followed during following decades.
[37] Anonymous, 'London Hospitals and Dispensaries', *The Times,* 30 January 1869, p.4.
[38]Derek Fraser, *The Evolution of the British Welfare State: A History of Social Policy since the Industrial Revolution* (4th ed, Basingstoke: Palgrave Macmillan, 2009), pp. 155-57.

heeled hospital attenders concealing their prosperity (or worse, flaunting it).[39] While this was the dominant discourse, not all contemporary observers accepted that medical charities were widely abused; Waddington's analysis of hospital admissions did not confirm a significant shift in social composition.[40]

Whether or not justified, alleged 'hospital abuse' continued as a major professional concern for decades, often ventilated in the pages of the *British Medical Journal (BMJ)* and the *Lancet.* In these discussions, dispensaries held an ambiguous place, charitable dispensaries often being regarded as subject to the same dubious demands as outpatient departments. Provident dispensaries, however, were seen by most COS members and some others as admirable for their espousal of forethought and self-help. More practically, some members considered that their services could divert some of the demand on general hospitals.[41]

The increases in outpatient numbers induced many general practitioners, at least in London, to consider hospital colleagues at least partly responsible for the crowds at hospitals. Large numbers in outpatient departments could, after all, as providing useful pools of potential subjects for clinical teaching.[42] Abel-Smith, in his pioneering work on late nineteenth-century hospitals, focused on the resulting tensions between different sections of the profession.[43] Abel-Smith noted the 'constant demarcation disputes' between them, and the threat experienced by the 'class of doctor who won a precarious living from the modest payments of skilled workers and the lower middle class'. [44] Some of Abel-Smith's arguments were echoed by scholars in

[39] Loudon, 'Historical Importance of Outpatients', p. 976.
[40] Keir Waddington, 'Unsuitable Cases: The Debate over Outpatient Admissions, the Medical Profession and Late Victorian London Hospitals', *Medical History* 42 (1998), 26-46; among those who doubted widespread abuse was J. Steele, the medical superintendent of Guy's Hospital, p. 31; the admissions analysed in Waddington's paper were those of inpatients, who would have previously been outpatients, p.32.
[41] Stedman Jones, *Outcast London,* pp. 271-2.
[42] Loudon, 'The Historical Importance of Outpatients', pp. 975-6.
[43] Brian Abel-Smith, *The Hospitals, 1800-1948: A Study in Social Administration in England and Wales* (Cambridge, MA: Harvard University Press, 1964), esp. a chapter headed 'General practitioners and consultants,' pp. 101-118,
[44] Abel-Smith, *The Hospitals,* pp. 102, 104.

the following decade.[45] Many Intraprofessional tensions linked with outpatient attendance were resolved (eventually) by the early twentieth-century outpatients' department developing an explicitly consultative function, coupled with a formalised referral system.[46] The increase in patient numbers became a public issue just during the decades (1850-80) that certain scholars, such as Peterson and the Parrys, have identified as the key epoch for professionalisation. These authors see most practitioners as gaining improvements in their social status, for instance following important legislation in 1858. This is when the Medical Act recognised official medicine through the concept of the registered medical practitioner, regulated by a new body, the General Medical Council.[47] Keir Waddington has emphasised how certain medical men gained a particular identity through hospital work and then sought increased institutional control from lay officials.[48] However relations between different elements of the profession were complex. There was a steady trend towards increasing differentiation between those holding institutional posts and those without. Nevertheless, most of the surgeons at the dispensaries in Warwickshire, and some at hospitals, practised mainly as general practitioners. Indeed, as Digby has shown, the role of 'GP-Surgeon' continued widely until the twentieth century.[49]

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[45] Ivan Waddington, 'General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict', in John H. Woodward and David Richards (eds.), *Health Care and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine,* ed. by John (London: Croom Helm, 1977), 164-88; Nicholas Jewson, 'Medical Knowledge and the Patronage System in 18th Century England', *Sociology,* 8 (1974), 369-85.

[46] Loudon, 'Historical Importance of Outpatients', pp. 974-7; Abel-Smith, *Hospitals*, pp. 101-18; Waddington, 'Unsuitable cases', pp. 27-28.

47 M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley and Los Angeles: University of California Press, 1978); Noel Parry and Jose Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London: Croom Helm, 1976).

[48] Keir Waddington explores the similarities between Abel-Smith's analysis (above) and those by Ivan Waddington and Nicholas Jewson; *Social History of Medicine,* pp. 157-65, 175-81.

[49] Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), pp. 107-27; Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press., 1999), pp. 2, 94-7.

Before considering events in the Midlands, it seems worth questioning how far the Charity Organisation Society and its activities were relevant to provincial towns. The Society was formed in response to various metropolitan crises in the 1860s that had only partial parallels elsewhere.[50] Such conditions contrast with Birmingham's continuing, if uneven, industrial prosperity; Coventry had its own industrial and subsistence crisis at the start of the 1860s but by the end of the decade was recovering and developing embryonic new industries. Branches of the COS formed in provincial towns, including Birmingham, never gained a high degree of support. Birmingham manufacturers, like their peers in in the Black Country, seem to have regarded traditional philanthropy as both an obligation and a means of expressing social leadership.[51] However COS publications, especially after the formation of its medical committee in 1871, had a continuing influence on debates concerning outpatients and the role and functioning of provident dispensaries.

Three Medical Disputes in Birmingham

In 1868 the General Dispensary experienced a staff dispute, followed by reorganisation of its personnel and premises, which will be described in detail below. The events at the dispensary may have been influenced by clashes in the 1860s at several medical institutions in Birmingham.

The most prominent of these involved the Birmingham Medical School, founded in 1825 by the surgeon William Sands Cox, assisted by his father Edward Townsend Cox.[52] In 1841, largely through the efforts of Sands Cox, Queen's Hospital opened as a linked teaching institution. The medical school evolved into the strongly Anglican Queen's College, which by the 1850s was providing courses in the arts, law, and divinity alongside medicine. Its buildings

[50] These included harsh weather conditions, a cholera epidemic, and the collapse of Thames shipbuilding; Stedman Jones, *Outcast London,* pp. 241-2.

[51] Robert Humphreys, *Sin, Organized Charity and the Poor Law in Victorian England* (London, Palgrave Macmillan: 1995), pp. 64-100, 110-143.
Richard H Trainor, *Black Country Elites: The Exercise of Authority in an Industrialized Area 1830-1900* (Oxford: Clarendon Press, 1993), pp. 313-30.

[52] K.D. Wilkinson, *The History of the Birmingham Medical School* (Birmingham: Cornish, 1925), pp. 32-37. In its first few years the school was simply an anatomy class at the Cox family home in Temple Row (the original dispensary building); see Ch 2, figure 1.

near the Town Hall resembled those of an Oxford college, and church dignitaries occupied key roles.[53] The warden was the Reverend James Law, chancellor of Lichfield diocese, while the Dr Samuel Warneford, a wealthy Gloucestershire clergyman, was a major and highly influential donor. His gifts were accompanied by a stipulation that students should be exclusively adherents of the established church (such views probably also influencing staff appointments).[54] Sands Cox was in the late 1850s still acting as dean of the medical faculty but was then widely considered both inefficient and dictatorial. His actions provoked complaints and resignations, for instance in 1858 by the physician Thomas Heslop, then professor of physiology. Heslop and others instigated an investigation by the Charity Commission (Heslop also resigned from Queen's Hospital in 1860 because of disagreements there).[55] The subsequent strongly critical report led to Queen's Hospital separating from the College and, in due course, to the retirement of Sands Cox from key roles.[56] By then Birmingham also possessed a second, non-denominational medical school, Sydenham College, founded in 1851 by General Hospital staff.

An unified medical school seemed desirable and careful negotiations were followed by an act of Parliament.[57] The Unitarian physician James Russell played a major role in encouraging members of both staffs to join forces, which nearly all did, enabling the new merged institution to open early in 1868.[58] Opponents of Sands Cox disliked his sectarianism but objected even more to his habitual bad temper, his over-ambitious and under-funded expansion plans,

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[53] In buildings, staffing and connections it resembled King Edwards's school, then centrally located in New Street.

[54] Jonathan Reinarz, 'Towards a History of Medical Education in Provincial England', *Medical History Bulletin (Liverpool Medical History Society)* 17 (2006), 30-37 pp. 34-6.

[55] As Reinarz suggests, the repeated resignations in his career do suggest that Heslop may not have been an easy colleague; Reinarz, *Healthcare in Birmingham,* p. 76.

[56] Wilkinson, *History of Birmingham Medical School*, pp. 38-41; Reinarz, *Healthcare in Birmingham*, pp. 61-4

[57] This was the Queen's College (Birmingham) Act of 1867, required because the college was established under royal charter.

[58] James Russell was then on the General Hospital staff, and, like his surgeon father (also James) had served at the Birmingham dispensary. He was a staunch Unitarian from an established local family; Reinarz, *Healthcare in Birmingham,* pp. 61-4.

and the unsatisfactory pedagogic consequences, all practical concerns noted by Wilkinson and Reinarz.[59] An alternative analysis by Dennis Smith identifies the changes as marking the displacement of traditional elites by new groups from dissenting and industrial backgrounds**.** He considers that in the middle third of the century, the local medical world was dominated by some well-connected Tory and Anglican figures, such as the Coxes, father and son, and the Johnstone family of physicians.[60] These were factors that led Smith to argue that Inkster's concept of the 'marginal man', developed in relation to contemporary Sheffield and discussed in Ch.4, was much less applicable to the Birmingham scene.[61] On the other hand, urban historians such as Briggs and Fraser offer nuanced versions of contemporary changes, recognising the long-standing local prominence of Dissenters.[62] This writer's view is that educational, social, and religious factors all played a part in changing local institutions, and that any shifts in the balance of power between different groups, would have been very subtle.

The Lying-In Charity, founded in 1842, was another medical charity (previously discussed in Ch.2) that changed in this decade.[63] By the early 1860s this was caring for women during confinement both at home and in the beds of its hospital in Broad Street. Its in-patient beds were also used for sick children

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[59] Wilkinson, History of Birmingham Medical School, pp. 39-41; Reinarz, Healthcare in Birmingham, pp. 62-3.

[60] Dennis Smith, *Conflict and Compromise : Class Formation in English Society 1830-1914: a Comparative Study of Birmingham and Sheffield* (London: Routledge & Kegan Paul, 1982), pp.151-58. Edward Johnstone (1757-1851) and his brother John (1768-1836) were leading Birmingham physicians, in the early 1830s successively elected president of the Provincial Medical and Surgical Association (the PMSA, forerunner of the British Medical Association).

[61] Ian Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850', in John H Woodward and David Richards (eds.), *Health Care and Popular Medicine in Nineteenth Century England* (London: Croom Helm, 1977), 128-63; this concept was discussed closely earlier in this thesis, esp. Ch.4.

[62] Derek Fraser, *Urban Politics in Victorian England: The Structure of Politics in Victorian Cities* (Leicester: Leicester University Press, 1976); Briggs, *Victorian Cities*, pp. 174-5, 182-90.

[63] The events are well summarised by Frances Jane Badger, 'Delivering Maternity Care: Midwives and Midwifery in Birmingham and Its Environs, 1794-1881' (Unpublished PhD Thesis, Birmingham, 2014), pp.159—68; also see Lockhart, 'Women, health and hospitals in Birmingham', p. 29.

and diseases 'peculiar to women', hospital costs consequently being high. Difficulties arose there in 1867 due to a shortage of funds and major disagreements between the medical officers, the management board, and the influential ladies' committee. Two committees of enquiry were set up, eventually leading to closure of the hospital and (in January 1868) the charity's reopening as a purely domiciliary service. From then, most confinements were conducted by midwives (and by new medical officers who replaced those who had resigned). Current medical opinion was moving against maternity hospitals, because of unacceptable rates of maternal mortality in many of them, but both Badger and Lockhart argue that in Birmingham the internal disputes were much more significant.

A third probable influence on the general dispensary was a large Birmingham friendly society, which experienced its own dispute over medical pay and conditions. From about mid-century, such societies extended their activities from paying benefits during sickness and after death into providing medical and surgical treatment. Their functions thus came to overlap with those of dispensaries. [64] They typically appointed local practitioners as part-time medical officers. As the work expanded, many doctors objected to the low earnings from such posts and their lack of independence (as they also did regarding Poor Law employment). Such issues were ventilated at BMA meetings and in national journals, together with grumbles about the 'hospital problem' as outlined above.[65] All these factors seemed to contribute to a general mood of medical militancy. In Birmingham in 1867, the eleven practitioners serving approximately 6000 members of the Cannon Street Benevolent Institution sought improvements in their payments, unchanged for many years (unlike both private practice fees and manual workers' wages).[66] As their duties ranged from full physical examinations to surgical operations, they pressed for

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[64] Gorsky possibly underplays the dislike of general practitioners for this work; for a contrasting view, see, e.g., Digby, *Making a Medical Living*, pp.47-50.
[65] Peter Bartrip, *Themselves Writ Large: The British Medical Association 1832-1966* (London: BMJ Publishing Group, 1996), pp. 135-9.
[66] 'Birmingham', *Medical Times and Gazette,* 16 November 1867, p.552.

increases in their annual payments from 3s 3d to 5s per member. They gained support from the BMA, to be discussed below, and from some sections of the local press.[67] After the institution's committee resisted any change, refusing to put the doctors' case to a general membership vote, several medical officers resigned.[68]

The Cannon Street dispute, reported in local newspapers and in national medical journals, was also a lively topic at the Birmingham branch meetings of the BMA. At one such meeting In June 1867 the physician Thomas Heslop delivered a speech in strong support of the medical officers.[69] Heslop was a notable local figure, always ready to speak up for medical autonomy and to criticise abuses of charity. Occasionally his views were so forthright as to offend his colleagues; he was also to play a role in the dispute at the dispensary as a physician there. [70] The dispute at Cannon Street contributed to a discourse of hostility to unpaid (or ill-paid) medical service, which in turn seems likely to have influenced the dispensary staff. Others to argue against gratuitous medical service instances include Dr Percy Leslie, in a BMA paper, and the newly Medico-Political Association formed the same year.[71] Ruth Hodgkinson

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[67] Editorial, *Birmingham Daily Gazette,* 21 October 1867; letter from 'Invenis' *Birmingham Daily Gazette* 21 October 1867; Editorial, *Birmingham Daily Gazette 26* December 1867.

[68] Or at least most of them; six (out of eleven) resigned according to the *Birmingham Journal,* 1 February 1868; eight resignations were reported in the *BMJ,* 22 February 1868.

[69] T. P. Heslop, *On the Present Rate of Remuneration of Medical Officers of Sickness Assurance Societies: A Speech Delvered at the BMA Meeting, June 1867* (London, Birmingham: Cornish, Hardwick, 1867)

[70] Thomas Pretious Heslop (1823-85) was born in Bermuda, of Scottish and Irish parentage, but grew up with a medical uncle in Tipton, Staffs. He studied in Dublin and Edinburgh, where he gained an MD in 1848. He served at different Birmingham institutions, indeed co-founding several hospitals later in life, notably the Children's Hospital in 1861; Jonathan Reinarz, 'Heslop, Thomas Pretious (1823–1885), physician.' *Oxford Dictionary of National Biography*. 23 Sep. 2004; Last accessed 12 Jul. 2021. https://0-www.oxforddnb.com.pugwash.lib.warwick.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-13131

[71] Leslie's Birmingham paper was 'On gratuitous medical services, their evils and their remedies'; see 'Birmingham News', *the Lancet,* 20 February 1868; the Brighton-based Medico-Political Association' was also reported in *the Lancet* 91, 4 January 1868, pp. 24-25.

compares the mood in the Birmingham disputes with that in the 'Battle of the Clubs' that developed from the 1890s. While there are similarities, they are not directly related. She does seem to overstate her case when she describes the dispensary doctors as 'resigning in sympathy' with their colleagues.[72]

The Birmingham General Dispensary: medical work 1850-80 [73]

'The General Dispensary has long ranked high amongst local institutions', according to a local journalist in 1863. His articles in the *Birmingham Daily Gazette*, later published as a pamphlet, constitute a significant and largely critical contemporary source for Birmingham medical charities.[74] Thomas Heslop provides the view of a medical insider in his overview of local medicine (including the dispensary) in a volume on regional industries.[75] The dispensary's internal documents, both meeting minutes and annual reports, provide fine detail for fuller interpretation. All these sources convey the picture of a significant local institution that shouldered many of the medical needs of the growing town.

The dispensary became much busier in this period, with admissions increasing steadily in the 1850s and then rising more sharply (approximately doubling) in each decade following (see Table 22). Although the two local general hospitals both experienced similar changes, the increases at the dispensary were greater. At the General Hospital during the fifties, annual outpatient attendance increased by 80 per cent, while the patchy surviving records suggest a similar rise at Queen's Hospital (which may have levelled off in the 1870s due to new charges imposed on outpatients).

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[72] Ruth Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law 1834-1871* (London: Wellcome Historical Medical Library, 1967), pp. 606-07.

[73] This chapter includes a summary of some events in the 1850s (although covered in Ch.3), as they help to make sense of events in 1868.

[74] Scrutator, *Birmingham's Medical Charities* , quote p.62.

[75] T.P. Heslop, 'The Medical Aspects of Birmingham', in Samuel Timmins (ed),*The Resources, Products, and Industrtial History of Birmingham and the Midland Hardware District,* (London: Frank Cass & Co., 1866), 689-703. This largely celebratory volume covered local industries as well as some medical and social issues.

Table 22: Outpatient Admissions to Birmingham Voluntary Institutions 1850-80

	Birmingham General Dispensary		Birmingham General Hospital	
	'Sick patients'		Outpatients	
Year		%		%
1851	2902	100	11417	100
1852	2962	102	12885	113
1853	3086	106	11806	103
1854	3365	116	10760	94
1855	3381	117	12807	112
1856	3649	126	13192	116
1857	3932	135	13520	118
1858	4313	149	15811	138
1859	3292	113	16314	143
1860	4456	154	20584	180
1861	4613	159	20670	181
1862	5357	185	25902	227
1863	5716	197	29820	261
1864	5364	185	29011	254
1865	5769	199	22541	197
1866	7100	245	19830	174
1867	6841	236	19908	174
1868	7548	260	19937	175
1869	8567	295	20003	175
1870	9711	335	23327	204
1871	10570	364	24379	214
1872	12001	414	24806	217
1873	13380	461		
1874	14652	505		
1875	16396	565		
1876	17848	615		
1877	19286	665		
1878	20365	702		
1879	18954	653		
1880	17759	612		

Sources: General Dispensary Annual Report 1880; John T. Bunce, *A History of the Birmingham General Hospital and the Musical Festivals* (Birmingham, 1873)

Thomas Heslop's comments on the dispensary in his paper on Birmingham medicine helps in understanding its work. He reported that a total of 5769 cases were treated at the Dispensary in 1865, versus 18678 at the General and 12636 at Queen's, while the recently founded Children's Hospital had treated 9184 patients.[76] The implication that the dispensary did much less work than the hospitals is corrected by internal dispensary documents. The dispensary's own records show that in 1858 it had dealt with 4313 'cases' (which Loudon defines as 'episodes of illness'); these resulted in 11,200 separate attendances. In 1859 there were slightly fewer, 3292 cases and 10,728 attendances (one-third of which were probably home visits, as Loudon argued).[77] In contrast, the hospital figures seem to be for total *attendances*. In other words, in the early 1860s the dispensary was dealing with about the same number of patients, many of them seen at home, as the outpatients at either general hospital. Heslop thus, rather oddly, appeared to understate the workload of the Dispensary. The sharp increases in the dispensary's workload, compared with the hospitals are shown in Table 22. Its numbers nearly quadrupled during the 1850s and 1860s, whereas at the General Hospital they merely doubled. In proportion to population, in the early 1850s the dispensary was dealing with 2.27 per cent of Birmingham's inhabitants, rising to 6.7 per cent in the late 1870s. This compares with the aggregate numbers for the Metropolitan dispensaries, which rose to 7.5 per cent in the 1880s. The honorary officers complained that their work for the dispensary was much more laborious than in equivalent roles at local general hospitals, not least through the large number of visits to patients' homes. In their report to the governors in 1868, they reported dealing personally with half of all patients seen in the previous year (3672 out of 7241), besides seeing others at the request of

[76] Heslop, 'Medical Aspects of Birmingham', pp. 700-01.
[77] BAH, MS 1759/1/4/1, Medical Committee Minutes, draft medical reports, 17 February 1859 and 15 February 1860; Loudon, 'Origins and Growth',pp. 328-9; Loudon suggests that each dispensary 'admission' typically resulted in between three and four attendances, with about one-third of these being at home.

resident staff (many of these also requiring visiting at home). As noted above, some London dispensary practitioners had an even more arduous workload, seeing from seventy to one hundred patients daily. Dr Alexander Stewart, a London dispensary physician, suggested the likely effect on professional morale: 'frequent exhaustion of body, depression of spirits, and utter unfitness for intellectual exertion after the day's work'.[78] It seems likely that the effect on morale for the Birmingham dispensary staff was similar, even if none of them unburdened himself in the same public way; such views seem likely to have influenced the medical officers when they confronted the governors in 1868. In contrast, the honorary staff at the Birmingham General Hospital saw rather fewer patients, and all on hospital premises; an estimated 3000 (12 per cent) of the 24,650 outpatients in 1861-2.[79] Interpreting the workload figures above and those in Table 22 together with Loudon's comments, each of the three honorary physicians would see an average of around thirty patients on each of their two duty days weekly, visiting about one-third of them in their homes. [80]

[78] The experiences of Dr D. Hooper at the Surrey Dispensary and Dr J Chapman at the Farringdon Dispensary have already been noted; Alexander Stewart's remarks are in a pamphlet, *Sanitary Economics* (London: J. Nisbet, 1849), pp.17-18; see Chamard, 'Medicine and the Working Class', pp. 82--83, 103,106, 117,144.
[79] BAH, MS 1759/1/4/1) 'Report by Honorary Medical Officers to the Management Committee', January 1868; Scrutator, *Birmingham's Medical Charities,* p.26. The latter was a critical view of the crowded General. Hospital outpatients' department; for the more favourable comments on the dispensary, p.62.
[80] Loudon, 'Origins and Growth', pp. 324, 329.; as noted above.

Figure 26: Birmingham General Dispensary in 1910; its appearance was probably similar in the 1860s (Birmingham History Forum, www.birminghamhistory.co.uk)

To turn to clinical experience at the dispensary, Heslop's work there evidently informed his paper's comments about local epidemiology. He remarked that the salubrity sometimes ascribed to Birmingham was surprising in view of its 'irregular construction, smoke-loaded atmosphere, dingy-looking buildings, and dense population.' Birmingham did indeed have a lower mortality than other great towns, but in Heslop's view, the statistics were misleading as they commonly aggregated the middle-class suburb of Edgbaston with Birmingham and Aston. Cholera epidemics, however, had largely spared the town.[81]

In annual dispensary reports (or in their notes in the minutes) the medical staff comment on epidemics and other varying factors, such as the increased amount of chest disease in 1858 and its probable link with air pollution that year. In 1867 they also noted a larger proportion of bronchitis

[81] Heslop, 'Medical Aspects of Birmingham', pp. 689-90.

and phthisis, due to the 'ungenial atmospheric changes of the year gone by.' During successive decades the dispensary treated larger numbers of patients with bronchitis, but the proportion of total cases changed little (from 8.6 per cent in 1853 to 8.2 per cent in 1874; see Table 23). The proportion of phthisis cases likewise showed little change.[82]

Table 23 Diseases at the Birmingham General Dispensary, 1853-74.

Date	1853		1863		1866		1874	
	N	%	N	%	N	%	*n*	%
Zymotic': Fever unspecified	88	2.9						
Continuing fever			52	1.6	19	0.3	60	0.4
Diarrhoea & dysentery	58	1.9	94	1.6	75	1.1	113	0.8
Other conditions:								
Asthma	56	1.8	24	0.4				
Bronchitis, acute & chronic	268	8.7	454	7.9	623	8.8	1204	8.2
Phthisis (pulmonary tuberculosis)	257	8.3	404	7.1	548	7.7	1682	11.5
Heart disease			85	1.4	112	1.6	400	2.7
Dyspepsia & gastritis	217	7	547	9.6	409	5.8	885	6
Liver disease			157	2.7	381	5.4	34	0.2
Intestinal disorders	60	3.1	51	0.9				
Rheumatism & joint disease	96	3.1	247	4.3	237	3.3	186	1.3
All surgical:	336	10.8	630	11	247	3.5	433	2.9
Total patients	3086	100	5716	100	7100	100	14652	100

Sources: Dispensary Annual Reports for 1853, 1863, 1866, 1874 (after 1874, annual reports give little clinical detail)

Heslop noted how certain occupations predisposed to chest disease, just as his predecessor John Darwall had done thirty years previously (see Ch. 2). These were mainly those engaged in the grinding of metals, horn, or mother of pearl (for the local button trade). Affected workers typically developed progressive

[82] Tuberculosis was recognised (then as now) as being strongly influenced by general social conditions, especially nutrition and overcrowding; other infectious diseases often predisposed to the infection. Anne Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900* (Oxford: Clarendon Press, 1993), pp. 218-21.

chest disease in their 40s and 50s, fatal within a few years.[83] The generic term 'fever' (Table 23) still largely referred to continuing fever, but this was by the 1860s increasingly recognised as covering two distinct conditions, typhus and typhoid. The distinction was only slowly embraced by many practitioners, but Heslop makes pointed comments:

> The true typhus, the Irish fever…the disease of camps, gaols, ships, and overcrowded dwellings, is rarely seen in this town, even among the Irish immigrants. This is a noteworthy circumstance…well known to the physicians in practice in the borough.[84]

Typhus is now understood to be spread by microbes carried by the body louse; hence the association with poverty, poor hygiene, and economic dislocation. The organisms causing typhoid are mainly waterborne but may also be spread by milk and foodstuffs. The persistence of this disease is unsurprising, given that Birmingham's central districts were in the 1860s and 1870s served only incompletely with clean water and piped sewage disposal, while public health controls on food and drink were minimal.[85] The 'intestinal disorders' in the table were mainly worm infestations, especially tapeworm, which was highly prevalent in Birmingham.[86] As regards other conditions in the table, 'rheumatism' and other joint diseases were common everywhere, while the experience of other dispensaries suggested that dyspepsia was more prevalent in urban environments.[87]

Overall cases of infectious disease (other than phthisis) appear to decline in these years, while heart disease becomes more evident (noting that

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[83] Those grinding organic materials worked in button-making, while the metalworkers' disease was widely known euphemistically as 'grinders' asthma'; Heslop, 'Medical Aspects of Birmingham', pp. 696-7. For Darwall's life and significance, see Ch. 2 and Ch. 4; John Darwall, 'Artisans, Diseases Of', in John Forbes, John Conolly, and Alexander Tweedie, (eds), *Cyclopædia of Practical Medicine* (1833), 149-60.
[84] Heslop, 'Medical Aspects of Birmingham', p. 696.
[85] Hardy, *The Epidemic Streets*, pp. 151-3.
[86] There were 44 cases of 'worms' at the Dispensary in 1865 and 29 among outpatients at the General Hospital. Heslop, 'Medical Aspects of Birmingham', pp. 696-7; these can be acquired from infected meat or from water; for the contemprary condition of meat, see Smith, *The People's Health,* pp. 213-5.
[87] See Ch.2 and Ch. 3; in Ch.2, dyspepsia is discussed in relation to Coventry.

these are instances of disease rather than deaths). Such a shift is consistent with the 'mortality transition' of the late nineteenth- and early twentieth centuries, when a pattern of early infectious mortality gave way to a regime where chronic and degenerative diseases were associated with death at later ages.[88]

Dispensary Funding

'Scrutator', the journalist already quoted, considered the General Dispensary in 1863 to be in 'an unrivalled financial position', compared to other Birmingham medical institutions, and indeed to most dispensaries elsewhere. Its annual income consistently exceeded expenditure (in the 1860s by about £200).[89] The dispensary gained most of its income, like other medical charities, from individual subscriptions (Table 24). The table reveals the changing patterns of support in 1860-80 as summarised in annual reports, together with parallel statistics for the two local general hospitals.[90] Numbers of dispensary subscribers increased over time, although they never matched the hospitals' totals. The proportion of female subscribers also tended to rise, with a near-doubling at the Dispensary between 1860 and 1880 (although remaining below the figures for the Children's and the Women's Hospitals). As the annual reports omit details of age and gender, it remains unclear whether such statistics reflect changes in the proportion of women and children treated. Little is known about the composition of the subscriber base otherwise, although a comparison of subscription lists with local directories suggests that many subscribers were modest tradesmen or small business proprietors. The managing committee always included several Unitarians (a group that provided most chairmen 1840 -

[88] Although the dispensary figures were for *morbidity* rather than *mortality***.** Simon Szreter and Ann Hardy, 'Urban fertility and mortality patterns', in Martin J. Daunton (ed), *The Cambridge Urban History of Britain: 1840-1950* (Cambridge: Cambridge University Press, 2000), pp. 629-72.

[89]BUSC R988.B5 Dispensary Annual Reports, various years; Scrutator, *Birmingham's Medical Charities*, p. 62

[90] Reinarz, 'Charitable Bodies', p.43 for his table.

80).[91] Therefore the Birmingham Unitarian congregations may have come to regard the Dispensary as peculiarly 'their' charity.

In managing the finances, the governors carefully avoided debt, Investing both the common surpluses and the unpredictable sums from one-off donations and legacies. The institution lacked the heavy fixed expenses of general hospitals, but even so, its financial position contrasts strikingly with the debts of both Queen's and the General Hospital (in 1863 £5000 and £4000 respectively). [92] In 1863 its investment income was £320 and by 1868 the reserves were said to amount to £15,000.[93] In 1863 'Scrutator' (the journalist quoted above) referred to the 'the poor management of almost all' the local medical charities; he was critical of their lax control of costs and the tendency of some to embark on unfunded expansion plans.[94] However he considered the dispensary a striking exception, as it was well supported by its adherents and prudently managed by its governors. A consistent approach was favoured by the tendency for chairmen to remain in post for several years.

The role of industry in funding medical charities is suggested by the increasing subscriptions from companies. The rise, however, was greater at the two general hospitals, which (especially the Queen's Hospital) played a greater part in the care of injuries.[95] Workmen also supported medical institutions, both through mutual organisations like friendly societies, and through collective subscriptions at workplaces. Such collective fundraising could however arouse objections, for instance from the General Dispensary medical officers in 1863 concerning dispensary recommendation letters from 'clubs', especially when produced by apparently well-paid workmen. The doctors interpreted this as

[91] Five of the six chairmen identified from annual reports between 1840 and 1880 were Unitarians.
[92] Scrutator, *Birmingham's Medical Charities;* pp. 44 & 33.
[93] Editorial, *the Lancet*, 26 September 1868, pp. 420-21.
[94] Scrutator, *Birmingham's Medical Charities*; the quotes are on v and p. 62
[95] Accident cases increased tenfold during the 1860s at the General Hospital, while Queen's was located close to much industry; Reinarz, 'Funding Birmingham's Hospitals', p.44

paying for a recommendation letter, which was prohibited by the dispensary rules.

Table 24: Breakdown of Subscribers at Birmingham General Dispensary and at local general hospitals 1860-1880
BGD =General Dispensary; GHB =General Hospital; QH = Queen's Hospital

	BGD	BGD	BGD	GHB	GHB	QH	QH
Year	1864	1870	1880	1860	1890	1860	1880
	%						
Female	8.7	13.9	15.3	10.2	8.8	7.2	7.3
Clergy	2.1	2.4	4.6				
Corporate	8.4	6.4	9.5	16	15.6	13.8	23.9
Work-people	1.9	3.8	13.2	3.5	4.1	2.5	2.5
Mutual	2.0	1.3	1.8	2.8	2.5	2.0	1.0
Congregations	2.2	2.0	2.4	0.7	0.44	0.09	1.7
Miscellaneous	2.2	1	4.7	1.2	1.6	1.6	1.2
Total (*n*)	872	979	1279	1567	2042	1120	690

Sources: General Dispensary Annual Reports, 1864, 1870, 1880: for hospitals, J. Reinarz, 'Charitable bodies: the funding of Birmingham's Voluntary Hospitals in the Nineteenth Century', in M. Gorsky and S. Sheard (eds.), *Financing medicine: the British experience since 1750,* London, Routledge, 2006

Other figures in contemporary Birmingham had a more optimistic vision of the potential of working- class support for medical charities. In 1869 the influential preacher George Dawson urged that active contributions from

artisans could help develop a cooperative approach to hospital funding.[96] His remarks followed the fund-raising initiative launched by the surgeon Sampson Gamgee in late 1868, who recruited a group of workmen to organise workplace collections. They raised several thousand pounds in just over one year, which enabled the provision of much-needed improvements in outpatient facilities at Queen's Hospital. When Gamgee suggested in 1873 that such collections could become a regular event, to be used to benefit medical charity throughout the town, the Birmingham Hospital Saturday Fund was created. Gamgee worked with Henry Burdett, then the Queen's hospital superintendent, and later a leading national expert on hospital administration.[97] The fund absorbed the local Artisan's Fund that started in 1846, and resembled earlier workplace collection schemes in Derby, Walsall, Liverpool, and Manchester.[98] The provinces seemed to show London the way, the metropolitan Saturday Fund being started in 1873-4.Collections in Birmingham's places of worship, basically among the middle classes and often organised *ad hoc*, formed a long-standing component of medical charity funds. From the 1850s these were formalised as the Hospital Sunday Fund, which raised £100,000 for local institutions between 1859 and 1882.[99] As sums generated were distributed according to numbers of patients treated, the dispensary gained a share of both the Saturday and Sunday schemes. Representatives of the Saturday Fund gained representation on hospital committees, if initially not the main governing boards; a Mr J Ganly joined the dispensary management committee in such a role in February 1884 (although the minutes say little about any contributions to discussion).[100] Thus

[96] Gorsky, Mohan, and Willis, 'Splendid Spirit of Cooperation', pp.167-91; Dawson was a preacher who greatly influenced the political Unitarians; his remarks, noted in a local newspaper, were quoted by Gorsky *et al,* 'Splendid Spirit of Cooperation, p.171, n25 and n26

[97] Sir Henry Charles Burdett, KCB (18 March 1847 – 29 April 1920), as he became, was a financier and philanthropist, with great powers of organisation.

[98] Reinarz, 'Funding Birmingham's Hospitals', p. 48.

[99] Reinarz, 'Funding Birmingham's Hospitals', p. 46.

[100] Steven Cherry, 'Hospital Saturday, Workplace Collections and Issues in Late Nineteenth Century Hospital Funding', *Medical History* 44 (2000), 461-88 ; for the Birmingham General Dispensary, BUSC R988.B5, Dispensary Annual Report for 1883.

workmen's representatives were playing a greater part in fundraising, and the dispensary was one of the institutions where they gained a limited voice.

The Birmingham Dispensary dispute: doctors versus governors

The regime at the Birmingham General Dispensary had been challenged in the 1850s. Early in the decade, a series of personnel changes started when its long-serving chairman, the Reverend Dr Kentish (a Unitarian minister), resigned in March 1852 due to age and infirmity. He was replaced by the Unitarian businessman Howard Luckcock.[101] Three physicians and six surgeons resigned in 1852 and 1853, some moving to posts elsewhere, but it is unclear whether dissatisfaction with overwork or other factors contributed to this high turnover. In May 1854, when they first asked that they should receive honoraria, the dispensary medical officers pointed to the institution's general prosperity and to their increasing workload. They cited the local Queen's Hospital as one of the institutions making such payments to senior staff. After brief consideration, the committee dismissed this request, Luckcock as chairman stating that the current state of the institution's funds precluded such a move.[102]

In January 1868, in an atmosphere of increased medical militancy and with steadily rising workloads, the senior clinical staff again asked for financial recognition of their efforts. By this point the medical officers were treating about 7500 individuals each year on the dispensary premises or in patients' homes (see Tables 22 and 23) The work was divided between three recently qualified practitioners acting as resident surgeons (paid a relatively generous £100-150 per annum), and about six honorary physicians and surgeons.[103] The latter pointed out that their heavy unpaid workload, did not carry the prestige of a voluntary hospital posts or any income from teaching medical students.

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[101] John Kentish (1768-1853), a leading Unitarian divine, was then aged 84; Howard Luckcock (1802-77), was the son of James Luckcock, an upwardly mobile Unitarian jeweller, who settled happily in a small Edgbaston villa in 1810. Howard Luckcock was a public man, a JP, and Commissioner of Taxes. The Luckcocks were one of the case studies in Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class 1780-1850* (London: Routledge, 1992), pp. 18-21.

[102] BAH MS 1759/1/2/3, medical committee minutes, May 1854; the honoraria at Queen's Hospital were short-lived.

[103] BUSC R988.B5, Birmingham General Dispensary Annual Reports 1863, 1866.

They recommended other organisational remedies for the steadily increasing demand, including the addition of a more experienced resident and the discontinuation of midwifery. In support of their financial case, the doctors again quoted metropolitan institutions where honoraria were paid (such as the Surrey and the Bloomsbury Dispensaries).[104]

The medical request seemed to receive more attention than previously, a subcommittee of governors being appointed following the annual meeting in February, and a special general meeting of all subscribers called for 29 April. A committee member, Joseph Nettlefold, launched a formal survey of about forty other dispensaries to clarify policy elsewhere. The completed questionnaires revealed that only a handful paid honoraria, and these were often suspended through financial pressures. The special general meeting in April was attended by sixty-four subscribers (7.6 per cent of the total of 840) and included some prominent citizens. While there was some sympathy with the medical officers, many speakers expressed caution about the risky precedent of a philanthropic institution making such payments. The committee recommendations endorsed the medical officers' suggestion of a new resident physician (a 'middle-grade' post), as well as withdrawing from midwifery provision. They also supported implementing honoraria for senior staff – but for a newly appointed consulting physician and surgeon, not the existing staff members.

The committee's report and recommendations received general support at the meeting. An amendment by the Reverend F Williams (supported by Howard Luckcock) proposed honoraria to the existing physicians of £50 and £20 to the surgeons. Joseph Chamberlain, attending as a subscriber, instead suggested a one-off 'testimonial' to the medical staff. Eventually subscribers approved the committee report (and rejected both the Williams amendment and Chamberlain's suggestion) by 43 to 21 votes.[105] In the face of this response the medical officers implemented their resignations in early May.

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[104] BAH MS 1759/1/4/1) 'Report by Honorary Medical Officers to the Management Committee', January 1868

[105] 'Birmingham General Dispensary – the Medical Staff and the Governors', *Birmingham Journal*, 30 April 1868

A new phase at the Birmingham dispensary: 1868 and after

The April general meeting also initiated another important policy change. Joseph Nettlefold introduced a proposal to establish a branch dispensary in the expanding suburb of Highgate, southeast of the centre. Following strong support for this proposal at the meeting, Howard Luckcock resigned as chairman and was replaced by Nettlefold. Luckcock's objections induced him to leave the committee early the next year; in his resignation letter, he referred to the dispensary's 'disastrous new policy'; it is unclear whether he meant the changes in staffing or the innovation of branch dispensaries, or both. His departure was not accompanied by the usual warm expressions of gratitude, hinting at tensions within the governing body.[106]

The dispensary also altered its policy on midwifery, a decision linked with contemporary changes in the Lying-In Charity, which became a purely domiciliary service in 1868, as outlined above.[107] The dispensary provided vaccination as a further ancillary service, which medical officers were also keen to abandon. The governors initially insisted that this work should continue as part of the dispensary service (also noting that the institution held a supply of vaccine lymph that was a valuable local resource). The decision reflects the attitudes that Peterson noted in London: 'Governors…seem not have blinked at the idea of interfering directly' in medical and surgical matters.[108]
From July 1869, the medical staff achieved their wish when they were relieved of vaccinations in favour of the Poor Law service.[109]

In May 1868 the dispensary advertised the new post of paid consulting physician but initially received no applicants. In June John Anthony (who had resigned in May) applied and was reappointed, being awarded an annual honorarium of 100 guineas. The *Lancet*, criticising the dispensary's ungenerous

[106] BAH, MS 1759/1/2/2 Birmingham General Dispensary, Minutes, May 1869.

[108] Peterson, *the Medical Profession*, p.140.

[109] BAH MS 1759/1/2/2 Dispensary general committee minutes, 28 April 1868; new vaccination policy, MS 1759/1/4/1, medical committee minutes, 8 July 1869; as early as 1858, several Poor Law medical officers (public vaccinators) had written to the dispensary asking to take over the work, for which they were paid a fee; MS 1759/1/4/1, 10 December 1858.

treatment of its staff, was also caustic about Dr Anthony's decision to return there, especially as he evidently did not consult his colleagues.[110] The new arrangements for difficult surgical cases were that the resident staff were expected to refer to the senior surgeon at the General Hospital. In 1869 Albert Baker, who was then senior surgeon, was appointed consulting surgeon (at 2 guineas a case seen, usually about £100 annually).[111] Of the other staff who had resigned, the surgeons continued in general practice, while Thomas Heslop re-joined the staff at Queen's Hospital. Balthasar Foster was appointed to the chair of medicine at Queen's College jointly with James Russell.[112]

In considering each side's motivations in the dispensary dispute, the doctors were influenced by the spirit of professional assertiveness, perhaps somewhat short of militancy, that had shown itself recently in Birmingham. Their attitude would inevitably be modified by customary deference to wealthy governors, as suggested by Peterson and Trainor. Pickstone suggested that Manchester manufacturers in an earlier period may have seen doctors as comparable to factory managers or engineers --men with skills but essentially employees or tradesmen.[113] The governors did not act in a magnanimous manner, and one needs to note the robust, and at times ruthless, stratagems

[110] Editorial, the *Lancet,* 26 September 1868, pp. 420-21*;* John Anthony (1813-95) qualified MB at Cambridge in 1850 (later MD, MRCS, FRCP); Munk's Roll claimed that he was more interested in various branches of natural history than in medicine (*Lives of the Fellows (Munk's Roll: Inspiring Physicians*), Vol IV, p. 237, https://history.rcplondon.ac.uk/inspiring-physicians/john-anthony, last accessed 29 October 2021.

[111] Both Anthony and Baker served in these roles until their retirement in 1882.

[112] These nearly contemporaneous appointments may cast a different light on the apparently brave move of the medical officers. Wilkinson, *the Birmingham Medical School*, p. 41; Foster (1840-1913, later 1st Baron Ilkeston) developed a growing interest in public health and social medicine in the 1870s. In 1885 he was elected a Liberal MP for Chester and from 1887 sat for Ilkeston, Derbyshire. As Parliamentary Secretary for the Local Government Board in 1892-5 he organised sanitary measures that helped to protect Britain from cholera.

[113] 'Medical men's professional lives were subject to the authority of the governors.' Peterson, *the Medical Profession,* p.140; also p.195; in the Black Country, 'Professionals generally deferred to top manufacturers'; Trainor, *Black Country Elites*, pp. 44, 84.

used by Nettlefold and Chamberlain to achieve and consolidate their dominance of local markets.[114]

At other Birmingham institutions (both voluntary and statutory) medical roles and policies also changed during 1860 -1880, influenced by changing workload and by wider policies. In 1875, following years of debate, the Queen's Hospital introduced the 'free system' for admissions. This obviated the need for a subscriber's letter, therefore enabling hospital doctors to better prioritise cases (and increasing their influence, in relation to lay governors).[115] Within the Poor Law system, the eighteenth-century Town Infirmary was replaced in 1851 by the new workhouse and its infirmary on Birmingham Heath. In the older institution about three hundred in-patients were attended by a house surgeon and four visiting surgeons (in rotation), who were replaced in the new arrangements by a single medical officer, who alone was responsible for 599 beds. Six medical officers were now responsible for the 'outdoor' paupers. So in the workhouse here the medical presence had diminished.[116] On the other hand, the Birmingham guardians in 1871 followed London and other large towns in opening a Poor Law dispensary for outdoor paupers, which was doubtless a convenience for both paupers who were relatively mildly sick and the medical officers.[117] From c.1870, epidemics, especially of smallpox, prompted Poor Law guardians to open fever hospitals in large Warwickshire towns.[118] Their patients with infectious disease came to include non-paupers. At Poor Law infirmaries in the next few decades, nursing care improved, as they

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[114] Marsh, *Joseph Chamberlain*, pp. 45-48

[115] The 'free system' was contrasted with the 'privileged system'; ironically, outpatients at Queen's were now required to pay a registration fee of one shilling, intended to deter trivial complaints; 'The Free System of Admissions, Queen's Hospital, Birmingham', the *Lancet* (1875), 2, 925

[116] The infirmary was later known as Dudley Road Hospital and is now City Hospital. Alistair Rich, 'Sick, Aged and Infirm; Adults in the New Birmingham Workhouse, 1852-1912' (Unpublished MPhil Dissertation, Birmingham, 2009), pp. 13-14; Heslop was scathing about the new medical staffing arrangements at the workhouse; see Heslop, 'Medical Aspects of Birmingham', pp. 701-2.

[117] Although their salary was reduced by £25 p.a., as reported in 'Birmingham', the *Lancet* ii 1871 (14 October 1871), p.562.

[118] Alistair Ritch, 'New Poor Law Medical Care in the Local Health Economy', *Local Population Studies*, 99.1(2017), 42-55; Birmingham smallpox facilities, pp. 52-54.

evolved into municipal hospitals, increasingly considered comparable to their voluntary counterparts.[119]

The Birmingham General Dispensary responded to urban expansion and increasing numbers of patients with new branch openings and minor organisational changes. Early in 1870 the medical officers discussed a form of triage for patients attending each morning, with the resident physician playing a major part. The dispensary frontage was essentially unchanged from 1808 (see fig. 1) but several phases of rebuilding had extended the accommodation to the rear, with a large, subdivided waiting room.[120] In 1878 the staff discussed operative surgery, which they agreed, could continue to be performed in patients' homes 'as most cases were minor' (rather than all being directed towards hospitals, as was becoming more common).[121]

During his chairmanship (1868-1881) Joseph Nettlefold promoted the opening of branch establishments, as initiated at the general meeting in April 1868. Each of these had a small subcommittee, a dispenser, and a resident surgeon, while the new residential or stipendiary physician visited each on different days. The first one opened in Highgate (Camp Hill) in February 1871, another in Aston in 1874, and then in Ladywood in October 1883 (approximate locations are shown in the map in figure 2). At the annual meeting in February 1883 the committee noted with regret Mr Nettlefold's recent death, also noting his generosity to the branch dispensary building funds.[122]

Especially in later years, as additional branch establishments opened, the dispensary provided a more decentralised service. Such provision facilitated access to care for patients, but this would come at the cost of some isolation for

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[119] Stuart Wildman, *'He's Only a Poor Pauper Whom Nobody Owns': Caring for the Sick in the Warwickshire Poor Law Unions, 1834-1914* (Stratford-on-Avon: The Dugdale Society/Shakespeare Birthplace Trust, 2016), pp.40-41; there was a similar transition in London and other large towns; see Abel-Smith, *The Hospitals,* 'The Transition from Pauper Hospitals to Public Hospitals', pp. 119--132.

[120] In 1870 Alexander Bottle (MD Edin, MRCS Eng.) started his long service as resident physician.

[121] BAH MS 1759/1/4/1 Medical minutes 22 February 1870 (triage); medical minutes 24 September 1878 (surgery).

[122] BUSC R988.B5, Dispensary Annual Reports for 1871, 1874, 1883

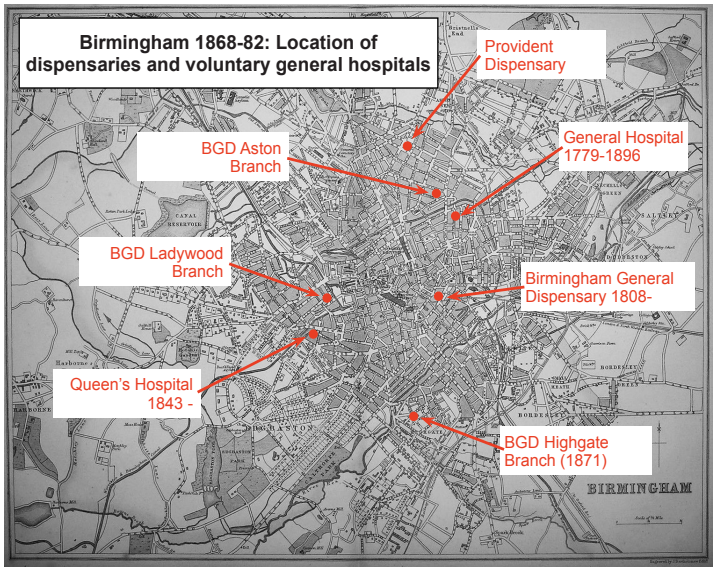

Figure *27*: Locations of hospitals, of General Dispensary and its branches, and of Provident Dispensary (adapted from 'Birmingham' in *Imperial Gazetteer of England & Wales*, 1870 (Wikimedia Commons) **(adapted by D. Steele)**

the inexperienced medical officers (who would have reduced opportunities for senior supervision and informal education).

The policies of the General Dispensary in this period show clear responses to urban expansion. It evolved from a unitary institution into a city-wide service (more like a 'brand' in modern terminology). In its development of scattered branch dispensaries, it resembled some contemporary institutions in other industrial towns (Leicester, Manchester, and of course London).

Varied dispensaries in late nineteenth-century Birmingham

During the later nineteenth century, the General Dispensary worked alongside new foundations, based either on specific ideologies (homoeopathy or evangelical Christianity) or distinct funding (the Provident Dispensary and the friendly society institutions). Each of these institutions treated several thousand patients annually, and all continued well into the twentieth century. Their role is summarised here but covered in more detail in an appendix.

The Birmingham Homoeopathic Dispensary was founded in 1847, in 1859 expanding into a hospital, with an initial 18 beds.[123] As at other institutions, patient numbers increased, with 142 inpatients and 14,971 outpatient visits in 1873.[124] The institution appears to have found a role treating chronic diseases unresponsive to other treatments.

The Birmingham Medical Mission started in 1875 in the industrial locality of Deritend. While this functioned like a charitable dispensary, its timetable included regular group prayers and bible classes. [125] It treated large numbers of very poor individuals, with over 14,000 people attending in its second year.[126] The activities of the institution and its temperance campaigns were supported by Nonconformist congregations and by prominent families.[127]

The Provident Dispensary was founded in 1878 using a legacy from William Sands Cox, with rules closely following those recommended by the Charity Organisation Society medical committee.[128] The ordinary members elected the committee (there were no honorary members), which in turn appointed medical officers. The dispensary worked from a new building in Farm Street, Hockley, which by January 1880 had 3000 members. After unsatisfactory experiences with part-time medical officers the committee replaced them with one full-timer, who in early years was expected to be resident.[129]

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[123] By the 1870s, homeopathic hospitals existed in five other towns (London, Bath, Doncaster, Hastings, Manchester, and Southport); there were also 37 charitable and 75 fee-charging dispensaries. See Peter Nicholls, 'The Social Construction and Organisation of Medical Marginality', in Robert Jütte, Motzi Eklof and Marie C. Nelson (eds.), *Historical Aspects of Unconventional Medicine: Approaches, Concepts, Case Studies* (Sheffield: EAHMH Network, 2001), 163-82, pp.178-9. Warwickshire CRO, CR1646/1, Birmingham Homoeopathic Hospital and Dispensary, Minute Book, p.39. Evelyn John Shirley (1788-1856), of Ettington Park near Stratford, had been a Conservative MP, and bequeathed £500 for 'a homoeopathic hospital in Birmingham or elsewhere').

[124] WCRO CR1646/1, 1874 Minutes, Annual Report for 1873; 1884 Minutes, Annual Report for 1883; in 1883, 4731 outpatients attended a total of 23969 times.

[125] Kathleen Heasman, 'The Medical Mission and the Care of the Sick Poor in Nineteenth-Century England', *The Historical Journal* (1964*, 7*(2), 230-245.

[126] BAH, MS 4038, Papers relating to Birmingham Medical Mission.

[127] These were, respectively, manufacturers of weighing scales and of chocolate, and bankers; the Averys were Congregationalists, while the others were Quakers.

[128] Hans F. Reichenfeld, The Birmingham Provident Dispensary: Hockley Branch 1877-1948', *The Birmingham Historian* (2002), 16-28, pp. 18-19.

[129] Reichenfeld, 'Birmingham Provident Dispensary', pp. 20-23.

A survey in 1879 on behalf of the COS was conducted in Birmingham and several other towns, focusing on provident dispensaries and similar institutions established by friendly societies.[130] Its author, a Mr W. Allam, described two dispensary-like institutions formed by combined friendly societies. The older of these was the 'Birmingham General Provident and Benevolent Institution' in the central Ann Street since 1833; in 1879 there were 5000 members and twenty-two doctors. 'The Amalgamated Friendly Societies Provident Medical Institution' was founded in 1876 by 51 societies, with 4510 members and a single resident medical officer. Allam was also told about many 'private clubs' founded by local general practitioners. Birmingham appeared in earlier periods to offer unpromising soil for provident dispensaries, but the success of the Hockley institution, combined with the friendly society associations, showed what was feasible. In addition, the small-scale doctors' private clubs may have covered many local inhabitants, but these were unpublicised and therefore their scale and coverage are unclear.

[130] Mr Allam visited Birmingham, Coventry, Derby, Leicester, Scarborough, and York. W. Allam, *Provident Dispensaries and Friendly Societies' Medical Institutions*: extracts from the report of Mr. Allam ... respecting inquiries made in Birmingham, Coventry, etc ... on behalf of the Medical Committee of the Charity Organisation Society (London, COS Medical Committee, 1879); comments on Birmingham, pp.4-8; remarks about medical officers, p.18.

Coventry: crisis and recovery 1860-80

Moving from Birmingham to Coventry, this section of the Chapter will outline the social and economic context before exploring the local role of the Provident Dispensary and, its own development; then addressing its place in growing debates on the provident principle. In the 1860s and 1870s, Birmingham underwent political change superimposed on broadly increasing prosperity, while Coventry suffered a severe crisis followed by a slow and fragile recovery. Earlier in this thesis (esp. Ch.1 and Ch.2), there were accounts of the ribbon-weavers' lengthy strike in 1858-59. In 1860, following a free trade agreement, foreign competition had devastating effects.[131] The mass unemployment among weavers prompted a national charitable appeal and organised overseas emigration.[132] Later consequences included bankruptcies among many manufacturers and a local population decline.[133] Watchmaking also suffered from French and Swiss factory-made imports, albeit at later dates, especially in the early twentieth century. During the later 1860s new industrial ventures aiding recovery included cotton and worsted mills, sewing machine manufacture, and from 1868 the production of bicycles.[134]

Coventry's medical provision was on a smaller scale than Birmingham's. The Provident Dispensary was a prominent institution but was restricted to members paying regular contributions (either directly or through friendly societies, the latter comprising about three-quarters of its total membership). In 1859-60 it had about 5000 members (12.5 per cent of the population of 40,000), 3500 of whom were treated that year. In Coventry in the 1860s and

[131] Searby, *Coventry in Crisisis;* For the strike and its resolution, see pp. 3-5; the accord was the Cobden-Chevalier Treaty; the French ribbons were both more fashionable and cheaper. Searby, *Coventry in crisis,* pp. 5-7.
[132] Searby, *Coventry in crisis,* pp. 7-10, 11-12. Lord Leigh of Stoneleigh (Lord Lieutenant of Warwickshire) launched the national appeal.
[133] John M. Prest, *The Industrial Revolution in Coventry* (Oxford: Oxford University Press, 1960), pp. 127, 129-30; between the censuses of 1861 and 1871 the city's inhabitants declined by 1,555, and the surrounding North Warwickshire districts by 4818; more than half the eighty masters in 1858 were no longer trading in 1865; Searby, *Coventry in crisis,* p. 13.
[134] Stephens, 'The City of Coventry: Crafts and Industries: Modern Industry and Trade', *VCH Warwickshire,* 8, pp. 162-89.

1870s, the *Medical Directory* listed 2-3 physicians and 14-18 other doctors (surgeons and general practitioners). In the 1860s the Coventry and Warwickshire Hospital, the only general hospital, treated about 1600 outpatients annually with recommendations from subscribers and a similar number of 'casualties' without them. As in other towns, the hospital experienced a rising number of outpatients seen (1363 attended in 1840 and 2909 in 1860; see Table 1 and discussion of outpatient numbers early in the Chapter).[135] Paupers received treatment at home or at the workhouse, 98 being admitted for illness or injury in 1860.[136]

The Coventry Provident Dispensary and its Influence, c.1860 –c.1880 [137]

From the 1860s provident dispensaries began to attract renewed attention among philanthropists and medical practitioners, given their apparent potential for affordable medical care for working people without the risk of undue dependence. The Coventry Provident Dispensary was often cited as an instructive instance, with its large membership and thirty-year history. Chamard has described how several metropolitan provident institutions were influenced by Coventry.[138] Despite greater interest in the principles of provident dispensaries, relatively few new foundations across England were initially of this type, fourteen being established during 1860-75 as against thirty-nine dispensaries of other varieties.[139] In Warwickshire in 1869, the new Leamington Provident Dispensary was closely modelled on Coventry, two of the medical

[135] Anonymous, *The Coventry and Warwickshire Hospital, 1838-1948* (Coventry, Coventry and Warwickshire Hospital Saturday Fund: 1938), unpaginated.
[136] Rosemary Hall, 'Distressed Weavers, Deserted Wives and Fever Cases: an Analysis of Admissions to the Coventry Workhouse', *Warwickshire History,* 13 (2007/8), 226-39, p.230.
[137] The dispute that involved the dispensary from the 1890s onwards will be considered briefly below.
[138] Chamard, 'Medicine and the Working Class'; the Western Dispensary (later Marylebone Provident) was directly influenced on its founding in 1843, p.79; others were Hampstead (1845) and Haverstock Hill (1864), p.204.
[139] During 1860-9, 41 dispensaries were founded in England, 9 provident, 20 general (or unspecified) and 12 hybrid institutions (including those noted as dispensary/infirmary, dispensary & cottage hospital, medical mission etc). During 1870-5 13 were founded of all types, 5 provident, 6 general and 2 'hybrids'; Whitfield, *The Dispensaries,* pp. 124-37.

officers from the latter attending the inaugural meeting.[140] In other places, charitable dispensaries became wholly or mainly provident institutions, such as Leicester in 1862, Reading in 1870, and Warwick in 1873.[141] In Manchester a number of provident dispensaries were founded, becoming part of an umbrella organisation (the Provident Dispensaries Association). Medical men contributed to the debate by reporting on their own institutions, usually with more general remarks and recommendations; examples included J. F. Anderson in North London and the veteran surgeon, J.T. Jones, in Derby.[142] After 1870 the Charity Organisation Society played a leading role in promoting this type of dispensary, holding conferences in 1870 and 1871, as well as establishing a medical committee which promulgated model rules.[143]

To turn to the routine functioning of the Coventry dispensary, the rhetoric of the annual meeting in May 1860 hardly reflected current economic ravages, instead referring to sound institutional finances and steady improvement. The mayor, Henry Soden, referred to the 'increasing prosperity and usefulness' of the institution.[144] Fifteen individuals attending the meeting were mentioned by name in the newspaper report. These included clergymen, both Anglican and Dissenting, silk manufacturers, merchants, and others. Such members of the urban elite formed the 'honorary members', each contributing a small annual sum and with a role broadly equivalent to the governors of a purely charitable institution. Some of them had strong and long-lasting connections with the dispensary. For instance, Abijah Pears and Charles Bray,

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[140] John Wilmot, ''Advice and Medicine for the Working Classes'; The Leamington and Warwick Provident Dispensaries,1869-1913', *Warwickshire History* 16 (2014), 26-42, p.32

[141] Timothy Holmes **'**Remarks on Provident Dispensaries'**,** *BMJ***,** 1(898) (16 March 1878), 355-357

[142] John T Jones, *Self-Supporting Dispensaries, their Adaptation to the Relief of the Poor Working Classes…(*London, Churchill: 1862); John F Anderson*,* 'Provident Dispensaries: their Object and Practical Working.' *BMJ,* 1(490) (1870): 516-8*.*

[143] COS Medical Committee, *First Report, with Rules for Provident Dispensaries,* (London: HK Lewis (for Charity Organisation Society), 1872 (orig. publn. 1871)

[144] 'Coventry Provident Dispensary: Annual Meeting', *Coventry Herald*, 5 May 1860: Henry Soden (1806-88) was a silk manufacturer and later a banker, a Liberal councillor, JP, and philanthropist; Obituary, *Coventry Herald*, 17 August 1888.

both with many years of experience as silk manufacturers, had been members of the founding committee in 1831. Luke Dresser (an actuary from a silk manufacturing family) was the longstanding honorary secretary. In common with his counterparts at other provident dispensaries, he performed most of the administrative work. Up to the end of the century, ribbon- and watch manufacturers (current and former) largely continued as Coventry's urban leaders, while the owners of the new light engineering businesses were barely involved in civic or philanthropic activities until after 1900.[145]

Table 25: Membership Numbers, Coventry Provident Dispensary, 1857-93

Year	Honorary Members	Free Members	City Pop. (last census)	Source
1858		4500	36208	Bracebridge, *JRStatSoc*
1866	57	5000	40936	Lord Leigh, 1866 AGM
1871	40	5000	39474	Nankivell, *BMJ*
1873	37	9500	"	Mr Hill, 1873 AGM
1882		15,000	44313	Bray, *Autobiography*
1893		25,000	53016	AGM Report, *Midland Daily Telegraph*, 27 April 1893

Following the 1860 general meeting, as noted above, the subsequent annual meeting, reporting on the year ending in March 1861, did note the economic downturn and some of its consequences.[146] The receipts from free members (the users of the dispensary) had fallen from £899 to £710, suggesting some lapsing or arrears of contributions. Despite this, 482 new members had

[145] Kenneth Richardson and Elizabeth Harris, *Twentieth Century Coventry* (Coventry: Macmillan for Coventry City Council, 1972), pp.18-23; Brad Beaven, John Griffiths, 'Urban Elites, Socialists and Notions of Citizenship in an Industrial Boom Town: Coventry c. 1870-1914', *Labour History Review*, 69.1 (2004), 3-18, pp. 8-9.
[146] 'Coventry Provident Dispensary', *Coventry Herald*, 11 May 1861

joined. Numbers of members, when available, are summarised in Table 25. The totals were presumably rounded, usually upwards. One must be sceptical of a rise from 5000 to 9500 members between 1871 to 1873: one figure at least is probably erroneous.[147] The table indicates the growth in the institution's membership, especially from the later 1870s, when numbers reached about one-third of the city's inhabitants.[148]

Coventry Provident Dispensary: medical work

Over this twenty-year period the trends in disease incidence broadly resembled those in contemporary Birmingham. These are shown in Table 26, where statistics for selected years have been extracted from the printed annual reports, when available, or otherwise from summaries in local newspapers.[149] Some differences between the two places arose from varying administrative arrangements. As treatment at Birmingham required a prior recommendation from a governor, people would be deterred from seeking help for trivial complaints. At Coventry, dispensary members would only suffer the loss of their own time, suggesting a lower threshold for seeking attention.

In 1861 the medical officers remarked of the year just ended that there 'had not been as much illness' as might be expected.[150] Most types of disease were less common in 1860-61 than in the previous year (notably of continuing fever, with its recognised connection with economic dislocation).

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[147] Oddly, the annual meetings rarely mentioned the current membership total and never with precision; see also Bracebridge, 'Notes on self-supporting dispensaries', pp. 462-63; Charles B Nankivell, 'The Provision of Medical Attendance on the Independent Poor by Provident Dispensaries', *BMJ* 2 (1871), 318-20 ; Charles Bray, *Phases of Opinion and Experience During a Long Life: An Autobiography* (London: Longmans Green, 1884).

[148] W. B. Stephens, 'The City of Coventry: Local Government and Public Services: Public Services', in *A History of the County of Warwick: The City of Coventry and Borough of Warwick,* (London: OUP, 1969), 275-98, pp. 287-8

[149] Some annual reports survive as bound copies (1872, 1873, 1875, 1876, 1880, 1884, 1885, and 1889). Coventry History Centre, JN362.12 Annual Reports of Coventry Provident Dispensary 1872-89.

[150] In the previous year (1859-60) weavers and their families had been suffering from the effects of the lengthy strike.

Table 26: Coventry Provident Dispensary -- Disease Statistics and Outcome 1860-80

Year	1859-60		1860-1		1865-6		1871-2		1875-6		1879-80	
Total cases	3523		2903		3321		4020		5335		6153	
'Cured'	3073		2534		2808		3318		3600		3618	
Cure rate %	87		87.2		84.5		82.5		68.9		58.8	
Died	68		69		42		87		140		190	
Death rate %	1.9		2.3		1.3		2.6		2.6		3.1	
		%		%		%		%		%		%
Continued Fever	115	3.3	92	3.1	80	2.4	101	2.5	35	0.6	44	0.7
Epidemic /eruptive fevers	142	4.0	86	3.0	80	2.4.	360	9.0	239	4.3	141	2.2
Lung disease	354	10.0	376	12.9	577	17.3	589	14.6	799	15	1249	20.3
Heart Disease	44	1.2	32	1.1	39	10.6	108	2.6	155	2.9	270	4.1
Digestive disorders	607	17.2	595	20.4	577	17.3	631	15.6	128	2.4	1132	18.3
Diarrhoea	252	7.2	234	8.0	224	6.7	203	5.0	311	5.0	235	3.8
Percentage rates refer to the total cases seen in a year.												
Source: summary or full annual reports	*Coventry Herald*, 5 May 1860		*Coventry Herald*, 11 May 1861		*Coventry Herald*, 18 May 1866		Annual Report, 22 May 1872		Annual Report, 18 May 1876		Annual Report, 15 May 1880	

Continuing fever, in earlier decades of the century, was commoner at Coventry than Birmingham, perhaps due to greater poverty and overcrowding in the early 1860s. This then declined over two decades to less than I per cent of the total. Both dispensaries treated several hundred cases of chest disease each year, the Coventry figures rising to one-fifth of total cases by 1880. These included bronchitis, pneumonia, and tuberculosis, which when combined did

not differ greatly between the two places; both would seem probably largely related to domestic and industrial coal smoke.

The more complex multifactorial causation of tuberculosis includes poor diet and overcrowded living and working conditions (as was already understood in the late nineteenth century).[151] In both cities, heart disease tended to become more common during the period, in line with earlier remarks about the 'mortality transition'.[152] Dyspepsia and similar gastric disorders continued to be common at Coventry, amounting most years to between one-fifth and one-sixth of the total. These are good examples of complaints that while troublesome, would not render the individual incapable of all work. In the 1830s the dispensary medical officer Charles Nankivell had linked this to various unhealthy features of the domestic weaver's life; long hours at the loom, rushed meals, and anxiety arising from economic uncertainty.[153] Fluctuations in 'eruptive fevers' in the table reflected outbreaks of contagious disease, the peak of 360 in 1871-2 being largely due to smallpox. This epidemic stimulated the corporation to build a fever hospital at Whitley, initially a small iron construction in 1871 followed by a more permanent building in 1873-4.[154]

In addition to the care of illness, the dispensary offered midwifery, medical officers attending 53 confinements in 1872 and 197 in 1880. From *c.*1884 midwives were employed; that year they attended 155 of the 225 total confinements and the doctors 70. As regards public health and prevention, officially vaccination was available at a small charge. Actual practice differed; annual reports omit any mention of vaccinations after 1860, so presumably they

[151] Tuberculosis; Hardy, *Epidemic Streets*, pp-216-21; air pollution, Wohl, *Endangered Lives*, pp. 205-32

[152] See above; Szreter and Hardy, 'Urban fertility and mortality patterns', pp. 629-72.

[153] See Ch. 3; Evidence by C. B. Nankivell, quoted by Fletcher, Assistant Commissioners' Reports (Handloom Weavers Commission), pp. 300-1; C. B. Nankivell, *The Influence of the Mind on Health: A Lecture Delivered to the Members of the Coventry Mechanics Institution* (London: Effingham Wilson, 1838), pp. 9-10.

[154] Of 360 cases of infectious disease in 1871-2, 'nearly 200' had smallpox. Dispensary Annual Report 1871-2, pp. 3-4; Stephens, *VCH Warwickshire* 8, pp. 287-8

were not taking place.[155] Honorary members stated that doctors regularly offered members advice on domestic hygiene and sanitary issues.[156] Such an advisory role was formalised in June 1874, when Dr Mark Fenton, a dispensary medical officer, was named Medical Officer of Health for Coventry.

Changing dispensary governance

By the 1860s the dispensary was losing honorary members from death and otherwise. The 1868 annual report stated that 'no effort was being made to replace them, as it was the great wish of the committee to make the institution as self-supporting as possible.'[157] The committee continued to invite a prominent individual (such as the mayor or a local MP) to preside at the annual meeting.[158] By 1871, the free members' annual contributions amounted to £800, while the honorary members together subscribed about £40.[159] For reasons that included their disproportionate financial contributions, the free members pressed for a fuller share in institutional governance. They seemed to have fairness on their side, and the 1871 annual meeting decided on equal representation on the committee of the two classes of members. [160]

The proposed innovation seemed to stimulate little comment, other than the misgivings expressed by Charles Nankivell, one of the founding dispensary surgeons and by now a physician in Torquay. He expressed the hope

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[155] Vaccination was mentioned in the set of rules issued to each member; but by the 1860s this was available gratis from Poor Law doctors (although Coventry was also said to be one of the towns whose inhabitants largely rejected vaccination). Stephens, *VCH Warwickshire* 8, pp. 288-9.

[156] e.g. Alderman John Gulson at the 1873 annual meeting; Gulson (1813-1904) was a ribbon manufacturer and later a banker; he was a prominent philanthropist and was twice mayor. JN362.12 Dispensary Annual Report 1873, pp. 10-11; Gulson argued for improved urban amenities, and thus was one of the few civic leaders to resemble the Chamberlainite Liberals in Birmingham; see Beaven and Griffiths, 'Urban Elites, Socialists and Citizenship', pp. 8-9; some of the ideas are developed in Brad Beaven, *Leisure, Citizenship and Working-Class Men in Britain, 1850-1945* (Manchester: Manchester University Press, 2005), esp. pp. 17-43.

[157] Most of the honorary members had played a role at the dispensary since the 1830s.

[158] Coventry Provident Dispensary: Annual Meeting', *Coventry Herald*, 22 May 1868.

[159] A penny weekly contribution would cover an adult or two children, while members of affiliated friendly societies gained the benefits at a slightly reduced charge.

[160] The committee had added two elected free members' representatives in 1866; from 1871 both the free and the honorary members elected ten committee members each.

that the dispensary would not suffer 'from this dangerous experiment', seeing the potential to 'lapse into the form … of sick clubs, with antagonism between practitioners and patients.'[161] However such proposals had qualified support, perhaps surprisingly, from the Charity Organisation Society. The COS Medical Committee suggested a proportion of elected free members' representatives in its model rules for provident dispensaries. The same body recommended exclusion policies for those earning over a certain amount (e.g., a family income of 30 shillings weekly in London). Elsewhere such limits were applied, but at Coventry evidently only informally, and later not at all.[162] Such restrictions were consistent with the COS philosophy and were also favoured by much medical opinion. General practitioners, after all, gained the bulk of their own earnings from private fees paid by those with middling incomes.[163]

During this period the dispensary readily recruited new medical officers, in 1871 choosing Richard Plowman from 25 applicants (five of them resident in Coventry).[164] As the number of members increased, so did the medical staff, with four doctors in 1884 and six in 1891. In 1873 the three doctors each received £269 in salary and during the 1880s between £250-300.[165] Ann Digby suggests that a typical contemporary income for established general practitioners would be £600-800 per annum (while of course there were numbers who earned much less). Part-time appointments, important in consolidating practices and making up total earnings, were held by between one in four and one in five practitioners.[166] However in Coventry they needed to

[161] Nankivell, 'Medical Attendance by Provident Dispensaries', p.320; this was a paper given at an annual BMA meeting in August 1871. Dr Nankivell had been a surgeon at the dispensary 1831-45; after studying at Pisa he had become a physician in Torquay. His name still appeared on dispensary reports as 'Honorary Consulting Physician'.
[162] COS Medical Committee, *First Report, with Rules for Provident Dispensaries* (London; H.K. Lewis, for COS, 1871, 2nd ed 1872), see p. 4 for election of free members' representatives; Appendix A for income levels.
[163] Robert Reid Rentoul, 'Provident Dispensaries and the Lower Middle Classes', *BMJ* (1887), 137
[164] 'Coventry Provident Dispensary (election of Surgeon)', *Coventry Standard* 22 September 1871
[165] CHC JN362.12 Dispensary Annual Reports 1872-89
[166] Digby, *Making a Medical Living*, p.123; incomes, pp.142-3; Digby, *Evolution of General Practice*, p.103

work hard for these sums, as will be explained. As total membership increased, so did the number that each medical officer was required to attend. This figure increased from 1500 per doctor in the 1850s to over 4000 by the late 1870s.The figures in Table 26 equate to six *new* cases daily for each doctor in 1861 and thirteen in 1880. Using the calculation that each patient was seen three to four times, the daily totals would be 18-24 in 1861, rising to 39-52 in 1880, about one-third of these being home visits.[167] The later numbers, large by any standard, exceeded the recommendations of the COS and others.[168] Unsurprisingly, grumbles were soon heard about the numbers in waiting rooms and consequent delays in receiving attention. In 1874 a local newspaper questioned Dr Fenton's pluralism; how could he give due attention to Coventry's public health, to dispensary members, and to his private patients? A letter in 1881 criticised waiting times and urged an increase in the number of medical officers.[169] For similar reasons the Manchester Unity Friendly Society appointed its own medical officer for its Coventry members (rather than following the general pattern of using the Provident Dispensary).[170] The high workloads may have influenced the outcome of the illnesses treated; the proportion of cases 'cured' (Table 26) fell from 87 to 58.8 per cent, while the death rate rose from 1.9 per cent to 3.1 per cent. It would be unwise to read too much into such figures, but they are certainly suggestive of a decline in medical standards.

The 'free members' representatives' are an interesting group. At least for the years examined, they appear to be mostly artisans and small or middling tradesmen, just the groups arousing most objections from the medical opponents of provident dispensaries (on the basis that they could afford private

[167] See Table 26; also Loudon, 'Origins and Growth, pp. 324, 329.
[168] See Table 25 for total numbers; Nankivell suggested a limit of 1000 per medical officer and the COS Medical Committee 1500; Nankivell, 'Medical Attendance by Provident Dispensaries', p.320; COS, *Rules for Provident Dispensaries*, p.23.
[169] Editorial, 'It don't look good', *Coventry Standard* 10 July 1874; Letter from 'L', *Coventry Herald*, 2 September 1881; an additional medical officer was soon appointed.
[170] The relevant remarks appeared in a report, 'Friendly and Benefit Societies in Coventry', *Coventry Herald*, 10 July 1874.

fees). W. G Fretton (1829-1910), however, was a schoolmaster, a local antiquarian, an active Oddfellow and an officer in many societies.[171] Their occupations thus include craftsmen in traditional trades, while some are minor members of the 'shopocracy' that was a persistent and important voice on Coventry's council. Their active role seems an example of the 'social citizenship' that philanthropists and social commentators of the era were keen to encourage.[172] The grouping was certainly assertive in dispensary management, and robust membership opinions had some important later consequences. At the 1873 annual meeting, the members' representative Mr T.G. Read commended the benefits that free members gained from the dispensary, not least the 'facilities to meet with medical men'. At the 1876 meeting, Mr Shortley offered the medical officers 'a little hint', based on remarks heard from members 'taken ill during the night'. Such individuals (he claimed) had sent word to the dispensary early the next day but might not receive a visit from the doctor until six or seven in the evening. The response of Dr McVeagh, the senior surgeon, was that patients were widely spread, also that messages were frequently conveyed by young children who gave misleading impressions of seriousness or urgency.[173]

In 1892-3 the Coventry Provident Dispensary again became embroiled in a disagreement with the wider medical profession that recalled the quarrels around its foundation in 1831.[174] While the later events lie outside the periodisation selected for this thesis, it seems appropriate to consider the medical grievances briefly, believing that these may well give clues to medical dissatisfaction at different dates.

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[171] Weller, 'Friendly Societies in Coventry', pp.144-5; Obituary: Mr W. G. Fretton, *Coventry Herald*, 20 July 1900.
[172] Beaven & Griffiths, 'Urban Elites, Socialists and Citizenship', pp. 8-9.
[173] Reed was a watch finisher; other new committee members included a Mr Bright, an ironmonger, and two licensees; W. G. Fretton, as noted above, was a schoolmaster. Shortley, mentioned at the 1876 meeting, was a bookbinder and copperplate printer. See Dispensary Annual Report, 1873, p. 12; Dispensary Annual Report, 1876, pp. 10-11. Details of occupations were found in directories, viz. *Morris's Warwickshire Directory* 1866 and *White's Warwickshire* 1874.
[174] The opposition c. 1831 was discussed in Ch.2.

The Coventry practitioners raised three principal objections: firstly, that unduly prosperous people were allowed to become members; secondly, that an originally charitable institution had become a 'gigantic commercial enterprise'; and thirdly, that the numbers of dispensary patients had grown unduly large. Therefore, for instance, the crowded waiting rooms were considered likely to encourage the spread of infections.[175] A general meeting of all practitioners in December 1892 was followed in March 1893 by a 'deputation' (Dr Milner Moore and four others) addressing such points to the dispensary medical staff. At one point the two groups of doctors seemed close to agreement, but injudicious and perhaps inaccurate reporting caused offence and hardened attitudes.[176] At later meetings dispensary members contested their specific arguments of the 'outside' doctors, arguing that they were hostile to the dispensary. At the general meeting in April 1893 the dispensary members, by now thoroughly irritated, resolved that the institution was self-supporting and therefore independent. They also stated that 'the pecuniary position [of potential members] should be no bar to admission'.[177]

Following this impasse, in April 1893 Milner Moore and ten other practitioners established the Coventry Public Medical Service (PMS); this was a dispensary-like association, aiming 'to provide efficient medical service for families…[with an average annual income not exceeding] £2 weekly.'[178] Adult members, who paid one penny weekly and children half that amount, attended participating doctors at their own premises and obtained medicines from specified chemists. The members intended to 'raise the tone' of the profession locally, partly by limiting the numbers of patients that they dealt with, and by

[175] 'Coventry Provident Dispensary', *Midland Daily Telegraph*, 22 March 1893
[176] The negative comments appeared in the *BMJ*, 15 April 1893; objections to this report appeared in the *Coventry Herald*, 21 April 1893 and were commented on in the *Lancet*, in 'Provincial Correspondence', 1 April 1893 and 30 September 1893. Around this time medical representation on the committee fell to two out of twenty members.
[177] Coventry Provident Dispensary 63rd Annual Meeting, *Midland Daily Telegraph*, 22 March 1893
[178] Coventry City archives (CCA,) Coventry Public Medical Service Minutes, PA 89/1/1; 1 April 1893; the income limit was reduced in 1896 to 30s weekly. PA 89/1/1; 9 November 1896.

refusing to act as agents to 'clubs.' One year after the start, 3261 individuals had joined, with 1116 lapsing; after two years the 2692 members had increased to 4564. The service continued (like the dispensary itself) until the middle of the twentieth century.[179]

The Coventry Provident Dispensary was one of various institutions to arouse widespread professional antagonism, for reasons including its direction by lay people and the absence of income limits for eligibility.[180] For such reasons the British Medical Association hardened its opposition to the 'contract care' provided by benefit societies and some dispensaries. Coventry became a leading site in the so-called 'Battle of the Clubs', chronicled in the *BMJ* and *Lancet* from the 1890s onwards.[181] The BMA drew on trades union methods, requiring its members to implement sanctions including a boycott of the dispensary and ostracism of its medical staff. As a result, the latter became unable to obtain consultant advice or the admission of patients to hospital. The embittered climate eventually led to a significant High Court case in 1918, when both the dispensary and its medical officers were awarded damages for libel and slander against the BMA and some of its members.[182]

Conclusions

The Birmingham and Coventry dispensaries of the middle to late Victorian period had some important experiences in common. Both grew greatly in their level of activity, and both experienced challenges to their systems of governance; however, the conflicts occurred at different times and with differing immediate causes. It is not straightforward to relate these clearly to underlying social and political changes. The challenge in Birmingham in 1868

[179] CCA, PA 89/1/1, clubs, January 1894; one-year figures, 11 May 1894; two years, 8 May 1895.
[180] Andrew Morrice, 'Strong Combination': the Edwardian BMA and Contract Practice', in Martin Gorsky and Sally Sheard (eds.), *Financing Medicine: The British Experience Since 1750* (Abingdon: Routledge, 2006), 165-81.
[181] 'The Coventry Provident Dispensary', editorial, the *Lancet* 2 (1897), 880; 'The Battle of the Clubs: the Coventry Provident Dispensary' letters by E. Phillips and W. J. Pickup, *BMJ* 2 (1900), 607, 1 September 1900.
[182] Stephens, *VCH Warwickshire,* 8, p. 285

occurred contemporaneously with the change in the general political climate in the city. This may be no more than a coincidence, but it is striking that Joseph Nettlefold, chairman from that year (and architect of the new policies) was a figure in the Chamberlain circle, albeit never politically active. Another background factor in both towns (as elsewhere) was recent legislation that enfranchised a large body of skilled working-class and lower-middle class people; one can see their greater assertiveness at Coventry, while in Birmingham this was very restrained. Harris has suggested that such individuals became more active in local organisations of various kinds. However, an alternative interpretation suggests instead that Coventry's new breed of affluent worker concentrated on work and avoided civic involvement. This would apply particularly from the later 1890s when the new boom industries were attracting recruits from other areas of Britain.[183] However, the period under consideration here is somewhat earlier than the Coventry boom-town era, which was from the later 1890s, extending into the twentieth century.

Both towns experienced a large increase in numbers attending medical institutions, both hospitals and dispensaries. The findings of this study do not support Loudon's view that dispensaries did not experience such an increase. As far as Birmingham and Coventry are concerned their workload seemed to increase rather more than did the general hospitals.[184] At the Birmingham general dispensary, such pressures seemed to be the main factor provoking a clear challenge of lay governors by doctors. Urban expansion and population growth were factors in the growth in activity, but there also appears to have been a greater inclination among working people to seek medical aid. The exact reasons for this shift in attitudes remain unclear, although as suggested, less unpleasant medicines may have played a part. In Coventry there developed a triangle of competing interests; namely, the members of the dispensary, their

[183] Jose Harris, *Private Lives, Public Spirit: A Social History of Britain, 1870–1914* (New York, Oxford University Press: 1993), pp. 191-3; Beaven & Griffiths, 'Urban Elites, Socialists and Citizenship', pp. 8-9; Beaven, *Leisure, Citizenship and Working-Class Men,* esp. pp. 17-43.
[184] Loudon, 'Origins and Growth', pp. 341-2 (quote p.342)

medical officers, and the medical profession generally. Each group may have been motivated by a sense of fairness and what was reasonably due to them.

The content of each dispensary's work altered over time, with acute infections subsiding somewhat (although smallpox remained an exception, as at Coventry in 1871-2) and being partly replaced by chronic conditions such as heart disease. Other changes in their work pattern developed as matters of policy, such as the discontinuation of midwifery and vaccination in Birmingham in 1868-9. At Coventry there was some delegation to midwives (from c.1880) and few vaccinations were ever performed.

The new staffing arrangements In Birmingham probably appeared to a business mind an obvious rationalisation, with a small group of permanent staff replacing a shifting cast of honorary physicians and surgeons. The latter, especially the surgeons, might stay only a few years, while they developed their skills through practice among the poor (including attending them at home). This was thus a form of 'in-service training'.[185] Earlier in the century, in the 1830s and '40s, the dispensary was heavily involved in medical student teaching, a function that the hospitals later took over. Both Loudon and Cope suggest that the loss of clinical teaching contributed largely to the decline in the prestige and perceived significance of dispensaries.[186]

The Coventry Provident dispensary could be regarded at an exemplary instance of its type, at least until the 1870s. The increasing workload in succeeding decades, however, seem to have eroded its perceived merits, leading to long delays for patients and possibly to impaired quality of care. The large numbers attending (with their evident link to medical earnings) probably increased feelings of resentment among 'outside' medical practitioners. The tensions in 1892-3 between the dispensary members and the two groups of doctors might, perhaps, have been resolved with the aid of a skilled mediator or

[185] Reinarz points to the 'opportunities' at dispensaries for medical men; Reinarz, *Health Care in Birmingham*, p.29; Cope implies such a training role, in Zachary Cope, 'The Influence of the Free Dispensaries on Medical Education in Britain', *Medical Education* 13 (1969), 29-36, pp.33-6.
[186] Loudon, 'Origins and Growth', pp. 341-2; Cope, 'The Influence of the Free Dispensaries on Medical Education', pp.33-6.

neutral figure. Here and elsewhere (perhaps due to external pressures), attitudes seemed to harden

Conclusions

Dispensaries were significant features of eighteenth- and nineteenth-century urban life and were key institutions for providing medical care to the poor. Those coupled statements represent the main argument of this thesis, although these institutions do not have a strong presence in public memory and have been relatively little studied by professional historians. The research mainly concentrates on the nineteenth century, which was a period highly eventful for medicine as science gained greater influence, and when training for practitioners became more organised. Largely as a result, health services extended their range of treatments and provided them to more people. During the period, the study area of Warwickshire also underwent huge social and economic change, as towns expanded and industry became more complex, processes that affected health care together with other aspects of life.

Some institutions studied here were affected by local or wider conflicts, such as the political disturbances in Coventry during 1829-32 and professional disputes in Birmingham in 1867-68. The research extended beyond large towns to embrace the health needs of country-dwellers, exploring medical provision in small towns and villages. This is an unusual feature, counterbalancing the strongly urban focus of most medical history, not least most previous work on dispensaries.[1] Therefore this concluding section offers an opportunity to situate dispensary provision both in the evolving medical world and the processes of economic, political and social change in local societies.

As noted above, dispensaries were, in large part, responses to poverty and its consequences. In Warwickshire, the distress that prompted their foundation was readily apparent in Birmingham and Coventry, while less obvious in Southam and Stratford-on-Avon. The early chapters of the thesis consider the motivations of founders. In summary these appear mixed,

[1] A study set in Northumberland is a distinguished exception; Alun Withey, **'**Medicine and Charity in Eighteenth-century Northumberland: The Early Years of the Bamburgh Castle Dispensary and Surgery, *c* .1772–1802', *Social History of Medicine*, 29 (2016),467–489.

evidently including genuine compassion, a desire to demonstrate benevolence to the needy, and a wish to reduce demands on public funds (the poor rates).[2] In some cases, founders may have wished to administer Roy Porter's 'social balm' between different urban groups, as Chapter 2 suggested both for the restless conditions of Birmingham in the 1790s and Coventry's unsettled society during 1829-31 (points explored further below).[3]

Chapters 1 and 2 also suggest another factor relevant to the late eighteenth-century foundations, in Birmingham at least; namely, the town's role as an important centre of the Midland and English Enlightenment. Members of the prominent Lunar Society supported medical charities, including the town's first dispensary, which was serving patients from 1793.[4] Humanitarian benevolence appears an important feature of the enlightenment world-view, expressed especially through medical philanthropy. However, this needs to be set against Porter's more critical analysis of provincial infirmaries, which he interpreted as expressing the form, much more than the substance, of compassion to the poor.[5] The dispensary governing bodies in the study demonstrate arguments that Morris made for voluntary societies generally, in that they were composed of prosperous local inhabitants, and were mostly led by the more prominent members.[6] Loudon's survey of early dispensaries

[2] I. S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine,* 55.3 (Fall 1981), 322-342; motivations, pp. 330-1.
[3] Roy Porter, *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900* (London: Reaktion, 2001), 'Social balm', p. 25.
[4] Peter M. Jones, *Industrial Enlightenment: Science, Technology, and Culture in Birmingham and the West Midlands, 1760–1820* (Manchester: Manchester University Press, 2008), pp. 31-6.
[5] Roy Porter, *Enlightenment: Britain and the Creation of the Modern World* (London: Penguin, 2000), esp. pp. 44-46, 353-59, 410-15, 428; *R*oy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in Lindsay Granshaw and Roy Porter (eds.)*, The Hospital in History* (London: Routledge, 1990), 149-78.
[6] R.J. Morris, 'Voluntary Societies and British Urban Elites, 1780–1870: an Analysis', *The Historical Journal,* 24 (1982), 95–118.

underlined the influence of distinctive local societies, and especially of their elites.[7]

To explore patronage further, Chapter 2 showed how the original Birmingham dispensary governors of the 1790s were all businessmen, recruited by Matthew Boulton: manufacturers, merchants, and bankers. Their motivations seem likely to have included the easing of current hardships for local working people and the fostering of public order following the destructive local riots of 1791.[8] Nevertheless, early rules showed their wish to limit the calls made on the charity's generosity (such as not allowing treatment beyond three months). While such restrictions were not unusual in institutional rules, in Birmingham the dispensary continued to observe both their letter and spirit, and later medical officers observed the consequent difficulties for patients.[9]

For the contemporary foundation in Coventry (established 1789), the scanty sources limit the inferences that can be drawn. However, as also outlined in Chapter 2, the Public Dispensary there was evidently less generously supported than its counterpart in Birmingham, and the institution ceased to function after about a decade. In both large towns (and elsewhere) medical charities were administered with an eye to the 'ideals of economy, frugality…and financial rectitude' that Hilton linked especially with the evangelical world-view, but which was widely shared among middle-class

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[7] Loudon, 'Origins and Growth', p.328, as shown by the legal luminaries who were governors at London's Public Dispensary near Lincoln's Inn, and the merchants involved with the Liverpool dispensary, located near the docks.

[8] For the riots, see R. B. Rose, 'The Priestley Riots of 1791', *Past and Present*, 18 (1960), 68-88; John Money, *Experience and Identity: Birmingham and the West Midlands, 1760-1800* (Manchester: Manchester University Press, 1977), for a calming intention for the dispensary, see pp. 266-7.

[9] The time limitation was prominently displayed on the printed recommendation letters handed by subscribers to needy patients to authorise dispensary treatment. Adverse comments were made by medical officers in the clinical sections of annual reports, while Dr Ogier Ward criticised the policy in his paper; T. Ogier Ward, 'Report of Medical Cases in the Birmingham Dispensary', *Transactions of the Provincial Medical and Surgical Association*, 6 (1838), 429-46, p.435; however, the journalist 'Scrutator' later commended such strictness as contributing to the dispensary's financial soundness; see Scrutator, *The Medical Charities of Birmingham: Being Letters on Hospital Management and Administration*, 2nd ed (Birmingham: Sackett, 1863), p.62.

people of the era.[10] Any tendencies to harsh treatment through restrictive rules, as noted above for Birmingham, were softened by additional assistance (of cash grants, food, or other comforts) provided to the sick poor by relief committees or 'ladies' societies'. The latter, mentioned in chapters 2, 3 and 5, were associated with the dispensaries at Atherstone, Birmingham, Coventry, Stratford and Wellesbourne and were an important, if unobtrusive, route for women to contribute to the work of nineteenth-century medical charities.[11] One argument made by Morris was that the work of voluntary societies could assist in resolving tensions between Evangelicalism and utilitarianism (and also between different religious denominations).[12] An analysis in Chapter 2 demonstrated how in Birmingham during the 1820s and 1830s, the dispensary governors and medical staff included Anglicans and Unitarians, among others, who collaborated in their philanthropic efforts.[13] As regards the ordinary subscribers there, considered in Chapters 2 and 6, their religious convictions remain unknown but they were of varied economic status, including many proprietors of small and medium-sized concerns.

In contrast to such philanthropic cooperation, Chapter 2 also revealed how in Coventry during 1829-31, medical professionals and prosperous donors came to separate into rival factions. While the twists and turns in the story are intriguing, the lack of surviving dispensary records means that local newspapers (supplemented by journal articles) become the main guides to events.[14] Other

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[10] Boyd Hilton, *The Age of Atonement:The Influence of Evangelicalism on Social and Economic Thought 1795-1865* (Oxford: Clarendon, 1991), pp. 6-7.

11 Frank Prochaska, *Women and Philanthropy in Nineteenth-century England* (Oxford: Oxford University Press, 1980); see pp. 8-11; oversight of charities; pp.141-3.

12 Morris, 'Voluntary Societies and British Urban Elites', p. 113.

13 Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class 1780-1850* (London: Routledge, 1992), pp. 357-97, 416-449; Ian Cawood, Chris Upton, '"Divine Providence": Birmingham and the Cholera Pandemic of 1832', Journal of Urban History, 39.6 (2013), 1106-1124, esp. pp.1113-14.

14 Robert Arrowsmith, 'An Account of the Coventry Self-Supporting Dispensary', *London Medical Gazette,* XII (1833), 426-29 ; Robert Arrowsmith, 'Progress of the Coventry Self-Supporting Dispensary', *London Medical Gazette*, XIII (1834), 234-7; Charles H. Bracebridge, 'Notes on Self-Supporting Dispensaries, with Some Statistics of the Coventry Provident Dispensary', *Journal of the Royal Statistical Society*, 21 (1858), 460-63.

scholars depict the tensions existing, between reformers and conservatives, between weavers and other local groups, and between the moral economy and a strengthening ideology of political economy.[15] The new 'self-supporting' institution that opened in 1831, later known as the Coventry Provident Dispensary, was partly funded by small payments from its working-class patients. Its originators comprised manufacturers, middling tradesmen, a few professionals, and some of the urban gentry, of mixed political and religious views. Nearly all the city's medical men, who had opposed this foundation over two years, launched the rival General Dispensary (also in 1831). As explored in the chapter, during its nine-year existence the latter gained its chief support from opulent local businessmen (a banker, a coal owner, a large silk ribbon manufacturer) and from landed gentry in the city's hinterland. These individuals were evidently all Anglicans, included both Whigs and Tories, and were of greater wealth and social status than the Provident Dispensary founders. There are echoes of such fractured local relations in *Middlemarch,* where George Eliot portrays the adherents of two medical institutions forming into opposing camps. In the novel, undeclared alliances and hidden suspicions accounted for many of the hostility that became apparent, but in the real Coventry of 1829-32, such factors tend to remain obscure.[16]

Moving from the two large towns to Warwickshire market towns and the countryside, the politics differed in detail, but Chapters 3 and 5 outline the establishment in the 1820s by influential groups in several small towns of new institutions for the 'sick poor'.[17] Medical men generally took a leading part, in collaboration with clergymen, other professionals, and members of the gentry, while the founders' motivations seem to resemble those of the eighteenth-

[15] Peter Searby, 'Paternalism, Disturbance and Parliamentary Reform: Society and Politics in Coventry, 1819-32', *International Review of Social History*, 22 (1977), 198-225; Peter Searby, *Coventry Politics in the Age of the Chartists, 1836-1848* (Coventry: Historical Association, Coventry Branch, 1964), pp. 4-8; Bradley Beaven, 'Custom, Culture and Conflict: a Study of the Coventry Ribbon Trade in the First Half of the Nineteenth Century' , *Midland History*, 15 (1990), 83-99, esp. p. 91.
[16] George Eliot, *Middlemarch* (Harmondsworth: Penguin,1974 (orig. publ. 1871)).
[17] The foundation dates were Stratford-on-Avon and Southam (both 1823); Leamington Dispensary in 1816, becoming a hospital in 1825; Warwick Dispensary 1826.

century dispensary founders. Chapter 3 deals with Stratford-on-Avon, where the new public dispensary of 1823 can be seen as a benevolent activity of the local oligarchy, most of the dispensary governors being members or officers of the borough Council. For the institution's first decade, the records of Stratford's local governing bodies (corporation and select vestry) traced in the chapter contribute a richer picture of the interplay between a small town's political, welfare, and charitable processes. In this instance, analysis tended to confirm Rosemary Sweet's argument that many small-town oligarchies of the early nineteenth century were conscientious and reform-minded.[18]

Chapter 5 built on previous research by Wheeler to address provident dispensaries and the striking story of their creation.[19] A few miles from Stratford-on-Avon in 1823, the same year as the Stratford foundation, the surgeon Henry Lilley Smith collaborated with other prominent inhabitants to establish the new Southam Dispensary. His intention, initially in this town of about one thousand inhabitants, was to establish a more humane medical service for the local poor, including both parish paupers and labourers working for small wages.[20] The tripartite funding included payments from Poor Law sources, charitable donations from the better-off 'honorary members', and small weekly contributions from working people, known as the dispensary's 'free members'. The truly innovative feature was the last of these, modelled on existing self-help provision such as savings banks and friendly societies. This study's findings are consistent with analyses by Ismay and Weinbren of such arrangements, especially as regards the widespread belief that they encouraged

[18] Penelope Corfield, *Power and the Professions in Britain 1700-1850* (London: Routledge, 1995), pp.8-10, 141-63; Rosemary Sweet, *The English Town 1680-1840: Government, Society and Culture* (Harlow: Longman, 1999), pp. 30-35, 116-24, 154.
[19] Simon Wheeler: 'Dr. Henry Lilley Smith and the invention of self-supporting dispensaries', *Warwickshire History*, XIII (5) (2007),180–96.
[20] Henry Lilley Smith, *Observations on the Prevailing Practice of Supplying Medical Assistance to the Poor, Commonly Called the Farming of Parishes* (London: Philanthropic Society, 1819); Southam Dispensary, 2nd Annual Report, 1825.

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self-esteem and independence among the poor .[21] Lilley Smith evangelically promoted his ideas in writing and in local lectures; thus during the next decade, reflected in comments by contemporaries cited in the chapter, 'self-supporting' or 'provident' dispensaries modelled on Southam started in six Warwickshire towns and villages, as well as a few places elsewhere.

The pioneer provident dispensaries can be seen as instances of collective self-help supported by paternalism. Many people remained unconvinced of their advantages, local medical practitioners being typically and especially sceptical. Their objections included the likely threat to their earnings from artisans' fees if a dispensary started nearby; and if they became medical officers, of control of their working lives by the wealthy honorary members.[22] While Lilley Smith gained some support in the medical press, Thomas Wakley, in general no friend to dispensaries, echoed and amplified the professional opposition in the pages of the *Lancet*.[23] The early foundations had mixed fortunes, several ceasing to operate after a few years; reasons were suggested by contemporary authors and considered in chapter 5. Relevant factors evidently were competition from 'clubs' or benefit societies, injudicious application of charitable principles, or simply marginal economic viability.

In smaller Warwickshire towns during the nineteenth century, the established church had a prominent role in welfare and charity matters; but political views in these towns were mixed, probably inclining to Liberalism. In their range of convictions, dispensary founders in Warwickshire seem to resemble their counterparts in the West Riding of Yorkshire rather than the fractious groups in early nineteenth-century towns surrounding Manchester (as

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[21] Daniel Weinbren, 'Supporting Self-help: Charity, Mutuality and Reciprocity in Nineteenth-Century Britain', in Bernard Harris and Paul Bridgen (eds.), *Charity and Mutual Aid in Europe and North America since 1800* (London: Routledge, 2008), 67-88, esp. pp. 68, 70-71; Penelope Ismay, *Trust Among Strangers: Friendly Societies in Modern Britain* (Cambridge: Cambridge University Press, 2018), esp. pp. 85-118.
[22] Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London: Routledge, 2001), p. 90-91; objections of local practitioners, pp. 92-93.
[23] 'Fallacies in Mr Smith's System of Self-Supporting Dispensaries', *Lancet,* 19 (1833) pp. 566-67 (26 January 1833).

analysed by Marland and Pickstone).[24] Evidently differences in beliefs did not prevent collaboration for public benefit. In larger towns during the same era, as noted above and addressed in Chapters 1 and 2, religious beliefs and rivalries influenced medical charities as well as other fields. An analysis in Chapter 2 revealed the growing presence of Unitarians at the Birmingham General Dispensary, where they collaborated with Anglicans and others. In contrast, Dennis Smith addressed the ascendancy of the established church, during the middle third of the century, at other local medical institutions. Powerful Anglican figures controlled recruitment to the medical school as it transformed into Queen's College in 1841-43, and possibly also to the associated Queen's Hospital.[25] Chapter 6 noted the rise of the non-denominational medical school founded by General Hospital clinicians (Sydenham College, 1851–1868), which seems likely to have appealed to students from Dissenting backgrounds.[26] During the 1860s, local pressure prompted intervention by the Charity Commission, the two existing institutions were dissolved, and a new medical school was established. Smith's analysis of these events lays stress on the displacement of traditional elites by new groups from dissenting and industrial backgrounds. While this view undoubtedly has validity, I believe the interpretation of Reinarz is more accurate, pointing to the difficult atmosphere

[24] Political views in Stratford, for instance, were explored by Fogg; Nicholas Fogg, '"Tracts and Bills Galore"': Political Processes in Victorian Stratford-on-Avon', in Robert Bearman (ed), *The History of an English Borough: Stratford-upon-Avon*, 1196-1996 (Stroud: Sutton/Shakespeare Birthplace Trust, 1997), 139-59; pp. 141-43; John V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and Its Region, 1752-1946* (Manchester: Manchester University Press, 1985), esp. pp. 10-11; Hilary Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge: Cambridge University Press, 1987), pp. 141-4.
[25] Unitarians became a significant group on the management committee and supplied most of the chairmen during 1830-70; Dennis Smith, *Conflict and Compromise: Class Formation in English Society, 1830-1914* (London: Routledge, 1982), pp.154-60.
[26] This school was established by General Hospital staff and probably concentrated clinical teaching there (not at the dispensary); see Jonathan Reinarz, 'Towards a History of Medical Education in Provincial England', *Medical History Bulletin (Liverpool Medical History Society),* 17 (2006), 30-37, pp. 32, 36.

and flawed management at Queen's College, the poor educational effects, and resulting professional dissatisfaction.[27]

Several chapters of this thesis have explored the medical work of dispensaries, in greater detail than most previous scholarship, a factor which partly reflects my own clinical background. From their earliest days, some dispensary staff published observations on diseases they treated, especially concerning the important common fevers.[28] Chapter 2 observed how Birmingham's place as an important Enlightenment centre, noted above, can be linked with some early experimental and observational activities at the local dispensary.[29] The same chapter also outlined publications by medical staff based on their daily clinical work, aiming to demonstrate the significant and under-recognised role of dispensaries in collecting and disseminating such findings. As Tröhler argued, such activities should be seen as forming a significant part of the so-called 'Paris medicine', the new style of scientifically informed practice that gained great influence from the early nineteenth century.[30] Chapter 2 addresses the work of notable clinicians at Birmingham in the 1820s and 1830s, such as John Darwall and T. Ogier Ward. During the 1860s, as addressed in Chapter 6, Thomas Heslop became a significant Birmingham clinician. In a summary of locally prevalent diseases and medical provision, written for general readers, he introduced recent thinking on the continuing fevers, then increasingly viewed as two separate disorders, namely typhus and typhoid. In the earlier period, Darwall and Ward were undoubtedly assiduous in documenting clinical encounters, but they apparently failed to

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[27] Jonathan Reinarz, *Health Care in Birmingham: the Birmingham Teaching Hospitals, 1779-1939* (Woodbridge: Boydell, 2009), pp. 54-57.
[28] For publications on fevers, see Loudon, 'Origins and Growth', pp. 332-3.
[29] These include the early experiments with medical gases, Robert Bree's lost treatise on fevers *c.*1800, and the launch of vaccination in 1801 (also led by Bree).
[30] Loudon, 'Origins and Growth', publications on fevers, pp. 333-34; Stephen Jacyna, 'Medicine in Transformation, 1800-1849', in W F Bynum, Anne Hardy, Stephen Jacyna, Christopher Lawrence, and E.M. Tansey (eds.), *The Western Medical Tradition, 1800-2000* (Cambridge: Cambridge University Press, 2006), 11-110; Ulrich Tröhler, 'The Doctor as Naturalist: The Idea and Practice of Clinical Teaching and Research in British Policlinics 1770 –1850', *Clinical Teaching, Past and Present,* 21 (1989), 21-34.

encourage similar diligence from their colleagues, their statistics therefore covering no more than about one-third of the dispensary population.

These Birmingham practitioners contrast with other dispensary clinicians studied in earlier personal research. When a new provident dispensary started in Leamington in 1869, a founding dispensary medical officer evidently encouraged meticulous habits of clinical recording among colleagues. The staff charted most diseases encountered by the institution during 1870 -1914, and the data in a long run of annual reports could thus be used for inferences about the late nineteenth- and early twentieth-century 'mortality transition'.[31] This is the process, now widely accepted, whereby the predominant pattern of adult mortality from infections was replaced by deaths at later ages, from chronic degenerative disease. [32] The findings added to the evidence base by demonstrating the operation of such processes on a local scale.

Most of the clinical sources mentioned above were based on dispensary registers and other administrative records (the Stratford Dispensary's admission register 1823-32 being particularly valuable). Among other scholars, Graham Butler used registers and other records at Newcastle to explore the varied and complementary roles of the dispensary, the hospital and the Poor Law service in the care of the poor. Daisy Cunynghame was able to go further, in a study of the Newcastle Dispensary alongside two institutions located in southeast Scotland. As she could draw on extant medical casebooks, documents that rarely survive elsewhere, she was able to develop a deeper understanding of dispensary encounters. The sources chronicled medical thinking on the patients' ailments, often as they evolved during weeks and months. They also reflected, to some

[31] J.F Wilmot, '"Advice and medicine for the working classes": the Warwick and Leamington Provident Dispensaries 1869-1913' (Unpublished MSc Dissertation, Oxford, 2013); J.F. Wilmot, '"Advice and medicine for the working classes": the Leamington and Warwick Provident Dispensaries 1869-1913', *Warwickshire History,* XV (2014), 26-42; J. Wilmot, ''Indeed a Health Resort'? Mortality at the Leamington Provident Dispensary, 1869-1913'', *Local Population Studies,* 93 (2014), 54-67.

[32] Simon Szreter, Anne Hardy, 'Urban Fertility and Mortality Patterns' in Martin Daunton (ed) *The Cambridge Urban History of Britain*, 3 (Cambridge: Cambridge University Press, 2001), 629–72.

extent, the reactions and experiences of the patients themselves, in a manner not feasible with the sources available for the present study.[33]

During the 1830s, as traced in Chapter 2, institutional records reflected how dispensary medical officers were using everyday clinical observations to teach students based at Birmingham's new medical school. In little more than a decade, however, dispensary teaching seems to have been superseded by the new Queen's Hospital, which opened in 1841. This reflects a general trend among English dispensaries up to about mid-century (fostered by ever-stricter regulations from the Royal College of Surgeons), whereby the institutions lost their educational role to hospitals. In Scotland, however, this teaching continued into recent times.[34]

The thesis has also addressed the wider roles of medical practitioners, especially those based at dispensaries. Their general pursuits, mainly explored in Chapter 4, included participation in cultural and scientific societies, in Birmingham and other towns. The chapter drew on the interpretation of Ian Inkster, who identified such activities, as well as support for mechanics' institutes and public libraries, as features of the medical 'marginal man'. Influenced by the Chicago sociologist, Robert Park, Inkster applied this concept to the late eighteenth- and early nineteenth-century provincial medical practitioner, and it seems appropriate for the dispensary clinicians considered here.[35] Inkster suggested, however that after *c.*1850 the description was less applicable to the more professionalised medical and scientific worlds.

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[33] Graham Alan Butler, 'Disease, medicine and the urban poor in Newcastle-upon-Tyne, c.1750-1850', (unpublished PhD thesis, Newcastle-on-Tyne, 2012); Daisy Cunynghame, 'The Roles of the Edinburgh, Kelso, and Newcastle Dispensaries in Charitable Relief, 1776-1810' (unpublished PhD thesis, Edinburgh, 2020).

[34] Zachary Cope, 'The Influence of the Free Dispensaries Upon Medical Education in Britain', *Medical History,* 13 (1969), 29-36 pp. 30, 32, 34.

[35] Robert E. Park, 'Human Migration and the Marginal Man', *American Journal of Sociology*, 33-6 (1928), 881-93; Ian Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850', in John H Woodward and David Richards, eds., *Health Care and Popular Medicine in Nineteenth Century England* (London: Croom Helm, 1977).

Chapter 4 also considered the related topic of the part-time careers that some dispensary clinicians followed in medical writing and editing. The chapter included brief biographies of John Darwall of Birmingham and his friend John Conolly, who was successively at Stratford, London and Warwick, set against the early nineteenth century explosion in medical periodicals. The analyses of Burney, Desmond and the Loudons of such publications were addressed, in relation to issues of politics, medical reform, and professionalisation.[36] Shared scientific interests also stimulated the growth of professional journals, and similar factors inspired the formation of medical societies, such as the Provincial Medical and Surgical Association in 1832. These activities also appear consistent with Michael Brown's concept of a 'imagined community', identified as developing among early nineteenth-century practitioners.[37] In Brown's thinking, professionalisation was based on shared ideas and culture, much more than ascribed status or credentials. The 'imagined community' certainly seems applicable to practitioners discussed in this thesis, including the friends and associates of Conolly and Darwall involved both in medical journalism and in the new Association as it developed in Worcester.

The epidemiological data that dispensary practitioners charted in their daily work (in Chapters. 2, 3 and 6) seem to answer some questions but raise others. To take one example, the incidence of some important diseases varied less than might be expected, for instance between urban and semi-rural settings. As noted in Chapters 3 and 6, the incidence of chest disease seemed to

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[36] Adrian Desmond, *The Politics of Evolution: Morphology, Medicine and Reform in Radical London* (Chicago: Chicago University Press, 1989), esp. pp. 3-5, 9, 21; Jean Loudon and Irvine Loudon, 'Medicine, Politics and the Medical Periodical 1800-50', in William F. Bynum, Stephen Lock, and Roy Porter (eds.), *Medical Journals and Medical Knowledge: Historical Essays* (London: Routledge, 1992), 49-69; Ian Burney, 'The Politics of Particularism: Medicalisation and Medical Reform in Nineteenth-Century Britain', in Roberta Bivins and John Pickstone (eds.), *Medicine, Madness and Social History: Essays in Honour of Roy Porter* (London: Palgrave Macmillan, 2007), 46-57.

[37] Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c.1760 – 1850* (Manchester: Manchester University Press, 2011), pp. 5-6; Michael Brown, 'Medicine, Reform and the 'End ' of Charity in Early Nineteenth-Century England', *English Historical Review,* CXXIV (2009), 1354-88; this was developed from Benedict R. O' G Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* (2nd ed, London: Verso, 1991).

increase between the 1820s and 1870s but was not notably more common in the smoky industrial towns. Stomach disorders did, however, seem to occur more frequently in urban industrial workers, particularly among the ribbon weavers of Coventry. This seems likely to be related to the anxiety and uncertainty of their lives, as the dispensary practitioner Charles Nankivell argued in 1838.[38] Some trends in disease incidence seem clearly beneficial, such as the decline in continued fever observed in various settings (Birmingham, Coventry, and Stratford-on-Avon, addressed in Chapters 2, 3 and 6).[39] This may have resulted from sanitary improvements, some limited improvements in prosperity, changes in personal hygiene practices, or a mixture of all these.

Both Chapters 1 and 6 outlined how the third quarter of the nineteenth century brought wider social and political changes that affected dispensaries, albeit in complex and contradictory ways. The industrial landscape differed between the two large towns, Birmingham from the 1850s becoming more 'modern' as some large factories arose amongst the many small and medium-sized workshops. Coventry followed a different trajectory, the two staple trades being mainly followed on a small and often domestic scale, until a crisis around 1860 resulted in lasting changes (to be discussed further below).

The thesis was influenced by scholars such as Asa Briggs and Tristram Hunt, who explored the role and influence of Joseph Chamberlain and his associates in Birmingham. From the late 1860s these Unitarian industrialists were increasingly dominant in local (and later in national) Liberal politics. These individuals gained inspiration from influential local preachers, who argued that civic authorities had a duty to improve the environment and the daily lives of all

[38] C. B. Nankivell, *The Influence of the Mind on Health: A Lecture Delivered to the Members of the Coventry Mechanics' Institution* (London: Effingham Wilson, 1838), pp. 9-10.

[39] The dispensary figures suggest that in the 1830s, continuing fever was more common at Coventry than Birmingham, perhaps due to greater poverty and overcrowding. This then declined over two decades to less than one per cent of total cases. Both dispensaries treated several hundred cases of chest disease each year. These included bronchitis, pneumonia, and tuberculosis, which when combined did not differ greatly between the two places, both apparently being largely related to domestic and industrial coal smoke.

citizens, a set of beliefs summarised as the 'civic gospel'.[40] Those involved with municipal developments also continued their involvement with medical charities, including the General Dispensary.

Chapter 6 also considers how during the same period, discontent with heavy workloads led some medical practitioners in Birmingham to become more assertive or even militant. Medical officers at a large friendly society pressed for increased pay and resigned when this was refused. At the General Dispensary, the honorary physicians and surgeons requested honoraria to recognise their heavy unpaid burdens. The two trends, reflecting professional attitudes versus those arising from business and politics, seemed to collide in April 1868. The governors considered the medical grievances, but called a subscribers' general meeting, where they delivered a tough response. They refused any payment to existing honorary officers, who then resigned. The management committee also created new staffing arrangements and chose an outlying area to locate a new branch dispensary (the first of a series). These changes, led by the dispensary's new chairman, Joseph Nettlefold (Chamberlain's cousin and business partner), may have helped to maintain the dispensary's continuing relevance.

Chapters 1 and 6 also explore events in Coventry, where the silk ribbon industry was affected by an extensive strike during 1858-59. A free trade treaty in early 1860 followed, and this ended the existing protection for the trade. As the market was flooded by French products, many firms collapsed, weavers suffered widespread hardship, and local populations declined. Similar changes affected the other local industry, watchmaking, but less dramatically and at later dates. New businesses were gradually established during the next two decades, mainly in light engineering, including the manufacture of bicycles, motorcycles, and eventually cars. The local provident dispensary gained many members and therefore seemed to thrive. In the 1880s and 1890s its increased

[40] Asa Briggs, *Victorian Cities* (London: Penguin,1990, orig. pubn. 1963), 186-236; Tristram Hunt, *Building Jerusalem: The Rise and Fall of the Victorian City* (London: Weidenfeld & Nicholson, 2004) pp. 230-4, 240-49, 326-34.

wealth and dominance sparked renewed and persistent opposition from 'outside' medical practitioners.[41] The discord at Coventry was matched in many places during a similar period, in events often summarised as the 'Battle of the Clubs, when general practitioners objected to aspects of the 'contract care' provided by provident dispensaries and some other bodies.

Later nineteenth-century changes in institutional governance are also addressed in Chapter 6. In parallel with extensions to the franchise, working people gained representation on managing bodies, including the Saturday Fund delegate at the Birmingham dispensary and the representatives elected by dispensary members at Coventry.[42] At the Coventry Provident Dispensary, an ethos of self-help and democratic arrangements seemed to displace the older paternalist elements. As working-class members and their elected representatives became more assertive, dispensary governance altered. During this period, dispensary practitioners may have lost some influence on institutional direction, as seen with the changed personnel at Birmingham in 1868, and the reduction in medical representation on the committee at Coventry from the 1870s. Those objecting to the reduced medical voice and influence included the British Medical Association, the *Lancet*, and others. The later nineteenth-century provident dispensaries have received relatively little scholarly attention, but Chamard and Hewitt, respectively, have explored similar changes affecting institutions in London and Manchester.[43]

As regards relations with external organisations, Chapters 1, 2 and 3 analysed the reporting by various dispensary practitioners to national and local

[41] Beaven and Griffiths, 'Urban Elites, Socialists and Citizenship', pp. 8-9.
[42] Martin Gorsky, John Mohan, and T. Willis, 'A 'Splendid Spirit of Cooperation': Hospital Contributory Schemes in Birmingham before the National Health Service', in Jonathan Reinarz (ed), *Medicine and Society in the Midlands 1750 - 1950* (Brentwood: Midland History/Doppler, 2007), 167-91.
[43] Mary J. Chamard, 'Medicine and the Working Class: the Dispensary Movement in London, 1867-1911' (unpublished PhD thesis, Toronto, 1984), regarding the debates in London provident dispensaries, see pp. 129, 154-57, 174-76; also in Manchester, Martin Hewitt 'Fifty years ahead of its time? The provident dispensaries movement in Manchester, 1871–85' in Alan Kidd, Melanie Tebbutt, eds., *People, Places and Identities: Themes in British Social and Cultural History, 1700s –1980s* (Manchester: Manchester University Press, 2017), 84-108.

bodies investigating urban sanitary conditions. As these men were in close contact with unhealthy local environments through their daily work, they were well placed to supply evidence, for instance, to Chadwick's commission in 1842.[44] Similar reports also influenced local municipal policies, most obviously at Stratford-on-Avon and addressed in Chapter 3, where several medical officers became councillors and in due course, mayors. Such an unusual degree of civic engagement was facilitated by Stratford's small scale and compact layout, but perhaps also encouraged by the prevailing local medical ethos.[45]

Various chapters addressed the role of friendly societies, as organisations serving working people whose functions overlapped with those of dispensaries. Chapters 1 and 2 discuss the close links of Coventry friendly societies with the Provident Dispensary from its foundation in 1831. In Birmingham, friendly societies were strongly supported, but generally did not form equivalent links with early nineteenth-century dispensaries. However, as scholars such as Gorsky investigated on a national scale, from around mid-century such organisations played an increasing role in the direct provision of medical care.[46] In Birmingham during the later nineteenth century, as considered in Chapter 6 and the Appendix, friendly societies established shared medical institutions (dispensaries in effect, if not always in name).

As regards relations with the Poor Law medical service, these were complex over the period of this study. Chapter 5 outlined the intentions of the early provident dispensaries to provide medical care both to paupers and to the working poor, which occurred at Southam and a few other places up to around

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[44] M. W. Flinn, 'Editor's Introduction' to Edwin Chadwick, *Report on the Sanitary Condition of the Labouring Population of Great Britain,* orig. pubn 1842, London Poor Law Commissioners (Edinburgh: Edinburgh University Press, 1965); Chadwick quotes extensively from the Birmingham practitioners; in his introduction, Flinn points to the especial role of dispensary and Poor Law doctors.

[45] R.I. Penny, 'The Board of Health in Victorian Stratford-Upon-Avon: Aspects of Environmental Control', *Warwickshire History,* 1 (1971), 1-19, pp. 9-10.

[46] Gorsky, M., 'Friendly society health insurance in nineteeth-century England', in Martin Gorsky and Sally Sheard (eds.), *Financing Medicine: The British Experience Since 1750* (Abingdon: Routledge, 2006), 147-63.

1834. From c.1840, however, statutory medical provision through the Poor Law service became increasing distinct.[47]

Dispensaries were affected by broader changes in the medical landscape from the later nineteenth century, these being considered in Chapter 6 and the Appendix. Ritch observed that the Poor Law service in Birmingham was from the 1870s increasingly operating alongside a range of providers. Likewise, the large dispensaries of Birmingham and Coventry were no longer unopposed monolithic urban institutions, but were working alongside, and often competing with, other providers as part of a mixed medical economy. The Poor Law system developed some dispensaries in conurbations (in Birmingham from 1872), while their urban workhouse infirmaries were evolving into municipal hospitals. Other relevant bodies included old and new charities, friendly societies, a new provident dispensary in Birmingham, Stratford's Provident Institution, the Coventry Public Medical Service from 1892, and the small clubs established by individual general practitioners.[48] This pluralism continued over decades and forms the next chapter in the developing story of health and welfare provision.

It was my intention to address in more detail the views and experiences of patients. The sources, however, offer limited opportunities to ascertain these. The clinical observations of Darwall and Ward in Birmingham include some brief descriptions of patients' experiences. The minutes of the Stratford dispensary offer glimpses of the lives of a few patients treated by the institution. At Coventry from the 1870s, some patients (especially the elected representatives) became more vocal, raising grumbles at annual meetings about waiting times and similar matters. Unfortunately, the surviving records in

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[47] M. W. Flinn, 'Medical Services under the New Poor Law' Derek Fraser (ed), *The New Poor Law in the Nineteenth Century* (London: Macmillan, 1976), 45-66, pp. 40-41; for Warwickshire, see Stuart Wildman, *'He's only a pauper whom nobody owns': Caring for the Sick in the Warwickshire Poor Law Unions, 1834-1914* (Stratford-upon-Avon: The Dugdale Society, 2016), pp. 24-28.

[48] Alistair Ritch, 'New Poor Law Medical Care in the Local Health Economy', *Local Population Studies*, 99 (2017), 42-55.

Warwickshire cannot match the richness of the casebooks that Cunynghame could draw on in her recent study.[49]

For some final reflections on the place of dispensaries, other authors have suggested reasons for their apparent loss of prestige and influence around the turn of the twentieth century. As Loudon and Cope argue, the withdrawal from medical teaching was an important factor in this decline, applicable to the capital and to important provincial centres like Birmingham. Related factors include their lack of involvement in laboratory medicine and, consequently, their failure to contribute to the advance of medical knowledge.[50] For metropolitan dispensaries, Chamard suggests that several larger changes had adverse effects. They were mostly small and very local institutions, while urban expansion was increasingly separating homes and workplaces. In Birmingham, the formation of branch dispensaries from 1868, as identified in Chapter 6, represented a response to similar urban growth, and may have helped to maintain the relevance of the General Dispensary. Chamard also points out that dispensaries in the capital were ignored by developments such as the Prince's Fund, founded 1897 (later known as the King's Fund), that channelled funds and management expertise towards the London hospitals. Sir Zachary Cope also cites the influence of Beatrice Webb's opinion, alleging that dispensary doctors were over-reliant on a rapid throughput of patients combined with high rates of prescribing (which seems unlikely to be a flaw confined to them). These opinions found expression in the Minority Poor Law report of 1909, whose view of dispensaries was also coloured by recollections, in Cope's words, of Thomas Wakley's long campaign of 'vilification'. In turn, all these views influenced Lloyd George and fellow Liberal politicians as they framed the National Health Insurance (NHI) scheme of 1911. The legislation largely ignored dispensaries, which thereafter mostly worked in parallel to the main NHI service provided by general practitioners. While the majority continued to operate until c.1948,

[49] Cunynghame, 'The Edinburgh, Kelso, and Newcastle Dispensaries'.
[50] Loudon, 'Origins and Growth', p.340-42; Zachary Cope, 'The Influence of the Free Dispensaries Upon Medical Education in Britain', *Medical History* 13 (1969), 29-36, pp. 32, 34.

they confined themselves mostly to the care of women and children, and could easily be regarded as outdated remnants of a former epoch.[51] Cope commends the dispensaries for their unglamorous labours, saying 'for more than a hundred years… [they]filled a gap that neither the hospitals nor the Poor Law service could fill'.[52] But as this study has argued, by the late nineteenth century, the dispensaries were increasingly functioning in a complex and varied landscape of medicine and welfare.

[51] Wellcome Library, London, MS 1863, Sir Zachary Cope, 'A forgotten health service: being the story of the General Medical Dispensaries (both Free and Provident) in Britain', typescript, 1966, pp. 131-35; see also Chamard, 'Medicine and the Working Class', pp. 257-58, 314-16, 319.
[52] Zachary Cope, 'The History of the Dispensary movement', in F.N.L Poynter (ed.), *The Evolution of Hospitals in Britain* (London: Pitman, 1964), 73-92, p.73.

Appendix

'Alternative' Dispensaries in late nineteenth-century Birmingham

In the later nineteenth century, the General Dispensary worked alongside, and was perhaps challenged by, new foundations, based either on specific ideologies (homoeopathy or evangelical religion) or distinct funding systems (the Provident Dispensary). These institutions treated broadly comparable numbers of patients, and all continued well into the twentieth century.

Homoeopathy: In 1847 the homoeopathic physician Dr Fearon founded the Birmingham Homoeopathic Dispensary, which in 1859 expanded into a hospital following a legacy from the Warwickshire landowner Evelyn Shirley.[1] There were 18 beds Initially. [2] In 1860 there were 39 inpatient admissions and 2400 dispensary patients.[3] In 1874 the hospital moved to Easy Row. As at other institutions, patient numbers increased, with 142 inpatients and 14,971 outpatient visits in 1873; in 1883, 4731 outpatients attended a total of 23969 times.[4] There are few details of the complaints treated, but in 1861 inpatient treatment was mainly given for 'chronic diseases that had resisted other treatments'; in 1863 they included patients with phthisis, leg ulceration and 'rheumatism'.

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[1] By the 1870s, homeopathic hospitals existed in five other towns (London, Bath, Doncaster, Hastings, Manchester, and Southport); there were also 37 charitable and 75 fee-charging dispensaries. See Peter Nicholls, 'The Social Construction and Organisation of Medical Marginality', in Robert Jütte, Motzi Eklof and Marie C. Nelson, eds., *Historical Aspects of Unconventional Medicine: Approaches, Concepts, Case Studies* (Sheffield: EAHMH Network, 2001), 163-82, pp.178-9; Warwickshire CRO, CR1646/1, Birmingham Homoeopathic Hospital and Dispensary, Minute Book, p.39. Evelyn John Shirley (1788-1856), of Ettington Park near Stratford, had been a Conservative MP, and left £500 for 'a homoeopathic hospital in Birmingham or elsewhere').

[2] The 'self-supporting' group was envisaged as including 'young men and women, domestic servants, and others'; the outpatient charges were 1s for a single consultation or 6s per quarter. CR1646/1, Minute Book, p.39.

[3] Warwickshire CRO, CR1646/1, pp.39-40.

[4] WCRO CR1646/1, 1874 Minutes, Annual Report for 1873; 1884 Minutes, Annual Report for 1883

The institution's governors included leading industrialists such as Robert Chance, Josiah Mason, and John Cadbury, as well as various clergymen; in 1874 Miss Susan Martineau was responsible for the 'Wardrobe Committee'.[5] While most of its income was from subscriptions and donations, it also received a share of Hospital Sunday collections (£272 in 1862, £365 in 1873).[6] The Homeopathic Hospital was one of twelve small medical charities to gain a share of the Hospital Saturday Fund after 1869, despite the objections of the fund's principal founder, the surgeon Sampson Gamgee.[7] Aristocratic patronage was a factor that fostered support for homoeopathy in England generally, but local experience suggests the significance of both workers and leading industrialists. [8]

Birmingham Medical Mission: opening its doors in 1875, this establishment functioned for many years from Floodgate Street near Deritend. The mission functioned similarly to charitable dispensaries, but like other urban missions held regular prayers and bible classes. Also like them, it dealt with the poorest individuals, whose means were comparable to paupers. [9] It was very popular from the outset, with over 14,000 people attending in its second year.[10] The staff strongly encouraged temperance among local people, and indeed monitored the activities of local public houses, gathering evidence to supply to licensing justices.[11] Free church congregations provided much charitable support, while the Avery, Cadbury and Lloyd families were also generous

[5] Robert Chance was a leading Black Country glass manufacturer; Josiah Mason manufactured pens and other items; John Cadbury established the family chocolate-making concern; the Martineaus were a prominent local business and intellectual dynasty.
[6] CR1646/1, 1862 Minutes, p. 45; 1874 Minutes, Annual Report for 1873.
[7] CR1646/1, 1869 Minutes, pp. 202-3. Gamgee's objections were based on the 'unscientific' basis of homoeopathy; the charity's governors noted at this time that some working men favoured homeopathic treatment, the relevant practitioners being included in the medical staff of some provident societies.
[8] Bernard Leary, 'The Influence of Patients in the Provision of Homeopathy', in Martin Dinges, ed, *Patients in the History of Homoeopathy* (Sheffield: European Association for the History of Medicine and Health Publications, 2002), 331-50, pp. 332-36
[9] Kathleen Heasman, 'The Medical Mission and the Care of the Sick Poor in Nineteenth-Century England', *The Historical Journal, 7*(2) (1964), 230-245.
[10] BAH, MS 4038, Papers relating to Birmingham Medical Mission.
[11] BAH, MS 4038/2/1/1, Report on Public Houses 1903.

donors.[12] The Cadburys were always leading supporters of temperance policies, on the grounds of the harmful social effects of alcohol. Joseph Chamberlain, and perhaps his allies too, regarded ignorance and poor education as the roots of social pathology. Chamberlain was not in favour of prohibition but favoured (municipal) regulation of alcohol sales.[13]

Provident Dispensary: After William Sands Cox retired from the dissensions of his Birmingham life to Kenilworth, he decided to devote some of his wealth to encouraging provident dispensaries. On his death in 1875, his will incorporated a bequest of £12,000 to purchase property and set up new dispensaries in three of Birmingham's poorer districts.[14] In July 1877 an initial meeting convened by the mayor stimulated work by a smaller group that planned the practical functioning, also consulting with existing charities and professional bodies. In line with Sands Cox's wishes, the rules were to follow the recommendations of the Charity Organisation Society. There would be no honorary members, while the ordinary members were to elect the committee and to appoint medical officers for five-year terms. The first dispensary was founded in Farm Street, Hockley; others intended for Nechells and Balsall Heath have left no records and may never have been established. The pioneering gynaecologist Lawson Tait was a member of the early committee and for a time the honorary secretary.[15] In January 1880, fifteen months after opening, there were nearly 3000 members at Hockley, and numbers steadily increased thereafter. After clashes with the early medical officers regarding pay and regulations, the committee replaced them with one full-timer, who was initially expected to reside at the dispensary.[16]

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[12] These were, respectively, manufacturers of weighing scales and of chocolate, and bankers; the Averys were Congregationalists, while the others were Quakers.
[13] See Andrew Weekes, *Two Titans, One City: Joseph Chamberlain & George Cadbury* (Alcester: West Midlands History, 2017), p.56
[14] Hans F. Reichenfeld, The Birmingham Provident Dispensary: Hockley Branch 1877-1948', *The Birmingham Historian* (2002), 16-28, pp. 18-19
[15] Reichenfeld, 'Birmingham Provident Dispensary', pp.19-20; Lawson Tait was a Liberal councillor; see Rosenthal, 'Chamberlain and the Birmingham Council', p.90.
[16] Reichenfeld, 'Birmingham Provident Dispensary', pp.20-23

Other Provision: In 1879 a survey on behalf of the COS reported on Birmingham and several other towns, covering both provident dispensaries and similar institutions established by groups of friendly societies.[17] Together with the Hockley Provident Dispensary described above, certain local practitioners, objecting to the lack of income limits applied at Hockley, had founded the 'West Birmingham Provident Dispensary'. Allam, the report's author, was also told about many 'private clubs' founded by local practitioners. He also described two dispensary-like institutions formed by combined friendly societies, of a type becoming more common in various towns. The 'Birmingham General Provident and Benevolent Institution' was in Ann Street and dated to 1833, with 5000 members and twenty-two doctors. 'The Amalgamated Friendly Societies Provident Medical Institution', founded in 1876, covered 51 societies and had 4510 members, attended by a resident medical officer. Allam commented that users of combined friendly society dispensaries in different places praised the salaried medical officers highly, contrasting them with a 'want of sympathy' they experienced from the familiar club doctors.

Birmingham appeared in earlier periods to offer unpromising soil for provident dispensaries but the success of the Hockley institution, combined with the friendly society associations, showed what was feasible. However, the small- scale doctors' private clubs may have covered many local inhabitants, and by their nature it is difficult to know how many.

[17] A Mr Allam visited Birmingham, Coventry, Derby, Leicester, Scarborough, and York. W. Allam, *Provident Dispensaries and Friendly Societies' Medical Institutions*: *extracts from the report of Mr. Allam ... respecting inquiries made in Birmingham, Coventry, etc ... on behalf of the Medical Committee of the Charity Organisation Society* (London, C.O.S Medical Committee, 1879); comments on Birmingham, pp.4-8; remarks about medical officers, p.18.

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