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**The Public-Private Interface of Domiciliary Medical Care for
the Poor in Scotland, c. 1875-1911.**

David A. Sutton

A thesis submitted in fulfilment of the requirements for the degree of PhD to
the University of Glasgow.

The Department of Economic and Social History Centre for the History of
Medicine

Faculty of Law, Business and Social Sciences

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Abstract

This thesis explores domiciliary medical care for the poor in Scotland. Domiciliary care is understood as medical care provided in the home by qualified medical practitioners, or medical students. The poor are understood as those simply unable to ‘pay the doctor’ for the services they received. Focus is upon service provision, and therefore this thesis is a study of the different medical agencies engaged in the visitation of patients, and of the diverse ways medical practitioners as agents of different medical services facilitated or administered treatment. The period under focus is from 1875 to the National Health Insurance Act, 1911. Particular focus falls on urban Scotland, and Glasgow and Edinburgh. The interface between public and private provision is understood as the distinction between services provided for paupers, the legal poor, and services provided for the remainder, also unable to pay, and described as occupying ‘the boundary line between self-support and parish help’. Three types of service provider are identified: the poor law, medical charity, and medical missions.

The thesis is divided into four main parts, buttressed by an introduction and conclusion.

Chapter One sets the parameters to study of domiciliary medical care for the poor by identifying a literature of home visitation, and by identifying pressing issues concerning treatment in the homes of the poor of Glasgow and Edinburgh, like physical structure and family.

Chapter Two is comprised of eight sections and looks at public provision in the form of the poor law medical services. Of particular interest are the local management, and the medical officers who provided the service. In turn focus is put upon the role of medical relief under the Poor Law (Scotland) Act, 1911; the structure of outdoor medical services in Glasgow and Edinburgh; the role of the local medical sub-committee of the parish board; and the parochial medical officers and their work. A prosopographical approach is taken to profile the parochial medical officers.

Chapter Three, comprising five sections and conclusion, looks at private provision by medical charity. At issue is the range of charity dispensaries that provided outdoor services to the poor. A prospectus identifying the range of services is provided; outdoor medical services in Edinburgh and Glasgow are detailed; the interconnection between charity dispensary, domiciliary medical care, and medical educational requirements – particularly in Edinburgh – is investigated; and new developments occurring at the start of the twentieth century in health services requiring home visits are outlined.

Chapter Four is comprised of nine main sections plus conclusion and looks at private provision by home medical missions. An overview of the literature of medical missions is provided, before focus falls, in turn, on medical missions in Edinburgh; medical missions in Glasgow; the medical work of medical missions; opportunities provided for women; how medical missions work was justified against criticisms; differences between providers; the response to provision from the Catholic immigrant community, and the work of the St Vincent de Paul Society.

Prologue: The historical continuity of domiciliary medical care

One morning in April 2007, musing on this thesis, I heard a radio reporter announce that as part of a larger maternity services shake-up within three years every pregnant woman in Britain was to be automatically offered the choice of a home delivery.¹ This, it was said, represented a volte-face in British medical policy. Later, reading coverage of the announcement in the morning press, it quickly became apparent that this proposal was marked not so much by change or advance but rather by return, and the continuity of ideas and concerns about the safety, supervision, efficacy and efficiency of all forms of professional home medical visit, maternity and otherwise.² Maternity services are not the point here, as this is not a thesis about midwifery (which as a unique form of home-based service has a distinct history). Rather what are of interest are the commonalities that have guided attitudes to all forms of medical domiciliary care and that underpin these debates. Debates weighing advantages against disadvantages in domiciliary services, in Britain, go back over more than a century. Thus under the headline “Women ‘not told of home births risks’,” paraphrasing concerns attributed to the professor of obstetrics and gynaecology at Leeds General Infirmary, a *Daily Telegraph* correspondent ran through a familiar series of pluses and minuses attendant with all forms of home medical care.³ The journalist, Womack, quoted that ‘home births were at least twice as likely to result in foetal death as hospital births, even for women considered at low risk’. Home delivery as home treatment meant withdrawal from the hospital and the security of immediate specialist supervision: ‘I don't think women are being fully informed about the risks. All the safety of pregnancy we have achieved in the last 50 years has depended on the ready availability of intervention where necessary’. This was countered by a spokesperson from the Royal College of Midwives, who contrarily suggested that: ‘there is some evidence to show that

¹ *Talksport Radio* (3rd April, 2007).

² Lindsay Reid, ‘Scottish Midwives 1916-1983: The Central Midwives Board for Scotland and Practising Midwives’, unpublished PhD thesis (University of Glasgow, 2003), p. 2: ‘On the eve of the 1915 [Midwives] Act... most births (estimated at 95 per cent) of both the rich and the poor took place at home...’

³ Professor James Drife, former vice-president of the Royal College of Obstetricians and Gynaecologists, paraphrased by Sarah Womack, ‘Women ‘not told of home births risks’’, *The Daily Telegraph* (3rd April 2007), viewed via on-line edition < <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/04/03/nbirths03.xml> > [accessed 3rd April, 2007].

for very low risk women, a home birth may be safer than a hospital birth'. Infection and control were not the only issues in the balancing of the home and the hospital; cost was another. Womack quoted other 'experts' that such a proposal, if carried through, would prove entirely impractical for it would stretch the current health service beyond achievable capacity. Jim Thornton, professor of obstetrics and gynaecology at Nottingham, was quoted suggesting that such a move towards home deliveries would prove a major financial drain on limited NHS resources. In announcing the shift towards home care, health minister Ivan Lewis stated that just two per cent of hundreds of thousands of births in England each year currently occurred in the home. His comparison was Holland, where one-third occurred in the home. The government, in announcing the initiative towards greater domiciliary services, made great play that treatment in the home was a patient-centred initiative, one that promoted choice. The subtext here was that even after a century of the primacy of the idea of the hospital as the safest, most controlled and most scientifically successful arena in which to conduct medical procedures, given choice, many mothers (like other patients) might still preferred delivery (like other forms of medical treatment) at home.

Medical home visits as potentially dangerous (because transacted outside the orbit of a specialist, supervised, high technology structure of the hospital) yet conversely a potentially safer prospect (because of a parallel reduced exposure to virulent infections found on wards); as potentially expensive (because requiring a high number of personnel capable, willing and duly incentivized to man the visitation service) yet also potentially money saving (reducing need for large scale capital investment); as diverting and time-consuming and contrary to modern rounds of routinized, rhythmic practice yet something that might be preferred over hospital stay by many patients if just given the choice; and home visits also as a battleground between the vested interests of hospital practitioners (reluctant to cede control over any 'medical' procedure) and other medical and paramedical agencies: this thesis will show that there is nothing new in these arguments.

This mention here of debates surrounding the reintroduction of domiciliary-oriented maternity services is merely to advance a broader point. It is one of the main arguments

and justifications of this thesis that assessment of *all* forms of domiciliary medical care shows that the topic is marked by great thematic and historical continuity in terms of advantages that are deemed to accrue by it and the frustrations that are faced in implementing any such service. This is a salient point at a time when it seems that the value and role of the domiciliary care is once again under review on various fronts: home births seem set for a comeback, general practitioner visitation work has been under much review in Scotland, sparked by fears of a declining out of hours call-out service; hospital ‘super-bugs’ are rarely out of the news, leading to constant revision of domiciliary-based alternatives; and notions of a ‘fifth wave’ is refocusing the attention of various public health officials on the value of ‘holistic’ or whole-person medicine that involves knowledge of the patient’s health status in the broader context of their everyday home environment.

Four decades ago, during a time when the special role of general practice within medicine was being reasserted, Thomas McKeown and C.R. Lowe wrote on the pros and cons of medical home visitation in a larger study of *Social Medicine*, noting that: ‘Care at home had long been a feature of medical practice in Britain. Yet some people believe that it is wasteful of the doctor’s...time.’⁴ For McKeown and Lowe, whilst domiciliary care can be a wasteful use of precious time, especially in homes inadequately resourced for treatment of patients, visits by medical practitioners still have advantages. Visits can be economic (as they require no physical plant infrastructure); they can be used to support and draw pressure from hospital services; they can be good for determining trivial cases; they are necessary for the most chronically sick and infirm; they are a useful addition to the arsenal of measures employed in tackling infectious disease; they are a useful as a mechanism to support relatives caring and convalescing for house bound patients; they provide a platform for provision of a range of additional support services for patients, and in determining extra-medical requirements; they help establish a personal link between doctor and patient and thus enable said doctors to exert a greater domestic influence; and

⁴ Thomas McKeown and C.R. Lowe, *An Introduction to Social Medicine* (Oxford and Edinburgh: Blackwell Scientific Publications, 1966), chapter 17: The home.

home visits by practitioners can prove essential in the process of building up a sickness profile of patients.

Discussing forms of home treatment in another context, a recent witness seminar of eminent Scottish geriatricians also has lamented the ‘lost art’ of domiciliary visitation, in sharp decline in that discipline since the late 1970s.⁵ Drawing on collective personal experiences from medical visits carried out across Scotland between the 1960s and 1980s, variously the gathered doctors aired many of the pros and cons that had attached to the system and to the experience of visiting patients (many of whom were poor). Home visits, it was said, provided medical practitioners with ‘fantastic experience,’ with ‘noteworthy incidents,’ and opened them to ‘the full spectrum of things’. They provided greater insight into the humanity of patients, poverty and the human condition, into how illness manifests in everyday life, and how well equipped or otherwise were different patient groups to cope with and manage their illness. Visits provided lessons in practicality; they provided introduction and variety; and taught young doctors resourcefulness, and how to ‘expect the unexpected’. They provided crucial aspects of training, exposing young practitioners to ‘a florid pathology,’ and taught them how to ‘take histories on patient’s turf’. They thus improved negotiation and communication skills, essential to the management of patients’ expectations. Although the concentration of much of the resources of medical profession might be on acute cases, home visits provide important and easily under-valued care service, as well as a logistical solution for management and treatment of chronic, bed-ridden and terminally sick patients (not easily catered for outside the home). Home visits assist over-capacitated services. It was recalled that they were as much social as medical visits. They provided valuable opportunity to reinforce and reassure families coping with illness. The experience of home visitation was that some therapies were anyhow, in fact, better administered in the home. Cons highlighted, on the other hand, included the fact that the attitude of those visited is not always positive to the visiting doctor (being shaped by the sum total of

⁵ ‘Domiciliary Visiting by Geriatricians: The Good Old Days?’ a witness seminar held at the Centre for the History of Medicine (University of Glasgow, 4th May 2007). Arranged by Dr Keith Beard and Dr Malcolm Nicolson (with joint publication due on the event) and recorded by the Royal Society of Physicians and Surgeons Glasgow. Key speakers included Dr J. Davie, Dr W. Reid, Dr M. Roberts and Dr D. Kennie.

experiences with officialdom including - on poor estates - the police, the clergy, other social services, and bailiffs). Visiting medical personnel faced adverse and sub-standard home conditions and domestic arrangements, and an in-ability to utilise latest, costly 'big machinery' medical technology. They faced a 'huge number of frustrations': in co-ordinating and supervising services; in synchronising with other medical personnel during chaperoned or shadowed consultancy visits; in navigating difficult terrain to find a home on drab and dangerous estates; and, more simply, the frustration of many times failing to gain access and finding time wasted. There are ever-present problems of transportation; of preserving physical security; and (in total) the problem of simply justifying what often feels like an impractical use of limited time, energy and medical resources.

This is the echo of history. A historical understanding of domiciliary medical care in a specific historical context – such as provided here – can yield valuable lessons and serve as counter-point to contemporary discussions (particularly at a time when national health services are under such sustained pressure and constant review, and all sides of the political debate seem to agree on but one thing, that the patient should be central). Whilst the value to medicine of a domiciliary service has never seriously been in doubt amongst medical professionals of different ages, attitudes towards it, due to attendant difficulties in delivering it, have often been rather ambiguous; and the time and energy element have often meant that it is the first service done away with when services become overstretched. Historians, unlike medics, less ambiguously, have mostly tended simply to ignore the subject.

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I dedicate this to Shaheen, my grandmother Lilyan, my grandmother Ena, and my nephews, Azmat and Azeem.

Declaration

I declare that this thesis has been composed entirely by me without assistance. The research upon which it is based was my own work.

David Sutton.

Abbreviations

ACD	Anderson's College Dispensary
ADHAD	Anderston District Health Association Dispensary
AICP	Association for Improving the Condition of the Poor
BMA	British Medical Association
BMJ	British Medical Journal
BMM	Bridgeton Medical Mission
CFCMM	Cowcaddens Free Church Medical Mission
COS	Charity Organisation Society
EDSS	Edinburgh Destitute Sick Society
EETD	Edinburgh Eye, Ear, Throat Dispensary
EMMS	Edinburgh Medical Missionary Society
ENTD	Edinburgh New Town Dispensary
ERHSC	Edinburgh Royal Hospital for Sick Children
ERI	Edinburgh Royal Infirmary
ERMH	Edinburgh Royal Maternity Hospital
ERPD	Edinburgh Royal Public Dispensary
FPSG	Faculty Physicians and Surgeons Glasgow
GCA	Glasgow City Archives
GCD	Glasgow Central Dispensary
GMC	General Medical Council
GMH	Glasgow Maternity Hospital
GMJ	Glasgow Medical Journal

GMMS	Glasgow Medical Missionary Society
GPD	Glasgow Public Dispensary
GRI	Glasgow Royal Infirmary
GSI	Grove Street Institute
GSMS	Glasgow Southern Medical Society
GVI	Glasgow Victoria Infirmary
GWI	Glasgow Western Infirmary
HRA	Hospitals Reform Association
LGBS	Local Government Board of Scotland, formerly Board of Supervision
MOH	Medical Officer of Health
MSC	Medical sub-Committee of a Parochial Board
NHI	National Health Insurance Act, 1911 (1 & 2 Geo.V.c.55)
NHS	National Health Service
PMO	parochial medical officer, or poor law medical officer
QMC	Queen Margaret College, Glasgow
RC	Royal Commission
RCHS	Royal Commission on the Housing of the Industrial Population of Scotland Report (1917)
RCPE	Royal College of Physicians in Edinburgh
RCSE	Royal College of Surgeons in Edinburgh
SPLMOA	Scottish Poor Law Medical Officers' Association
SVDP	St Vincent de Paul Society

Thesis Introduction

This thesis explores domiciliary medical care in a particular historical milieu. It seeks to reclaim medical home visits of the poor – under-valued and generally overlooked - as a subject worthy of greater scrutiny. This is a survey and study of the nexus of public and private medical agencies engaged in the visitation and of the diverse ways medical practitioners as agents of different medical services interacted, secured entry to the homes of the urban poor, and then facilitated or administered treatment to them.¹ Under examination are the organisations that provided free medical care. Of interest are a number of basic questions relating to the agency of the medical visitors: who undertook these home visits; in what magnitude; under whose auspices; and for what reason? How was the medical practitioner employed for this task empowered to act? And what latitude did he (or she) have in providing treatment whilst serving a range of different organisations? Where evidence survives, also of interest is the kind of care provided in the trying circumstances of particular home visits.

Under specific consideration are the poor of late-Victorian and Edwardian Scotland during the last quarter of nineteenth century through to the National Health Insurance Act, 1911 (1 & 2 Geo.V.c.55) (NHI Act 1911). The period encapsulates a particular epoch of British history.² To take the series of themes explored in one recent general history, the decades around the turn of the twentieth century saw British imperial power reach its zenith; was a period of intense international rivalry, and of crisis of values; a period when principles of laissez-faire government were being more broadly challenged

¹ To avoid definitional and historical difficulties inherent in the use of interchangeable context-specific status, courtesy and descriptive nomenclatures like ‘doctors’, ‘surgeons’ and ‘medicos’, the term medical practitioner – or ‘practitioner’ for short - will be used throughout to describe the medical professional, except when in or referring to direct quotation or when referring to practitioners in appointed or specialist roles (i.e. as ‘medical superintendents’, or ‘parish medical officers’). The title Doctor, where avoidable, will only be used in the strictest legal sense when referring to a practitioner that had graduated M.D. The growing use by the public of the word ‘doctor’ in the non-legal sense, when referring to any qualified medical practitioner, was much bemoaned within the medical profession; particularly by fellows keen to see distinctions of rank and qualification and educational merit maintained. See, for example, John Simon, Subjoined Memoranda to *the Report of the Royal Commissioners Appointed to Inquire into the Medical Acts* [RC Medical Acts] (PP. C.3259-1 1882).

² David G. Green, *Reinventing Civil Society: The Rediscovery of Welfare Without Politics* (IEA Health and Welfare Unit, London 1993), and from R.K. Webb, *Modern England: from the 18th century to the present* (London: George Allen and Unwin, 1978) (1st published 1969), chapter 11.

and the role of the state re-evaluated; a period when poverty and unemployment were 'discovered' by the political classes and became embedded in the structure of the economy; a period 'of the slow march of democracy'; and a period that encompassed shifting perspectives in the public-private or state-market balance of welfare provision.³ Historians of medicine also describe the 1870s to 1910s as a period that saw the 'meteoric development' of the medical profession.⁴ There were fundamental changes in medical technology and technique, with celebrated developments, particularly, in anaesthesia and in antiseptic and aseptic medicine. These were closely linked to the work of medical men in medical institutions in Glasgow and Edinburgh.⁵ It was a period that saw the rise of epidemiology, of social medicine, and of the therapeutic potential of medicine;⁶ and the 'reluctant encroachment' by government into the predominantly private sphere of personal health.⁷ New innovations, new diagnostic techniques and new medical perspectives – having impact from the late 1850s onwards - presented 'new problems' for the generation in practice from the 1870s, and new challenges for the everyday work of Britain's medical practitioners.⁸ Additionally, from a position where at the beginning of 1875 a leading medical journal in Scotland was dismissing the notion of female medical practitioners with the reasoning that 'women have ever been devoid of genius,' this was also a period where attitudes quickly changed and women were soon undergoing medical training in Glasgow and Edinburgh.⁹

³ Themes from François Bédarida, *A Social History of England, 1851-1990* (London and New York: Routledge, 2nd ed. 1990).

⁴ Marguerite W. Dupree, 'Other than healing: medical practitioners and the business of life assurance during the nineteenth and early twentieth centuries' in *Social History of Medicine*, vol 10 (April 1997), pp. 79-103.

⁵ Anne Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), pp. 90-103; Sir John Brotherston and Dr John Brims, 'Introduction' in Gordon McLachlan (ed.), *Improving the Common Weal: Aspects of Scottish Health Services 1900-1984* (Edinburgh University Press, 1987), p. 23; Keir Waddington, *Charity and the London hospitals, 1850-1898* (London: Royal Historical Society/Boydell Press, 2000), p. 12.

⁶ Thomas McKeown and C.R. Lowe, *An Introduction to Social Medicine* (Oxford and Edinburgh: Blackwell Scientific Publications, 1966), p. 204; Jose Harris, *Private Lives, Public Spirit: Britain 1870-1914* (Oxford University Press, 1993), pp. 55-60.

⁷ Alan Kidd, *State, Society and the Poor in nineteenth century England* (Basingstoke: Macmillan Press, 1999), p. 2.

⁸ F.B. Smith, *The People's Health, 1830-1910* (London: Weidenfeld and Nicolson, 1990, 1st published 1979), p. 416. Edred M. Corner and H. Irvine Pinches, *The Operations of General Practice* (London: Oxford University Press, 1907), pp. 2-3.

⁹ GMJ (1875), pp. 139-41.

The story of late nineteenth and early twentieth century social welfare and healthcare provision, across Britain, is normally set against the backdrop of the rise of the welfare state and of the National Health Service. A teleological bent is reflected in the titles of numerous historical studies of this period and which, on their own terms, seek in the records of earlier periods traces of the origins and ideals of a health service implemented after World War Two: McCrae's *The National Health Service in Scotland: Origins and Ideals, 1900-1950* is the latest of a long line of such studies.¹⁰ An attempt has been made throughout this thesis not to look at issues through a prism of what was coming next; nonetheless, the passing of the 1911 NHI Act is identified as marking a definite end to the balance of public-private provision of medical care described.

The decades closing with the NHI Act, 1911, was also important in terms of urban Scottish society, with the development of heavy industry, 'a cheap labour economy,' and changing cityscapes. Scotland became characterised by 'economic success but social distress,' and by the vulnerability of urban labouring classes. Down economic periods meant a press for medical charity.¹¹ With the status quo between public relief provision, charity and self-help effectively confirmed by the 1869/71 Poor Law Select Committee in Scotland, battle lines were drawn by the mid-1870s: thus the *Poor Law Magazine and Parochial Journal* referred in 1877 to parliamentary disputes over the management of the poor law in Scotland as the clash of 'the two rival powers of charitable and of legal enterprise [which] were... for some time mustering their forces'.¹² National Health Insurance came to serve as a tipping point after decades of gradual drift.¹³

¹⁰ Morrice McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950* (East Linton: Tuckwell Press 2003). See, for example, David Roberts, *Victorian origins of the British welfare state* (New Haven: Yale University Press, 1960); B.B. Gilbert, *The evolution of national insurance in Great Britain: the origins of the welfare state* (London: Joseph, 1966); Ruth G. Hodgkinson, *The Origins of the National Health Service* (London: Wellcome Historical Medical Library, 1967); and Bernard Harris, *The origins of the British welfare state : society, state, and social welfare in England and Wales, 1800-1945* (Basingstoke: Palgrave Macmillan, 2004).

¹¹ Quotes from T.C. Smout, *A Century of the Scottish People, 1830-1950* (London: Collins, 1986), p. 4. See also T. M. Devine, *The Scottish Nation, 1700-2000* (London: Penguin Books 2000); W.W. Knox, *Work, Culture and Society in Scotland, 1800-Present* (Edinburgh University Press, 1999); Andrew L. Drummond and James Bulloch, *The Church in Late Victorian Scotland, 1874-1900* (Edinburgh: Saint Andrew Press, 1978); Irene Maver, *Glasgow* (Edinburgh University Press, 2000).

¹² *The Poor Law Magazine and Parochial Journal*, vol. V (Edinburgh: 1877), p. 1.

¹³ Anne Hardy, *Health and Medicine in Britain since 1860* (Basingstoke: Palgrave 2001), p. 79.

The idea that from around the mid-1870s Britain had moved irrevocably from a rural to an urban society goes back to the roots of modern British social history.¹⁴ As a plaque at the entrance to Dundee University Archives reminds, ‘by 1911 over three-quarters of the population of Scotland lived in Glasgow, Aberdeen, Dundee and Edinburgh.’ The focus in this thesis is therefore on the urban section of the Scottish society, its majority. In particular it is on the poor of Scotland’s two main cities, Glasgow and Edinburgh. Over and above the dearth of equivalent studies, focus upon these two cities is useful for both were vitally important provincial centres for medical education and innovation within Victorian Britain and its broader empire. Edinburgh is a natural choice for study, being internationally renowned as a centre of medicine, Scotland’s metropolitan and administrative capital, and its second largest city. Glasgow too is a natural choice for a thesis interested in the urban poor. As has been pointed out, ‘by 1911 Glasgow’s population of one million exceeded the aggregate population of the next five cities’ in Scotland’.¹⁵ Glasgow during its rise in the nineteenth century fared particularly badly in indices of poverty and ill-health such as infant mortality and (importantly in terms of domiciliary care) quality of housing.¹⁶

The main parts of this thesis explore three key types of provision that could be said to have made up the ‘mixed economy’ of domiciliary care for the poor in Glasgow and Edinburgh: parochial, charitable, and medical missionary.¹⁷ Historians of welfare have richly mined this notion of a ‘mixed economy of welfare’. It is a concept that has been utilised to explore the different forms of public and private provision that could be said to make up welfare provision at any one time. Whilst the mixed economy can be thought of as a particular defining characteristic of British society in the period of interest here, it is

¹⁴ G.M Trevelyan, *English Social History: A survey of six centuries, Chaucer to Queen Victoria* (London: Longmans, Green and co., 1946), chapter eighteen.

¹⁵ Callum G. Brown, Religion and the development of an urban society: Glasgow 1780-1914, unpublished Phd thesis (University of Glasgow 1981), p. 6. Also Helen M. Dingwall, *A History of Scottish Medicine* (Edinburgh University Press, 2003), p. 157 and 160.

¹⁶ For example, *The Lancet*, vol. 2 (1901), p. 1376: reported Glasgow M.O.H. figures that death rates in the city had fallen between 1876 to 1900 from 27.4 per 1,000 to 21.1 per 1,000 (although in some areas it was still above 40 per 1,000).

¹⁷ Kathleen J. Heasman, ‘The Medical Mission and the Care of the Sick Poor in Nineteenth-Century England,’ in *The Historical Journal*, vol. 7, no. 2 (1964), pp. 230-1, talked about ‘two main sources of treatment’ for the sick-poor in the nineteenth century being... statutory provision under the Poor Law... and the various voluntary agencies... [and] The alternative was the medical mission.’

a largely mutable term that has proven of wide utility for historians interested in many different periods.¹⁸ The mixed economy here consists of the three main estates of welfare provision for the poor of nineteenth and early twentieth century urban Scotland, *church*, *charity*, and *civitas*. Whilst these were not monolithic, these estates embody the three parts of this thesis. The mixed economy thus encompasses feelings of moral, social and political responsibility.¹⁹

From the second-half of the nineteenth century, health care services for the poor, including home visitation, were an integral part of the medical establishment, educational system, and network of medical charity established in both Edinburgh and Glasgow. Access to, and relations enjoyed with, the poor, could (and did) prove crucial to the status and prestige of medical practitioners. Before World War One, practitioners in Scotland encountered the poor on numerous levels. Large numbers of medical men drew salaries from parish authorities. Many others gave time and service gratis both to infirmaries and to other charities, welfare organisations and missions.

Although intrinsically a study of social relations, the focus here is the poor rather than the working-class, and the providers of charity rather than the middle classes. As Rev. Dr. Marshall Lang said in 1895 of the population of the ‘working-class’ district of Cowcaddens, in Glasgow, it consisted of a ‘class that was ever oscillating between poverty and want.’²⁰ Being working-class could mean being poor, although this conflation of the working-class and the poor could be much resented by sectors of workers; especially so in Glasgow, where denominational connotations attached to

¹⁸ Kidd, *State, Society and the Poor*, p. 2: Kidd points out that the ‘mixed economy’ still exists in Britain today, and attributes initial use of the term to Geoffrey Finlayson, ‘A moving frontier: Voluntarism and the State in British social welfare, 1911-1949’, in *Twentieth Century British History*, vol. 1 (Oxford: Oxford University Press, 1990). In 1996, Joanna Innes used the same framework of analysis to refer to a ‘mixed economy of welfare’ in early modern Europe in Joanna Innes, ‘The “mixed economy of welfare” in early modern England: assessments of the options from Hale to Malthus (c.1683-1803)’ in Martin Daunton (ed.), *Charity, Self-Interest and Welfare in the English Past* (London: UCL Press, 1996), chapter 7.

¹⁹ J. Cleland, *Annals of Glasgow*, vol. 1 (Glasgow: 1816), pp. 270-3; Stewart J. Brown, *Thomas Chalmers and the Godly Commonwealth in Scotland* (Oxford University Press, 1982), p. 98.

²⁰ *The Scotsman* (15 May, 1895), p. 9.

skilled working class political identity, and where poverty was more readily associated with the Catholic immigrant Irish.²¹

‘There is, in fact, no clear and inclusive definition of ‘the poor’’.

Stephen Reynolds et al (1912)²²

As Perkin has argued, determining the extent of poverty in any period can only begin when a working definition is arrived at.²³ There is, however, no universally agreed standard. Recent literature on poverty in Scotland refers to ways of life below a minimum acceptable standard and points to a range of indicators of poverty: unemployment, low wages, irregular work, inadequate housing, ill health, lack of education, powerlessness, exclusion, apathy, struggle and lack of choice. Elsewhere, Richard Rodger has pointed out that alongside issues of economy, education and exclusion, there was also a ‘Victorian umbilical cord connecting poverty and personality’.²⁴ Fissell’s notion of dependency, John J. Rodger’s notion of powerlessness, and Kidd’s concept of attachments all have utility in that they help deepen our historical understanding of attitudes and agency of the poor (aspects that are otherwise largely lost to the historical record).²⁵ However, this thesis seeks to define the poor in a more functional and a more historically sensitive manner.

²¹ *The Glasgow Observer* (25th April 1885), p. 1; Tom Gallacher, *Glasgow The Uneasy Peace: Religious tension in modern Scotland, 1819-1914* (Manchester University Press, 1987), p. 2.

²² Stephen Reynolds and Bob and Ian Woolley, *Seems So! A working-class view of politics* (London: Macmillan & Co 1912), p. 289.

²³ Harold Perkin, *The Origins of Modern English Society 1780-1880* (London: Routledge & Kegan Paul, 1969), p. 422.

²⁴ Lothian Anti Poverty Alliance Website < <http://www.lapa.org.uk/Poverty> > [accessed Jan 2002]. Richard Rodger, ‘The labour force’ in W. Hamish Fraser and Irene Maver, ed., *Glasgow, volume II: 1830 to 1912* (Manchester: Manchester University Press, 1996), chapter 5, p. 163 and p. 174-5.

²⁵ Fissell, Patients, power, and the poor, pp. 2-4: Fissell defines the poor as ‘those who might have been at risk of dependency’ by making reference to KDM Snell, *Annals of the labouring poor : social change and agrarian England, 1660-1900* (Cambridge : Cambridge University Press, 1985); Paul Slack, ‘Poverty and politics in Salisbury 1597-1600’ in Peter Clark & Paul Slack, ed.s, *Crisis and order in English towns, 1500-1700 : essays in urban history* (London : Routledge & Kegan Paul, 1972); and Olwen Hufton, *The poor of eighteenth-century France, 1750-1789* (Oxford : Clarendon Press, 1974). John J. Rodger, *Family Life and Social Control: A Sociological Perspective* (Basingstoke: Macmillan, 1996), p. 50, defines the poor as those: ‘living without resources, with financial insecurity... [and] with a sense of relative powerlessness’. This carries echoes of Robert Tressell, *The Ragged Trousered Philanthropist* (St Albans: Granada, 1965), p. 224. Kidd, State, Society and the Poor, pp. 2-3. Kidd argues that poverty should not be viewed as a fixed entity but a porous category. Survival for the vulnerable nineteenth century urban poor in Britain, in what was ‘an economy of makeshifts,’ depended upon the number of social ‘attachments’ one made.

Contemporarily medical men when referring to the poor amongst their patients meant not simply the destitute. The destitute was a term generally reserved for those entitled to parochial relief and who were sometimes therefore also referred to as ‘the legal poor’. Rather by the poor they meant all those that were ordinarily unable to pay the practitioner for his or her services and who were therefore requiring treatment (or the bulk of treatment) as a gratuity in one form or another. By definition therefore, for the purposes of this thesis, domiciliary care for the poor will be understood as: *non-hospitalising, outpatient or ‘outdoor’ medical care provided by qualified medical practitioners or medical students under training, most commonly as representatives and appointees of medical agencies, who visit the homes of those persons ordinarily considered destitute or who were otherwise adjudged to be simply unable to pay for the services they received.* The commonly used shorthand for such provision under the poor law was outdoor medical relief of the poor.

There are practical and pragmatic reasons for adopting this approach. This is a study of medical services and inability to pay or find funds to insure for provision in advance was the defining characteristic differentiating a poor or ‘destitute’ patient from a regular patient as understood within the medical profession du. For example, when, in the 1900s, James Thom, as medical superintendent of the Glasgow Royal Infirmary, was asked to comment on who attended at the dispensary outpatients for treatment, he responded: ‘the very poorest of the population’. Thom was very clear. ‘Patients seek advice owing to an inability to pay a general practitioner’.²⁶

In the decades under study a whole range of medical charitable endeavour existed for the porous category of non-pauper poor ‘just above actual pauperism’. Such poor were commonly described in Scottish medical literature as occupying ‘the boundary line between self-support and parish help’.²⁷ At the interface of parochial (or public) relief

²⁶ Evidence of James Maxtone Thom, (*Royal Commission*) *Poor Law and Relief of Distress, Appendix Vol. VI.: Minutes of Evidence, 95th to 110th Days, and 139th and 149th Days, with Appendix* [RC Poor Laws and Relief of Distress] (PP Cd.4978, 1910), Appendix CXLIV.

²⁷ ‘The boundary line between self-support and parish help’ was a common phrase and common distinction. See Jane K. Lorimer, *Ten Years Medical Mission Work in Glasgow* (Paisley, Glasgow and Edinburgh, 1878), p. 9; *Glasgow Medical Missionary Society Annual Report* (1876), p. 10; *The Scotsman* (11 Dec, 1896), p. 4, and (11th February, 1895), p. 7; William George Black, *A handbook of Scottish parochial law:*

and charitable and medical missionary (or private) relief was a fundamental legal distinction. Quoting Thomas Chalmers: ‘a poor man is a man in want of adequate means for his own subsistence. A pauper is a man who has this want supplemented in whole or in part out of a legal and compulsory provision’.²⁸ Distinction was made between what was referred to in Scotland as constituting ‘legal,’ public, ‘necessary’ or ‘monied’ medical provision *on one side*, and non-obligatory private-charity, voluntary or ‘moral’ medical provision *on the other*.

In considering public-private interface the term ‘public’ is used to refer to government or state managed provision funded by compulsory contribution: the public medical care service in the period looked at here being the poor law service. The antonym ‘private’ is a more ambiguous term. It can imply the unregulated. It can also imply the *indirectly* regulated. The latter, generally, is how it is understood here, given that qualified medical practitioners were actually regulated under a distinct law after 1858, and that medical charities, as forms of association organised along the lines of other limited companies, were also regulated. ‘Private’ also implies the market-driven, and the individualistic endeavour: both aspects characterised medical charity. It implies too the private domicile of the home. Despite the various connotations, here ‘private’ should be taken to imply what constituted voluntary charitable provision as opposed to state-funded poor law provision unless otherwise stated. None of this is meant to imply a simple polarity between private and public. The relationship between the state and private charity is often ‘symbiotic’, with private charity operating within the legal framework of the state.²⁹ The term ‘public’ when opposed to the term ‘private’ can denote notions of inclusiveness versus notions of exclusiveness. However, the division is again not so straightforward.

other than ecclesiastical (Edinburgh, 1893), p. 133, made the legal point that a ‘wide distinction’ existed in Scotland between those treated as ‘the legally poor’ and: ‘the poor who are ill-off truly – just barely raised above the condition of pauperism, but who are... not legal objects of relief’; Abijah Murray, Chief Clerk of the Local Government Board of Scotland, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 53882; Edinburgh practitioner Joseph Bell, RC Poor Laws and Relief of Distress (Cd.4978), Appendix X; and G.W. Balfour-Kinnear, Honorary Secretary of the Edinburgh Provident Dispensary, RC Poor Laws and Relief of Distress (Cd.4978), Appendix X.

²⁸ Thomas Chalmers, *The Christian and civic economy of large towns* (Glasgow: 1823), p. 397, quoted in A.C. Cheyne (ed.), *The Practical and the Pious: Essays on Thomas Chalmers* (Edinburgh: Saint Andrew Press, 1985), p. 131.

²⁹ John Mohan and Martin Gorsky, *Don’t Look Back? Voluntary and charitable finance of hospitals in Britain, past and present* (London, ACCA 2001), pp. 17-18.

Individuals could move in and out of different services as circumstances changed³⁰ 'Interface' is also simply meant. It refers here to the (shifting) boundaries and interactions between services, and to gaps – practical, physical or ideological - between the approaches of different sets of service providers. In Scotland the boundary lines between types of charity were mostly well understood (if fluid) and had spatial and ideological dimensions both. In physical terms all British cities were subject to philanthropic campaigning and other forms of social management. They were criss-crossed by a web of zones of interest by different public and private organisations, each keen to establish local territorial rights and demarcate spheres of influence and responsibility. Thus as was noted in 1909: 'Some years ago an understanding was arrived at between four of the general dispensaries in Edinburgh by which they undertook to restrict their work to certain districts... This understanding applies more particularly *to patients visited in their own homes*'.³¹

Whilst it might have been extensive, I am not here directly interested in the range of alternatives or peripherals to professionally provided medical care also involving visits to the homes of the poor, except as and where these affected or supplemented treatments provided by qualified medical practitioners. This focus on the poor, as defined, rules out study of friendly society services, trade union arrangements, and other self-help, benevolent, co-operative or assurance working-class forms of provision. These in Glasgow and Edinburgh (like other British cities of the period) were numerous, although the poor could not ordinarily afford them. Whilst numerous, there is evidence that in Edinburgh, and to a lesser extent in Glasgow too, albeit for slightly differing reasons, levels of friendly society membership were proportionally lower than elsewhere in towns across Britain, and lower than might be expected. There is suggestion that this lower

³⁰ The concept of public-private interface is explored by Giovanni Gurgel Aciole da Silva, 'Uma abordagem da antinomia 'público x privado': descortinando relações para a saúde coletiva' in Interface, vol. 3 (Botucatu: 2007), translated by Evanir Brunelli and made available on the Scielo Website: < <http://socialsciences.scielo.org> > [accessed May 1st, 2008]. Da Silva refers to 'the Babel of meanings and senses surrounding the "public-private" pair'.

³¹ RC Poor Laws and Relief of Distress (Cd.4978), Appendix C. A.C. Kay and H. V. Toynbee, *Report to the Royal Commission on the Poor Laws and Relief of Distress on Endowed and Voluntary Charities in certain places, and the Administrative Relations of Charity and the Poor Law* (P.P. Cd.4593, 1909) Appendix, Vol. XV, p. 242.

proportional uptake of membership correlated to greater than average levels of locally available supply of medical charity.³²

The focus on professional medical services also rules out forms of domiciliary medical relief provided by unregistered practitioners or other ‘quacks,’ for example bonesetters, druggists and travelling salesmen, unregistered midwives or other local ‘skilly’ women. In this period most babies were delivered at home but, whilst it is discussed, this aspect of medical work is not a particular focus for the history of midwives in Scotland has been well-explored elsewhere.³³ The focus of this thesis also rules out close attention on home treatment provided in the form of self-dosing or self-medication, or via hand-me-down traditional folk remedies, or treatments dispensed via mothers, housewives and neighbours. In stating this I readily accept the point that these self-help or informal forms – be they via home-made concoctions, traditional remedies, or stock or patent medicines acquired from local chemists or via more informal networks - were almost certainly the most common type of at-home medical treatment available, and the first resort for most of the poor when sick.³⁴ In addition, little will be said about inspection and surveillance visits by public health or sanitation department inspectors. Medical practitioners employed as medical officers of health were not directly engaged to administer treatment and prescribe medicines (although they obviously did impart ‘medical’ advice in attempts

³² Kay and Toynbee, Report to the Royal Commission (Cd.4593), notes that with an adult membership of permanent Registered Friendly Societies in Edinburgh in December 1905 of just 19,635 (or 6.2% of Edinburgh’s population) that this was much lower than other urban centres in Britain, and remarkably low given the social stratification of the city. These membership numbers equated to 21.4% of males above 14 years of age in friendly societies in Edinburgh. A higher figure of 32,450 was given by George Smith, J.P., president of Edinburgh & Leith District Friendly Society Council to RC on Poor Laws and Relief of Distress, (Cd.4978), App. CXXVI. John McC. Johnston, RC Poor Law and Relief of Distress (Cd.4978), Evidence 60150, argues that Scotland as a whole lacked the level of workmen’s medical clubs that could be found in English towns.

³³ For full list of recent sources on midwifery see bibliographies in Lindsay Reid, ‘Scottish Midwives 1916-1983: The Central Midwives Board for Scotland and Practising Midwives’, unpublished PhD thesis (University of Glasgow, 2003) and Ann Cameron, ‘Midwifery in Scotland, ca 1650-1820: an investigation of popular traditions and the impact of ‘Professionalization’, unpublished PhD thesis (University of Glasgow, 2003).

³⁴ The obvious point is that unless given without charge seeing the doctor was the most expensive alternative for the sick poor. For example, M.V. Everett, Glasgow Charity Organisation Society (COS) Visitor, *The Glasgow Herald* (Mar. 15, 1907), p. 4. Melodramatically, John V. Wallace, RC Poor Laws and Relief of Distress (Cd.4978), evidence 60312/9-12, argued that: ‘When the income is small, and sickness occurs in the family, fatal delay takes place in sending for medical skill. Every home effort, with the assistance of a powder, etc from the chemist, is first tried, and the doctor is called in to witness the end and grant a certificate...’

to reduce hazards to health). Police surgeons are also omitted because practitioners employed both as public health officials and police surgeons dealt with a broader clientele than just the poor.³⁵ Both the work of police surgeons and that of the medical officers of health are vast subject matters in their own rights warranting dedicated study. Despite claims regarding the spread of insurance to the 'lower social classes' during the later decades of the nineteenth century, and despite the fact that it has been argued perhaps one in six regular medical practitioners in Scotland were engaged in insurance activities as officers, examiners or referees, focus upon the poor rules out life insurance.³⁶

It should also be stressed that this thesis is particularly focused on medical practitioners going into homes in various guises as agents of public or private charity rather than the same medical practitioners who might also have, and in many cases almost certainly did, find occasion to visit the poor during the ordinary course of routine private practice. This is largely a pragmatic decision: quite simply medical charities have left far richer accounts documenting and justifying their activities than have rank and file medical practitioners.³⁷ Whilst dedicated domiciliary nursing provision for the poor in Scotland can be traced to the period of interest here, nursing care is also not central to this study.

This thesis looks specifically at provision in Scotland's main towns. In large urban centres, where charitable services were extensive, the onus of responsibility on individual medical practitioners to bear the burden of gratuitous treatment of the poor as an offshoot of their regular private practice activities was far less than in smaller, more isolated communities.³⁸ Where patients could not afford to pay, there is evidence that some

³⁵ Dr James Devon, President Edinburgh & Leith District FS Council to RC on Poor Laws and Relief of Distress, (Cd.4978), Appendix XLI, para. 3/4. On the full list of duties of police surgeons - including administrative, evidential, public nuisance reporting and sanitary inspection duties- see James Christie, *The Medical Institutions of Glasgow: A Handbook* (Glasgow: 1888), pp. 146-8.

³⁶ Dupree, *Other than healing*, pp. 79-103.

³⁷ Exceptions can be found. An example of a memoir that is especially informative of the work of medical practitioners amongst the poor is Clement Bryce Gunn, *Leaves from the Life of a Country Doctor* (Edinburgh and London: Ettrick Press Ltd, 1947) (1st published 1935). An example of surviving book of practice accounts is RCPSG College Library Collection, ref 1/20/3/7, 'Yearly Abstracts book of John Mathie and J. W. Mathie' (provenance unknown).

³⁸ That some private practitioners even in Scotland's main cities did find themselves backed into treating poor patients for free was reflected upon by W. Leslie Mackenzie in evidence, RC Poor Law and Relief of

medical practitioners cannily and routinely redirected or ‘referred’ patients to one or other charity service or the poor law.³⁹ It is one of the contentions of this thesis that in Glasgow, medical men, rather pragmatically, came to conceptualise involvement in the public service of poor law medical work as a form of charitable work by proxy. Seeing a virtue in necessity, grievance over pay (a major bugbear of serving medical officers) accentuated notions that poor law medical service represented just another form of charitable work (be it with some marginal financial reward attached). A sense of the duty ingrained in Scottish traditions of medicine philanthropy is perhaps one reason why able men in a city like Glasgow or Edinburgh continued to be drawn to it.⁴⁰

Whilst in certain working class areas in Britain some enterprising local practitioners provided different locally tailored and mutually beneficial forms of spread-the-cost payment plan or ‘penny’ savings clubs for hard-up patients, due to lack of evidence found on the subject for Glasgow and Edinburgh these options are not explored here. In any case, such ‘undercutting’ schemes would have found little favour amongst the well-populated, vociferous local medical societies. These societies invested much time in establishing mechanisms for smoothing inter-professional rivalry in populous medical markets, including commonly agreed member tariff schedules for visitation. Witnesses to the Royal Commission on the Poor Laws and Relief of Distress, 1905-7 – a major enquiry into medical provision for the poor in the decades to the 1900s, and therefore a major source for the study here - denied that the phenomena of the ‘sixpenny doctor’ was much to be found in any of Scotland’s main cities.⁴¹

Finally, in the attempt to map in specific local historical contexts the sheer range and diversity of medical agencies employing medical professionals for the task of home

Distress (Cd.4978), 56880: ‘At the present moment [private practitioners] ... are saddled with cases that they cannot very well refuse, and yet they can never get a copper for them.’

³⁹ R. H. Blaikie, M.D., Edinburgh, RC Poor Law and Relief of Distress (Cd.4978), Appendix XVIII.

⁴⁰ Brotherston and Brims, Introduction to Improving the Common Weal, p. 27; Evidence of John C. McVail, RC Poor Law and Relief of Distress (Cd.4573, 1909) Appendix XIV, p. 148. The sense of civic obligation is strong in the resignation letter of Glasgow Parochial Medical Officer George R. Mather in 1883. See City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/3 (June 21st 1883).

⁴¹ Dr William Limont Muir, representative of the B.M.A. and Scottish Poor Law Medical Officer’s Association, RC Poor Law and Relief of Distress (Cd.4978), 58038f. Asked by the Rev. L.R. Phelps: ‘Have you any large class of sixpenny doctors in Scotland?’ Muir replied: ‘I only know of one in Glasgow.’

visitation and domiciliary treatment, this study seeks to open up new lines of enquiry concerning attitudes to the poor law, charity and medical mission work of providers, supporters, recipients and their families before World War One. It seeks too to explore views of the sick-poor, and to deepen our understanding of the range of, and approach to, contemporary treatment. In his study *Family Life and Social Control*, Rodger evaluates practitioner-patient relationships by seeking to develop an understanding of the constraints and organisation of those relationships, arguing that ‘the most important issue when considering [any] intervention is how clients are to be managed’.⁴² The agencies sending medical practitioners into the home of the poor were the managers of those relationships. They are therefore the obvious starting point of any enquiry into domiciliary medical care.

Plan

Chapter One of this thesis sets parameters for historical study of domiciliary medical care for the poor by establishing a working literature. Working within these parameters, Chapters Two, Three and Four look in turn at provision of public and private charity, by the poor law, medical charity and medical missions.

The linchpin of the poor law medical service was the poor law “medical man” or “medical officer” as he later became known. Apart from the inspector, who was obliged by statute to visit paupers in their homes at least twice a year, he was the only person – with the exception of the parish minister – who ever saw the poor as they really lived amidst their suffering from fevers, bronchitis, rheumatism, pneumonia, consumption, “the itch” (probably scabies) and diseases of the eye.

William Watt Groves (1991)⁴³

Chapter Two is a study of outdoor medical provision under the Scottish poor law. It seeks to deepen historical understanding of the public aspect of medical home visitation of the poor in Scotland, 1875-1911, by looking at what is established as the most active domiciliary treatment provider at this time. Focus falls on the nature, organisation and provision of parochial medical care, and more particularly, the poor law medical officers

⁴² John J. Rodger, *Family Life and Social Control: A sociological perspective* (Basingstoke: Macmillan, 1996), p. 41.

⁴³ William Watt Groves, ‘The Administration of the Poor Law in Lanarkshire, 1845-1894’, unpublished PhD thesis (University of Glasgow, 1991), v.1, p. 421.

described by Groves as ‘the linchpin’ of Scottish parochial medicine, and the most expensive element of be-it a rather inexpensive outdoor medical system (Table 2.4). Medical relief in Scotland in this period remained typified by local vagaries in service. Issues explored touch on services across Scotland although concentration is on the culture of parochial practice in one key urban locality, Glasgow (including here the parish of Govan). The decision to focus upon this city was a practical one, dictated both by the excellent quality of the surviving parochial records in Glasgow City Archives and as well by the fact that parochial records in Edinburgh are ordinarily not available to researchers.⁴⁴

Each aspect of poor law medical care has been much criticised in the past. Quality, manpower, standards, scope, management, focus, and ambition: all these elements of poor law medical services across Britain have long been misunderstood, or found wanting. Because of the method for determining pauper relief entitlement, any comprehensive study of the poor law in Scotland must by default concentrate on the local medical service: this means focus upon the private practitioners engaged in the treatment and visitation of the poor as a public duty.⁴⁵ Understanding the atomised nature of the medical officer’s work is crucial to understanding the whole picture. Referred to in the literature either as *district medical officers*, *poor law medical officers*, *parish doctors*, or *district surgeons* (the term most widely used in the Scottish records of the early years), under particular focus in part two of this thesis is the collective profile of the outdoor parochial medical officers employed under the poor law in Britain: for convenience sake, parochial medical officer (PMO) is used hereafter.

Most historians of both the English and the Scottish Poor Laws present a rather disparaging and restricted view of the men that provided the medical treatment. Christopher Lawrence’s study of British medical men engaged under the new poor laws

⁴⁴ During preparation for this thesis this historian was advised by the Edinburgh City archivists that most Application for Relief ledgers and other administrative document for Edinburgh and Leith parishes have been lost. It is now understood that this might not actually be the case (being simply a ploy used to limit requests for access)!

⁴⁵ Sir George Newman, *The Rise of Preventive Medicine* (London: Oxford University Press, 1932), pp. 253-4.

of England and Scotland is typical in showing a simple dichotomy between the elite of the medical profession in the hospitals and the lowly rank-and-file who undertook parochial work.⁴⁶ Waddington's recent anthology of health and medicine in nineteenth century Britain describes a varied, unsystematic, 'piecemeal and pragmatic' poor law service marked by 'low levels of pay'; by the discouragement of 'the better-qualified from applying'; by medical officers who were 'overstretched and subservient to Guardians and Relieving Officers' [English terms]; by 'heavy workloads... [leading] to incidences of neglect'; and by an administration that was 'cumbersome' and characterised by 'parsimony and ignorance'.⁴⁷ McCrae's recent work on Scotland, when describing what came before the NHS, also points to a 'rudimentary' and 'unsatisfactory' poor law medical service, manned by graduates.⁴⁸

A stereotype was early established. The traditional view of the PMO can be seen in an early form in the much reproduced *Punch* magazine caricature of 1848 (Appendix I). In essence the image it created depicts the medical men who worked under the poor law across Britain as a universal set of put-upon, inexperienced and insecure medical practitioners engaged in unrewarding struggle in an inadequate and unvalued service. The cartoon works in two ways by seeking to lampoon both the types of person that routinely sought election to parochial boards, as well as the parish doctors. Criticisms of elected officials in Scotland were long lasting.⁴⁹ In July 1899, *The Lancet* had reinforced the view that: 'Without any disrespect to Parish Councils, they are often made up of a number of gentlemen possessed of but little medical knowledge, and without the experience and judgment necessary to pass an opinion on matters medical.'⁵⁰

⁴⁶ Christopher Lawrence, *Medicine in the Making of Modern Britain 1700-1920* (London: Routledge, 1994), p. 68.

⁴⁷ Keir Waddington, 'Health and Medicine' in Chris Williams (ed.) *A Companion to Nineteenth-Century Britain* (Oxford: Blackwell, 2004).

⁴⁸ W. Morrice McCrae, 'The Scottish Roots of the National Health Service,' unpublished PhD thesis (University of Glasgow, 2000), p. 219.

⁴⁹ Evidence of John Hill and Mrs Greenlees, Govan Parish Councillors, RC Poor Laws and Relief of Distress (Cd.4978), Appendix LXIX and LXIII. On standards of elected officials see E.P. Hennock, *Fit and Proper Persons: Ideas and Reality in Nineteenth Century Urban Government* (London: Edward Arnold, 1973), and Steven King, "'We Might be Trusted': female poor law guardians and the development of the New Poor Law: the case of Bolton, England, 1880-1906' in *International Review of Social History*, no. 49 (2004), pp. 27-44.

⁵⁰ *The Scotsman* (7 July, 1899), p. 9.

Added to the traditional picture and reinforcing the negative impression is a scattering of partisan, purposive contemporary material, such as the perennial complaints of underpay and insecurity of tenure that were leveled by, and on behalf of, vested interests such as the Scottish Poor Law Medical Officers' Association (SPLMOA).

Our Gideon Grays are certainly entitled to some consideration. Many of them are scientific physicians in the highest sense of the term, and yet they are miserably paid and scandalously treated. A man who has gained the highest honours in the course of time is appointed medical officer to the Parochial Board. They give him £10 or £15 per annum as salary, and too often out of this wretched pittance he is bound to provide the drugs which he requires. After he has grown grey in their service, a young fresh from college settles in the parish; he knows little or nothing of the practice of his profession...a canvas is immediately commenced on his behalf...Gideon Gray receives notice to quit. Such a system is disgraceful.⁵¹

The seminal work of Sidney and Beatrice Webb has also been extremely influential on historians interested in poor law medicine, and there was always a tendency to quote selectively from a few examples of poor quality service. In particular the medical practitioners that served the poor law across Britain suffer from a viewpoint that owes much to the longevity of criticisms that emanate from the findings of the Webb-influenced Poor Law Royal Commission Inquiry of the first decade of the Twentieth Century.⁵² Recent work by Alan Kidd makes the point that much historical writing on the pre-1911 period looks at the subject teleologically by anticipating the rise of curative

⁵¹ *Poor Law Magazine*, vol. V (Edinburgh: 1877), p.294.

⁵² For the 'Webbian' view see Beatrice Webb, *The relation of poor-law medical relief to the public health authorities* (Bristol: Wright 1906); *The Minority Report of the Report of the Royal Commission on the Poor Laws and Relief of Distress* (RC Poor Law Minority Report)(London: Wyman 1909) (Command Paper, 4499); Beatrice Webb, *The Poor Law Medical Officer and his Future* (London, National Committee for the Break-up of the Poor Law, 1909); Beatrice Webb, *The Minority Report in its relation to public health and the medical profession* (A paper read before the Society of Medical Officers of Health, January 14, 1910)(London, National Committee to Promote the Break-up of the Poor Law, 1910); and Sidney and Beatrice Webb, *The State and the Doctor* (Longmans, Green & Co, London 1910). F.B. Smith, *The People's Health, 1830-1910* (London: Weiderfeld and Nicolson, 1990), p. 424, points out that the Webbs created a 'new historical understanding': 'The groundwork for a new pattern of national redistributive expenditure was laid by Sidney and Beatrice Webb... They and their colleagues produced the information which exposed the old poor Law system of medical relief as morally and administratively intolerable.' Quote taken from a review of American publication of the Webb's *The State and the Doctor* in *The American Political Science Review*, vol. 5 no. 3 (Aug. 1911), pp. 468-471.

systems and state welfare systems, and through the prism of the Webbian view.⁵³ Imbued with scientific positivism, and coated in the language of contemporary concern for national efficiency, the Webbs' writings were both heavily ideologically grounded and distinctly purposive. They were designed not as considered and objective histories of the poor law but with the intention to influence a changed role for the doctors within the state apparatus, and for the state within ordinary people's lives. They attacked what they saw as the 'wrong headedness' of state medicine as it had previously existed.⁵⁴ The bulk of the Webbs' criticisms were therefore aimed at what PMOs had not previously been expected to do (that is, provide a preventive service) rather than what they actually did.

Jeanne Brand's pioneering study on the rise of state employment for British medical men during the nineteenth century is typical in leaning heavily on both the analysis and the carefully selected evidence of the Webbs.⁵⁵ Ironically, and despite his criticism of other overly Webb-inspired analyses, Kidd's own summary of the English poor law medical service also follows the Webbian line, that:

The [poor law medical] service remained parsimonious and fraught with contradiction. The medical officers were paid very little and doctors were only willing to compete for the posts because their profession was overstocked and income had to be sought from a variety of sources... it was lowly work and the guardians generally regarded their medical officers as servants. They were paid little and were often obliged to provide medicines out of their own pockets. In addition, the prime rationale of medical relief remained the relief of destitution, it was not conceived as a health service. Hence the decision about whether an applicant for out-relief needed medical attention was generally made by the union's relieving officer and not its medical officer.⁵⁶

It is only in recent studies with a local focus that a more sympathetic portrayal of PMOs has emerged.⁵⁷ Thus Marland has found for northern English towns in the period studied

⁵³ Kidd, *State, Society and the Poor*, pp. 6-7. See also Martin Daunt (ed.), *Charity, Self-Interest and Welfare in the English Past* (London: UCL Press, 1996), p. 1; and W. Hamish Fraser, *A History of British Trade Unionism, 1700-1998* (Basingstoke: Macmillan 1999), p. 1.

⁵⁴ Webb, *The State and the Doctor*, preface, p. vi.

⁵⁵ Webb, *The Poor Law Medical Officer and his Future*, p.4, quoted by Jeanne L. Brand, *Doctors and the State* (Baltimore: John Hopkins Press, 1965), p. 93.

⁵⁶ Kidd, *State, Society and the Poor*, p. 41.

⁵⁷ Hilary Marland, *Medicine and society in Wakefield and Huddersfield 1780-1870* (Cambridge: Cambridge University Press, 1987); Joan Lane, *A social history of medicine: health, healing and disease in England, 1750-1950* (New York: Routledge, 2001); and Samantha Williams, 'Practitioners' Income and Provision

that poor law posts in these places, in fact, ‘attracted an especially high calibre of medical men.’ Explaining why an unexpected number of ‘calibre’ men could be found engaged in what history had established as lowly work, Marland pointed to the competitive advantage inherent in public appointment and to the idea that good medical men did not necessarily a good parish service make. Qualifications, she argued, must be weighed in context: against opportunity, against attitude and motivation, against fitness for the specific task at hand, and against a person’s conscientiousness and compassion.⁵⁸ Lane has used evidence from Bristol to arrive at similar conclusions about the high calibre of poor law doctors, noting that however he should be regarded, ‘the parish surgeon was the same practitioner who also treated others in the community’.⁵⁹

In reassessing the work of PMOs a number of hypotheses are explored in Chapter Two.⁶⁰ Firstly, local factors were extremely important in the operation of Scottish poor law policy. Secondly, that facilitation to all forms of poor relief was as important as the specific provision of medical care in the work of PMOs in Scotland. Thirdly, the PMOs were not at any stage the poor relations in terms of status amongst their medical brethren, in the larger, urban parishes in Scotland. Fourthly, that the medical treatment of paupers was recognised to be of a comparable standard to that available generally to the working-class population, and in many cases perhaps even better: standards within parochial medical services were monitored in a way routine private practice was not. Fifthly, avenues of co-operation and communication did exist between what were formally fragmented strands of state and voluntary service, despite protestations to the contrary. Sixthly, the generic bottle of medicine was, and has been since, misunderstood, and therefore significantly undervalued. Seventh, and most fundamentally, that medical officers involved in the system in Scotland did not fit their stereotyped image.

for the Poor: Parish Doctors in the Late Eighteenth and Early Nineteenth Centuries,’ in *Social History of Medicine* Vol. 18 No. 2 (2005), pp. 159-186: Lane focuses upon Bristol and Williams upon London.

⁵⁸ Marland, *Medicine and society*, p. 77 & 79.

⁵⁹ Lane, *A social history of medicine*, p. 45, 47 & pp. 63-5.

⁶⁰ David Sutton, ‘Grateful For Small Mercies’, unpublished MPhil Dissertation (University of Glasgow, 2001), p.14. The working hypotheses outlined are established in this dissertation.

In addition to the men that operated the system, the local organisation of parochial medical provision also comes under scrutiny in part two of the thesis. Levitt and Blackden have both conducted extensive research into Scottish parochial medicine in the nineteenth century, and both emphasise the importance of the Local Government Board for Scotland and the Board of Supervision in instigating necessary improvements in the medical service in Scotland.⁶¹ They argue that the central authorities acted through both coercion and the strategic use of indirect mechanisms of control. Whilst both historians downplay any notion that the interests of the central and local parish boards were consistently confrontational, the concentration on the supervisory work of the central authorities in Edinburgh has left the impression that there was no effective local supervision of the outdoor medical care service. For the larger parishes, as indeed Blackden has acknowledged, this is not the case.⁶²

In Chapter Three focus shifts from public provision in the form of poor law services onto private provision for the poor, outdoors, by voluntary medical charity. A range of different type of medical charity is identified as providers of domiciliary care for the poor. Most substantially, visitation work amongst the poor was carried on by numerous independent general charity medical dispensaries. British 'dispensary doctors' have enjoyed a mixed reputation. It was often complained that they were popularly - if mistakenly - seen as a cut above the regular medical practitioner. This was much to the chagrin of those medical practitioners without such honorary appointment.⁶³

Despite Croxson's recent claims that too much medical history is focused on the hospital, different aspects of outdoor charity dispensary and charitable giving have been

⁶¹ On the work of the LGBS see Stephanie Blackden, 'The Board of Supervision and the Scottish Parochial Medical Service, 1845-95' in *Medical History No.30* (Wellcome Institute, 1986); Ian Levitt, *Poverty & Welfare in Scotland, 1890-1948* (Edinburgh: Edinburgh University Press, 1988); and Ian Levitt (ed.), *Government and Social Conditions in Scotland 1845-1919* (Edinburgh: Social History Society, 1988). See also Thomas Ferguson, *Scottish Social Welfare 1864-1914* (Edinburgh & London, Livingstone, 1958), and Helen M. Dingwall, *A History of Scottish Medicine* (Edinburgh University Press, 2003), p. 173.

⁶² Blackden, *The Poor Law and Health*, pp. 255-6. In recent years there has been a much greater questioning of the desirability of centralism and of 'mammoth bureaucracies in Whitehall'. See, for example, 'Trust the locals,' in *The Economist*, v. 382 no. 8513 (January 27-February 2 2007).

⁶³ *The Scotsman* (26 Dec, 1887), p. 7.

explored.⁶⁴ Historians have, for example, traced the eighteenth century origins of the charity dispensary movement in Britain, and the rise of organised charity in the nineteenth century. They have looked at the usurpation of 'traditional' almsgiving by impersonal forms of giving; and at the proliferation of medical charity in the social, political and economic context of different locations. Some studies explore funding and financial crises. Others concentrate upon the development of specialist medical services; or upon the development of referral systems, and at tiers of elitism. Others yet concentrate upon the role of local elites as lay patrons in shaping treatment priorities in a particular place; and the role of different dispensary institutions and medical charities, in turn, in shaping production of local medical knowledge.⁶⁵ From this list of topics of dispensary charity explored by historians there is one glaring, repeated absence: domiciliary medicine. Yet as Croxson's work on dispensary charity in eighteenth century London notes in its introduction, treatment of 'patients in their own homes' was one of the most important distinctions to be made between dispensary and hospital services.⁶⁶

Waddington's study of medical charitable giving in London points to what he terms the 'amorphous' nature of voluntarism in Britain in this period, suggesting (like Croxson) multiple layers of motive for philanthropic action in the city environment. Giving to medical charity at this time, Waddington says, was motivated by complex of impulses: evangelicalism; humanitarianism; obligation; social duty; sense of guilt; secular 'socialisation' concerns; social pressure; self interest; concern for national efficiency; concern for the 'safe' training of future medical professionals; desire to prevent contagion; social cachet; emulation; self-aggrandisement; or/and sense of personal

⁶⁴ Bronwyn Croxson, 'The public and private faces of eighteenth-century London dispensary charity', in *Medical History*, 41 (1997), p. 128: 'Dispensaries have received little attention from historians'.

⁶⁵ Sir Zachary Cope, 'The influence of the free dispensaries upon medical education,' in *Medical History*, 13.1 (1969); Irvine Loudon, 'The origins of the dispensary movement in England,' in *Bulletin of the History of Medicine*, 55 (1981); Frank Prochaska, *The voluntary impulse: philanthropy in modern Britain* (London: Faber, 1988); Donna Andrew, *Philanthropy and police: London charity in the eighteenth century* (Princeton, N.J.: Princeton University Press, 1989); Martin Daunt (ed.), *Charity, Self-Interest and Welfare in the English Past* (London: UCL Press, 1996); Ronald D. Cassell, *Medical Charities, Medical Politics: The Irish Dispensary System and the Poor Law 1836-1872* (Suffolk: Royal Historical Society, 1997); Keir Waddington, *Charity and the London hospitals, 1850-1898* (London: Royal Historical Society/Boydell Press, 2000); Joan Lane, *A Social History of Medicine, Health, Healing and Disease in England, 1750-1950* (London & New York, 2001), ch. 5.

⁶⁶ Croxson, *Public and private faces*, p. 127.

gratitude. Philanthropy fulfilled an important social role, and rewards of patronage for both lay subscribers and medical practitioners who volunteered could include: personal political or professional gain; enhancement or affirmation of social status; influence; recognition; territorial advantage; networking opportunity; prestige; access; and (it was expected) the gratitude of those that were assisted by your kindness.⁶⁷ Speaking also of the social role of philanthropy in the modern liberal state, Mohan and Gorsky have highlighted that there is something essentially moral and socially reinforcing at core of voluntary charitable action. Associational activity creates ‘dense interpersonal networks,’ as different individuals involved in numerous different charities, as subscribers, administrators, managers, practitioners, or volunteer helpers, publicly interact.⁶⁸

Motivation to act is based on a complex multi-layer of beliefs, understandings, interests, ambitions, reflexes, and conditioning. Motivations for giving therefore are always ambiguous: few acts of charity are either purely selfish or completely disinterested.⁶⁹ To understand motives for medical philanthropy one need understand the social origin of the act of giving. For this reason, Marland argues, it is always important to embed study of dispensary charity in particular local social contexts.⁷⁰ The emphasis on local contexts does not mean that findings elsewhere are an irrelevance to developments in given locations: in places like Victorian-Edwardian Glasgow and Edinburgh neither city was isolated; each existed and operated in wider domains.

From a Scottish perspective, Brotherston and Brims’ overview of the field of medical charity and medical dispensary makes several important observations. They point out both that the number and range of institutions for the poor in Edinburgh and Glasgow in the decades before the beginning of the twentieth century proliferated greatly, and that this was a phenomena made possible by two key factors affecting demand and supply: the high levels of poverty and wealth in each city, and the presence of large, popular medical

⁶⁷ Keir Waddington, *Charity and the London hospitals, 1850-1898* (London: Royal Historical Society/Boydell Press, 2000).

⁶⁸ Mohan and Gorsky, *Don’t Look Back*, p. 19, referring to R. D. Putnam, et al., *Making democracy work: civic traditions in modern Italy* (New York: 1993).

⁶⁹ Donna T. Andrew, *Philanthropy and Police: London Charity in the Eighteenth Century* (Princeton University Press, 1989), p. 4.

⁷⁰ Marland, *Medicine and society*, p. 4.

schools in both vicinities.⁷¹ Elsewhere, Whatley's study of Scottish society provides a paternalist-model description of the origins of the dispensary movement in Scotland which returns focus onto the particular social context of giving, and in doing so points out how the logic of gratitude was fundamental in the founding of most Scottish charities.⁷² Additionally, Walsh's account of charity in nineteenth century Dundee provides a precedent for exploration of issues of medical philanthropy in a local, urban Scottish context.⁷³

The fact that patients stayed at home during treatment - even if they did not always receive treatment there - is, of course, ultimately what differentiates all forms of outdoor charitable dispensary medical service from indoor services. Attitudes towards domiciliary care provision in Scotland, as can be presumed, varied over time. Nationally, by the first decade of the 1900s, changing social, economic, military and medical priorities, encapsulated in the new century in considerations of 'national efficiency,' had put a renewed emphasis on the health of the industrial population. Issues addressed at the Fourth International Home Relief Congress, held in Edinburgh during June 1904, meant it became a forum of the efficacy of medical home visitation. Consideration of the work of this congress provides a natural end point for this part of this thesis.

The parable has often been taken up... that there is "something wrong" in the charity which feeds and clothes Jews and Gentiles of every tribe and tongue under the sun, and lets the sick and hungry and destitute at our gate starve.

From *The Scotsman* (1892)⁷⁴

The medical missionary work carried on from day to day in the Cowgate dispensary is *a model* of what goes on in Medical Mission Dispensaries all over the world.

Edinburgh Medical Missionary Society (1893)⁷⁵

⁷¹ Sir John Brotherston and Dr John Brims, 'Introduction' in Gordon McLachlan (ed.), *Improving the Common Weal: Aspects of Scottish Health Services 1900-1984* (Edinburgh University Press, 1987), pp. 29-30.

⁷² Christopher A. Whatley, *Scottish Society, 1707-1830* (Manchester University Press, 2000), p. 323.

⁷³ Lorraine Walsh, *Patrons, Poverty and Profit: Organised Charity in Nineteenth Century Dundee* (Dundee: Abertay Historical Society, 2000).

⁷⁴ *The Scotsman* (1 Feb, 1892), p. 6.

⁷⁵ *Edinburgh Medical Missionary Society Annual Report for 1893* (1894), p. 21.

Chapter Four of this thesis looks at a particular strand of private provision in medical missions. A shift in the focus of charity from overseas to domestic interests encapsulated in the parable above is reflected in the rise of ‘home’ medical missions. Amongst the home medical missions in Britain foremost was the Edinburgh Medical Missionary Society (EMMS), with its training dispensary on the Cowgate. Found in 1841, the history of all home medical missions can be traced from here. In its interest in medical missionary activity overseas, Glasgow originally paralleled Edinburgh. The direct Glaswegian counterpart to the EMMS, the Glasgow Medical Missionary Society (GMMS), was instituted in 1867.⁷⁶ This was a crucial time when medical mission dispensaries began to appear across a number of Britain’s cities. The GMMS was the second attempt to establish a medical missionary dispensary in Glasgow. Wynd Church Medical Mission had operated briefly between 1859 and 1862 before being abandoned. Overwhelmed by the demand generated, its three founders had quickly drifted back into more manageable realm of paid private practice.⁷⁷

The third-quarter of the nineteenth century was a vibrant time for evangelicalism and missionary causes. Brown notes of religion in Glasgow that: ‘the working classes became increasingly badgered by missionaries,’ and that ‘by 1850, when Free Church congregation missions were operating in the central slums of the major cities, home visitation was occurring at least once a month and sometimes more often.’⁷⁸ Different evangelical movements flared in different cities. One evangelical Baptist enterprise, started in 1859, led ultimately to the founding of Glasgow’s second great medical mission station. The Grove Street Institute (GSI) was a major edifice completed in 1865 in the off-theatre district of Cowcaddens. Two decades after opening, in 1886, a medical mission service was added to its existing set of operations. Together Scotland’s home

⁷⁶ *The Scotsman* (1 Feb, 1845), p. 3.

⁷⁷ Rev. D. MacColl, *Among the Masses; or Work in the Wynds* (London: 1867), pp. 212-6. Rev. Dugald MacColl of Bridgeton Free Church claims he inspired Wynd Church Medical Mission. It was operated by three Glasgow doctors. These included the later midwifery lecturer at Andersons College, James George Wilson M.D. Wilson became one of the original directors of the GMMS and was a link between the organisations. Abandoned in 1862 by the three practitioners due, it was said, to the press of private practice commitments, it had treated around 3,000 patients per year, with ‘most of these, of course, returning several times’.

⁷⁸ Callum G. Brown, *Religion and Society in Scotland since 1707* (Edinburgh: Edinburgh University Press, 1997), p. 103.

medical missions provided example and ideological underpinning for others. Edinburgh, in particular, was at the vanguard of a movement that swept across Britain's main provincial cities from the late 1860s and 1870s, and was looked to for its lead by other Western nations.⁷⁹

Medical missions are of specific interest here for they provided one of the most important domiciliary medical visitation services amongst the poor. They were significant service providers in terms of both the level of support received from the medical profession and general public, and in terms of the sheer numbers of sick annually treated. The home visit was sacrosanct. The perceived value of visitation amongst the poor, and of medicine as a hook for lost souls, meant an array of evangelical organisations adopted home based medical treatment into their armory.⁸⁰ Whilst the main object of a medical mission was 'to promote, in every possible way, the consecration of the healing art to the service of Christ,' home medical mission dispensaries in fact were multifaceted.⁸¹ Set down as citadels amongst the poorest environs and immigrant districts, 'home' medical missions were arguably the quintessential Scottish charity. Ardent, earnest and practical, and of Scottish origin, they consciously reflected traditional Presbyterian values of pious,

⁷⁹ Home medical missionary dispensaries were established in Liverpool (1862 and 1871), Manchester (two in 1870), London (after 1871), Bristol (1872), and Birmingham (1874). They were also established in smaller town like Monkwearmouth in the north of England in 1873 and Oldham in 1875. For many the links to Edinburgh were crucial, with the EMMS providing inspiration, a template and/or staff. The training institution at Edinburgh also directly influenced subsequent institutions abroad, such as the work of Miss de Broen in Belleville, Paris, the facility at Tübingen, opened by the Combined Missionary Associations in Germany in 1909, and at Battle Creek, Michigan. Home medical mission dispensaries also opened in Philadelphia (1879) – per the *Quarterly Papers of the Edinburgh Medical Missionary Society* vol. 3 (Edinburgh: 1883), p. 137, 'the first American Home Medical Mission' -, New York and Chicago (early 1880s), Dublin (in the 1890s) and Toronto (in 1900). On the spread of home medical missions see Kathleen J. Heasman, 'The Medical Mission and the Care of the Sick Poor in Nineteenth-Century England,' in *The Historical Journal*, vol. 7, no. 2 (1964), pp. 233-8 and Kathleen Heasman, *Evangelicals in Action: an appraisal of their social work in the Victorian era* (London: Geoffrey Bles, 1962), p. 226. Edinburgh and especially the EMMS was not only an inspiration to protestant medical missions. A direct lineage through individuals like Dr. Agnes McLaren – who trained in Edinburgh under William Burns Thomson – can also be traced to retaliatory Catholic organisations, like the Catholic Medical Mission Institute in Wurzburg, Austria (founded 1922), and the Society of Catholic Medical Missionaries, founded 1925. On this see Katherine Burton, *The Story of Dr. Agnes McLaren and the Society of Catholic Medical Missionaries* (New York and Toronto: Longmans, Green 1946); *Catholic Archives: The Journal of the Catholic Archives Society* no. 8 (1986), pp.73-81; and Anon., *The Pioneer in Medical Mission Work: Doctor Agnes McLaren, Physician, Convert, Missionary* (c.1940), held in Edinburgh National Archives, ref: HP1.86.2695.

⁸⁰ On the value of medicine see, for example, R. Fletcher Moorshead, 'What is a Medical Mission?' in *Baptist Missionary Herald* (January 1903), republished in EMMS Quarterly, vol. 10, pp. 340-41.

⁸¹ John Lowe (ed.), William Jackson Elmslie, *Medical Missions: as illustrated by some letters and notices of the late Dr. Elmslie* (Edinburgh: Edinburgh Medical Missionary Society, 1874), pp. 231-2.

discriminate, localised, purposive, intimate, voluntary, visitation-based Christian giving. David Livingstone, an iconic figure, was held as the embodiment. Typically Scots (and more especially typically Edinburghian), medical missions had both international and local focus.

The religious census conducted in Glasgow in 1871 quantified the task at hand. It concluded that in that city, even when excluding Roman Catholics, there was ‘a residuum (in round numbers) of 130,000 who are habitually neglecting all public means of grace.’⁸² Even before the Census there had grown a realisation (or belief) that medical provision could be used as a Trojan horse for bringing Christianity back into homes and lives of the urban poor. Outreach work had long been central to the traditional pastoral role of the Scottish church, and visits, be they medical or otherwise, provided agencies access, the ability to gauge needs as well as deserts, and opportunity to gain influence over whole families.

A range of themes are explored in Chapter Four of this thesis whilst emphasising the significance of domiciliary care in the range of work of ‘home’ medical missions: Scottish origins of medical missions; connections between imperial attitudes, overseas missions, training, and the home medical missionary movement; the social, cultural, political and economic underpinning of developments in different vicinities; the ideology and rationale justifying the home medical missionary service, and challenges and reactions to it; approaches to medical mission work, organisation and finance; how medical mission provision was incorporated into wider networks of charitable and medical services; the type of medical work undertaken, and the medical services and opportunities provided.

Study of home medical missions, useful in and of itself, becomes by default study also of the *major themes* of late Victorian-Edwardian society: of imperialism and global adventure; of the problems of urban poverty; of changing social relations; of middle-class

⁸² *Report on the Religious Condition of Glasgow* (Glasgow: the Association for Promoting the Religious and Social Improvement of the City, 1871). This report held as part of Mitchell Library Collections, Glasgow [ref: G266 022ASS].

involvement in public life; of the rise of the labour movement; of issues connected to Ireland and the Irish; of the rise of women in society; and of the impact of science and technology and changing religiosity. Study of medical missions also requires study of responses to them. The overtly evangelical nature of much voluntary charity in the urban setting was a great issue for Scotland's immigrant communities. Challenge led to 'pillarization,' with disgust and derision within communities at 'soupers': that is, people considered willing to trade faith for temporary pecuniary or bodily relief.⁸³ Thus if the homes of the poor generally could be described as battlegrounds amongst different agencies seeking influence – Behlmer (Figure 1.1) - the homes of the non-Protestant poor, 'cling[ing] to their rags, their faith, and their filth,' proved doubly so.⁸⁴

The response to proselytising 'Christian' charity aimed at immigrant European Jews flooding into Scotland's cities around the turn of the twentieth century has been looked at in the work of Kenneth Collins.⁸⁵ Here attention is instead on the larger Catholic-Irish community. Of particular interest is the small knot of medical practitioners who emerged from the burgeoning first generation of Scots-born Irish-Catholic middle-class from mid-century, with focus necessarily falling upon the St Vincent de Paul Society (SVDP) as the most prominent Catholic visitation welfare agency.⁸⁶

Sources

In preparing this thesis this research uses a wide range of available sources. A list includes: surviving parochial board records; public health and police records and

⁸³ *The Scotsman* (2 Dec, 1891), p. 6, and (25 Feb, 1909), p. 6. Sheridan Gilley, 'Catholics and Socialists in Glasgow, 1906-1912' in Kenneth Lunn (ed.), *Hosts, Immigrants and Minorities* (Folkestone: Dawson, 1980), p. 164.

⁸⁴ Quoted from J. Myles, *Rambles in Forfarshire* (1850) by W.M. Walker, 'Irish Immigrants in Scotland: Their Priests, Politics and Parochial Life' in *Historical Journal*, XV, 4 (1972), p. 651.

⁸⁵ Kenneth Collins (ed.), *Aspects of Scottish Jewry* (Glasgow: The Michael Press, 1987), p. 15: 'The stimulus to open the [Jewish] Dispensary [in 1911] was to combat the problems of Jews being enticed into the well-equipped dispensaries of missionary groups operating in the Gorbals, who used welfare facilities as a cover for conversionist activities.' Collins also notes (p. 44): 'The poor Jews of Edinburgh were the target of various Christian missionary groups.' See also Kenneth E. Collins, *Glasgow Jewry: a guide to the history and community of the Jews in Glasgow* (Glasgow: Scottish Jewish Archives Committee 1993); and Kenneth Collins, *Be Well! Jewish Immigrant Health and Welfare in Glasgow, 1860-1914* (East Lothian: Tuckwell Press, 2001).

⁸⁶ The only notable previous study on topic is Bernard Aspinwall, 'The Welfare State within the State: The Saint Vincent de Paul Society in Glasgow, 1848-1920,' in *Studies in Church History* vol. 23 (Ecclesiastical History Society, Basil Blackwood 1986).

accounts; institutional archives; census data; newspapers archives; popular-lay and medical journal articles; M.D. theses describing aspects of domiciliary medical care; advertisements describing available medical treatments, services, products, and appointments; general practitioner medical practice and dietary guidebooks; Medical Directory and Medical Register entries; obituary records; court records describing encounters between patients and practitioners and detailing practice partnerships; surviving records of different voluntary organisations active in the relief of the sick; minute books and records of medical society affairs and transactions; surviving private correspondence and accounts such that have been found left by medical practitioners; lived memories; and an array of fictional, autobiographical and ‘factional’ accounts of medical treatments in Scottish homes and practitioner-patient encounters. Many of these sources were used to produce a prosopographic dataset profiling the careers of Glasgow and Edinburgh’s PMOs. (Appendix IV). This is the primary analytical tool used in evaluating the value and nature of the domiciliary medical work carried on under the Scottish poor law in Glasgow and Edinburgh.

Three government enquiries conducted during the first decade of the twentieth century form the backbone of numerous studies of poverty relief and medical provision in Scotland this period.⁸⁷ Rich in detail, they provide rigorous assessments of the Scottish poor law and medical charity care. These three reports consist of two LGBS Poor Law Reports produced in close succession, plus one British-wide survey. The Poor Law Medical Relief (Scotland) Report came first. It had an investigating committee of five. It was appointed in July 1902, and presented in March 1904. The more radical if mostly overlooked Large Towns Parishes in Scotland Report presented next, in April 1905. Of the three, by far the more influential was the Royal Commission Inquiry into the Poor Laws and Relief of Distress, 1905-7. Conducted from London rather than Scotland it heard from 283 Scottish witnesses during 1907, and presented in 1909.⁸⁸ Two of these

⁸⁷ For example, Thomas Ferguson, *Scottish Social Welfare 1864-1914* (Edinburgh & London: Livingstone, 1958), and Ian Levitt, *Poverty & Welfare in Scotland, 1890-1948* (Edinburgh University Press, 1988).

⁸⁸ *Report of the Departmental Committee appointed by the Local Government Board for Scotland to enquire in the system of Poor Law medical relief and in the rules and regulations for the management of poorhouses* (Edinburgh, 1904, P.P. Cd. 2008 and Cd. 2022); *Report on the Method of Administering Poor*

three inquiries took testimonies from parochial, medical and legal witnesses (some of whom gave evidence to both inquiries). The middle enquiry, which looked at parochial services as they operated specifically in Scotland's eight largest towns, was built instead on the first-hand observations of specially appointed commissioners. These commissioners, during investigations, shadowed PMOs as they went about their work. As a result the medical examination process became a key subject matter in the findings. Both the earlier reports produced in Scotland are linked by the guiding hand of Robert B. Barclay. Barclay, a civil engineer and statistician, was General Superintendent of Poor at the LGBS. He had a remit to oversee the parochial services for the South-Western portion of Scotland (including Glasgow). Barclay co-authored the Poor Law Medical Relief (Scotland) Report, 1904 with W. Leslie Mackenzie M.D. Mackenzie was the LGBS Medical Inspector. Barclay also oversaw the latter enquiry in Mackenzie's absence. Whilst these have long stood in the shadow of their successor, both Scottish reports made a number of telling observations and recommendations. Most radically of all, the Large Towns Parishes in Scotland Report, 1905, proposal that the Scottish poor law medical service should develop into a full-time, dedicated state medical service for all the poor.⁸⁹ Before this, the Poor Law Medical Relief (Scotland) Report, 1904, had admitted, if rather begrudgingly, that development in the lowland areas and the main urban parishes were already 'fairly adequate' and that (more tellingly): 'so far as medical attendance is concerned, the paupers are as a rule better off than the general population'.⁹⁰ Recommendations made by each were quickly overtaken as the political agenda shifted.⁹¹ None had real legislative impact.

Relief in Certain Large Town Parishes in Scotland (Glasgow, P.P. Cd. 2524, 1905); and (*Royal Commission*) *Poor Law and Relief of Distress, Report on Scotland* (PP. Cd. 4922, 1909).

⁸⁹ LGBS Large Towns Report, 1905 (Cd.2524), p. xvii: this recommendation was made on the basis that only full-time staff could be expected to be dedicated to the task without split loyalty (i.e. with private practice interests); only full-time staff could be expected to develop identity with administrative goals of the poor law; and only full-time staff could be paid salaries 'sufficiently large to induce them to devote much time to their duties.'

⁹⁰ Poor Law Medical Relief (Scotland) 1904 (Cd. 2008), vol. 1, pp. 68-9.

⁹¹ Ian Levitt, *Poverty & Welfare in Scotland, 1890-1948* (Edinburgh University Press, 1988), pp. 44-72, argues that the 1904 Report's recommendations were not acted upon partly because it was overtaken by the announcement in 1905 of a British-wide inquiry into all aspects of the poor law and also, partly, because of the impact that the trade depression of 1902-5 had on parochial resources and which meant that change to the system was unpropitious. Levitt ignores the interim medical findings of the Large Town Parishes in Scotland Report of 1905.

CHAPTER 1

SETTING THE PARAMETERS FOR STUDY OF DOMICILIARY MEDICAL CARE FOR THE POOR IN SCOTLAND, 1875-1911

1.1 A literature of home visitation

With today's system of health centres, clinics, and appointments, it is easy to forget that before the First World War a large proportion of medical consultations were what the British call "home visits"... *The round of visits was the essence of medical practice* [my emphasis]

Irvine Loudon (2001)¹

To the people there is a world of difference between the poor-house and out-relief; it is thought a disgraceful thing to go to the poor-house but not to receive out-relief. The clergy are encouraging that belief...

Unnamed Glasgow Charity Organisation Society worker (1909)²

Anyone coming to the topic of medicine in the late-nineteenth and early twentieth century for the first time could be forgiven for thinking that the rise of the hospital was the overwhelming feature, with many histories of hospitals reading as the history of medical progress and histories of medicine of the period doubling as histories of the progress of hospitals. In the long view of history the hospital is, in fact, the great anomaly.³ The rise of the hospital is undoubtedly one of the great themes of medical history in this period. Focus on the growth in size, function and significance of the hospital and asylum in much of the historiography on medical provision in the nineteenth and twentieth century has, however, been to the detriment of study of outdoor provision. This is despite the fact that overwhelming numbers of people, including the poor, were treated without hospitalisation. Whilst the range of medical services available for the poor outdoors has been largely overlooked, treatment in the home has particularly been under represented.

¹ Irvine Loudon, 'Doctors and their Transport, 1750-1914,' *Medical History*, 45 (2001), pp. 185-6. For the same point restated see also Irvine Loudon, 'The Concept of the Family Doctor,' *Bulletin of the History of Medicine*, 58:3 (1984), pp. 347-362.

²Quoted in (Royal Commission) *Poor Law and Relief of Distress, Appendix XVII: 'Report by Miss Constance Williams and Mr Thomas Jones on The Effect of Outdoor Relief on Wages and the Conditions of Employment'* (Cd.4690, 1909), p. 273.

³ This point made by Peregrine Holden, 'The Oddities of Hospital History: a Medieval Perspective on a Global Question' (unpublished paper presented at the centre for the History of Medicine, University of Glasgow, 24/4/2007).

A number of recent studies of poverty and welfare in nineteenth century Britain have sought claim to correct the imbalance. Marland and Kidd both note to justify the focus of their recent studies of poverty and welfare in nineteenth century Britain that the bias towards hospital provision in medical history means outdoor forms of treatment have particularly been neglected. Thus Kidd laments that: 'Dispensaries may have been of more direct importance in the treatment of the sick poor, although they have rarely been a subject of historical research.'⁴ For Marland: 'Even within the boundaries of institutional medicine, research has shown a clear bias; towards in-patient hospital facilities... the numerically more significant out-patient and dispensary facilities have been comparatively neglected.'⁵

Part of the explanation for the concentration on the hospital is the association of it with specialist treatment; part the invasion of history by sociological theory. Social theorists that have shaped the modern historiography of orthodox medicine, such as Jewson and Pickstone, posit that during the second-half of the nineteenth and into the twentieth century there were fundamental changes in 'ways of knowing' that affected treatment, diagnosis, and social power relations within the profession. They argue that these changes involved a shift in the dominant site of knowledge production, as the main medical encounter shifted from the patient's home and bedside (where the construction of a diagnosis had been built around the patient's account), to the institution, either in the shape of hospital or clinic, and then ultimately – from sometime towards the end of the nineteenth century – to the scientific or bacteriology laboratory.⁶ These models have been highly influential. The problem is they have encouraged historians to focus studies of nineteenth and early twentieth century medical services on the rise of the hospital and the more prestigious end of the

⁴ Alan Kidd, *State, Society and the Poor in nineteenth century England* (Basingstoke: Macmillan Press, 1999), p. 94.

⁵ Hilary Marland, *Medicine and society in Wakefield and Huddersfield 1780-1870* (Cambridge: Cambridge University Press, 1987), p. 2.

⁶ N.D. Jewson, 'Medical knowledge and the patronage system in eighteenth-century England', *Sociology* no. 8 (1974), pp. 369-55; N.D. Jewson, 'The disappearance of the sick man from medical cosmology', *Sociology* no. 10 (1976), pp. 225-44; John V. Pickstone, 'Ways of knowing: towards a historical sociology of science, technology and medicine', *British Journal for the History of Science* 26 (1993), pp. 433-58. See also Loudon, *The Concept of the Family Doctor*, p. 358, and Anne Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), p. 77.

profession: this has largely been at the expense of regular medical practice.⁷ Despite the focus on the hospital many patients in Scotland remained sceptical. Whilst developments had made surgical stay safer by the 1890s than the 1870s, where afforded control and choice over the matter, rich and poor alike often continued to opt to be cared for out-with the institution and to remain in the home.⁸ The hospital was not the only aspect of the changing nature of the medical encounter at this time.⁹ The rise of the hospital is not a story that can be told without reference to outdoor services and the homes of the poor. Indoor treatment and outdoor treatment are flipsides of the same coin.

The hospital never became the dominant site of treatment before 1911, for only acute or disabling cases were likely to gain admittance. Most medical care services for the poor therefore were built around outpatient and dispensary services, which included home visits. The economics of treatment of the poor were overwhelmingly in favour of home treatment. As Loudon (quoted above) points out, through the nineteenth century and up to before World War One, it was home visitation that was the essence of general practice in Britain. The pioneer of anaesthetic in childbirth, Edinburgh's James Young Simpson, made this point clearly when writing to his sister about his daily routine of his general practice:

We breakfast, 8.30. I see any patients that may come here, or receive messages, and afterwards drive off to see folks at their own houses at 9.30. I lecture at the College from 11 to 12; see hospital patients or others in the Old Town; walk here [Albany Street [in the new town]] to lunch at one, drive off

⁷ For a recent example, Helen M. Dingwall, *A History of Scottish Medicine* (Edinburgh: Edinburgh University Press, 2003), p. 178.

⁸ An example of popular scepticism of the claims of medicine from *The Fraternal Review: A Journal for the Affiliated Friendly Societies*, Vol. 2 No. 1 (Glasgow: Jan 1888), p. 20. On the home as the preferred place for care see Sir John Brotherston and Dr John Brims, 'Introduction' in Gordon McLachlan (ed.), *Improving the Common Weal: Aspects of Scottish Health Services 1900-1984* (Edinburgh University Press, 1987), p. 23, and Helen Jones, *Health and Society in Twentieth Century Britain* (London: Longman 1994), pp. 20-1. The issue is not clear cut. Evidence of William Baird, (Royal Commission) *Poor Law and Relief of Distress, Appendix Vol.VI.: Minutes of Evidence, 95th to 110th Days, and 139th and 149th Days, with Appendix* [RC Poor Laws and Relief of Distress] (PP Cd.4978, 1910), appendix IX, para. 7, on the sustained unpopularity of hospitals, contrasts with the evidence of George Smith, J.P., *RC Poor Law and Relief of Distress* (Cd.4978), App. CXXVII.

⁹ W.F. Bynum, *Science and the practice of medicine in the nineteenth century* (Cambridge: Cambridge University Press, 1994), p. 176: 'A patient seeking medical care on the eve of World War I would have had different expectations for those of his or her grandfather or grandmother in a similar situation around the middle of the nineteenth century. If the complaint were serious, the later patient could anticipate a more extensive diagnostic workup. The stethoscope [invented 1816] might have been used in either situation, but the earlier doctor would not have examined the eye with an ophthalmoscope [developed 1820s-1850], the ears with an otoscope [1855], or the throat and larynx with a laryngoscope [1830]'.

immediately again to visit sick folk, and generally here to dinner... about five. After an hour's rest I am generally off again, walking always at night... and then home to an egg or other supper about eleven or later.¹⁰

This visiting of patients at home, Loudon notes, has always been a central component of the art (or science) of medical practice, and particularly “family doctoring”.

Loudon's criticisms of the neglect of family doctoring in the early 1980s followed on the heels of two decades of soul searching from within the rank and file of the medical profession. These insights sought to conceptualise what it is and was that medical men engaged in regular or general aspects of medical practice do. They provide tools that to now most historians have neglected to use in evaluating practice in the recent past. A rallying cry for radical reassessment and re-conception of the ‘savant’ art of general practice was provided by the appointment of Britain's first professor of general practice at Edinburgh University in 1963, and by Balint's publication, *The doctor, his patient, and the illness* in 1964. Balint talked at length of the ‘special psychological atmosphere’ of general practice domiciliary work that demanded the doctor understand the patient in broader context and observed: ‘by far the most frequently used drug in general practice was the doctor himself.’¹¹ More recently Livesey has argued that non-specialist routine medical work is more about problem identification than strict diagnosis, and that all ‘knowledge and understanding of the patient grows from a knowledge of the family and the home’. Livesey also pointed to what he called the ‘doctor's dilemma’: visiting and listening to patient's takes time and time is not always available to general practitioners.¹² Despite Loudon and calls from within the profession for reassessment, historical studies that do look at home-based medical care tend to emphasise that it belongs to usurped or secondary forms of medical practice. Alternatively when concerned with domiciliary services they focus not on medical practitioners but instead on the rise of district nursing, health visitation or other peripheral and paramedical aspects.

Pickstone's *Medicine and Industrial Society* and Christopher Lawrence's study of *Medicine in the Making of Modern Britain, 1700-1920* are representative of the

¹⁰ From Eve Blantyre Simpson, *Sir James Y Simpson* (‘Famous Scots Series,’ Edinburgh & London: Oliphant Anderson & Ferrier, 1896), pp. 75-6.

¹¹ Michael Balint, *The doctor, his patient and the illness* (Surrey: Gresham Press, 1964), p. 1 and ch. XIII.

¹² Peter G. Livesey, *The GP Consultation: a Registrar's Guide* (Oxford, Butterworth Heinemann, 1996 2nd ed.), p. 3 & 12-18.

concentration on the conceptualisation of the rise of the hospital and the development of the 'real' business of clinical and laboratory medicine.¹³ Whilst this thesis follows Pickstone as a study of the development of medical charity and exploration of the mix of voluntarist and state medical services for the poor in evolving industrial society, Pickstone's focus throughout is different. Home visits he describes tangentially in his work, as what are soonest dropped by infirmary staff, a chore to be palmed off on junior doctors, or a burden devolved down. Lawrence for his part, whilst like many others ignoring Scotland in the British context, fails also to account at all for the most common site of the medical encounter over the two centuries studied, the home. In the few histories that do point to the on-going importance of the home as a site for medical treatment through into the early years of the twentieth century, domiciliary care is often sidelined, with observations regarding it wrapped up in broader theoretical framework of what had been necessarily laid aside.

Whether and why agencies deemed it necessary or worthwhile to send medical practitioners into the homes of the poor; why these visits were still desired; why and when abandoned, what was lost in the process; what kinds of practitioners were employed for this work; what motivated them; what these practitioners were asked to do on these visits, and how this remit changed; what they found once there; how these visits were negotiated; how successful were visit outcomes: these are important but generally overlooked issues in the recent history of medical services in Britain. A classic case in point is Loudon's own recent article on 'Doctors and their Transport' (quoted). Looked at in isolation, this article by Loudon focuses on the mechanics of how medical men went about their daily business of rounds of visits, and how they adapted to changes in transport technology to move between visits. Whilst this is an interesting topic, it is one that might be thought of as a preliminary without the main event. Loudon shines a spotlight but only into the wings; he brings us out the institution and doctor's surgery to the door of the poor, only to abandon us outside!

Written history of course reflects as much the time it is written as the time written about. Tellingly the lack of modern historical interest in medical home visitation

¹³ John V. Pickstone, *Medicine and industrial society: a history of hospital development in Manchester and its region 1752-1946* (Manchester: Manchester University Press, 1985) and Christopher Lawrence, *Medicine in the Making of Modern Britain 1700-1920* (London: Routledge 1994). On Pickstone's account of home visits and the development of medical dispensaries see pp. 42-44 and p. 54.

reflects a recent historical phenomenon mentioned in the prologue: from the 1970s, over the 1980s and into the 1990s, there had been a significant fall-off in the percentage of a working week that a typical general practitioner spent visiting patients at home under the National Health Service.¹⁴ Yet whilst it has not been the focus of extensive research previously, disparate and piecemeal elements of a history of medical home visits do exist. From these stands it is possible to assemble a workable body of theory on a neglected topic.

Hodgkinson's study provides a natural start point. Whilst focused upon England it makes universally applicable observations on the attendant value of home visits. She notes that although it was heavily criticised in the RC Poor Law Minority Report of 1909 for its lack of preventive focus, originally at the heart of poor law medical service, in both England and Scotland, was the notion that the service promoted early medical intervention. This was because the poor law medical service was firstly and fundamentally a home visitation service. An inexpensive form of treatment to establish, home visitation was the key to achieving both preventive and economic goals. Hodgkinson notes that a series of medical witnesses before an 1844 Select Committee reviewing the workings of the medical service as it was enacted in England and Wales pointed out that home visits by district medical officers amongst the poor saved 'time, expense and trouble'. She quoted: 'as one doctor significantly stated: early and good attention to the poor is in the end of the very best economy.'¹⁵ Hodgkinson also points out that the process of home visitation of paupers meant that poor law medical officers 'were in the supreme position' to offer comment on the realities of poverty. In a line of argument that found echo subsequently in Scotland, she quotes a Southwark-based PMOs argument that 'the poor law medical officer was

¹⁴ D.J. Pereira Gray, *Training for General Practice* (Plymouth, 1982), quotes a General Household survey for 1978 produced by the Office of Population Census and Surveys (HMSO 1980) that during 1978 about 17% of all NHS consultations between general practitioner and patient took place in the patient's home. Subsequent General Household Surveys showed that the percentage of patient consultations per week fell, to 14% in 1989; 10% in 1991/2; and to just 6% in 1998. This data quoted on *RCPG Information Sheet No. 3 (May 2001) General Practitioner Workload* viewed on-line < http://www.rcpg.org.uk/rcpg/information/publications/information/infosheets_index.asp > [accessed October, 2005]. See also Paul Aylin, F Azeem Majeed, Derek G Cook, 'Home visiting by general practitioners in England and Wales,' in *BMJ* No. 7051 Vol. 313 (27 July, 1996): Aylin et al looked at home visitation by sixty general practices in England and Wales over one year from 1991 to 1992. Looking at a recorded over half a million home visits they found that at this time 10.1% of patient contacts with general practitioners took place in patient's homes.

¹⁵ Ruth G. Hodgkinson, *The Origins of the National Health Service* (London: Wellcome Historical Medical Library, 1967), pp. 23-4.

the only person who ever saw the poor as they really lived'.¹⁶ Home visitation by medical practitioners provided a crucial two-way conduit of information connecting the classes. Pickstone's work on Victorian Manchester similarly argues that home visits under the auspices of medical charity 'again brought independent practitioners into regular and intensive contact with the sick poor,' and as a result, these practitioners became 'experts on the condition of the poor,' and the font of 'much of our knowledge of the new industrial working class'.¹⁷

In looking at poor patients in eighteenth century Bristol, Fissell points to two key factors that she argues determined whether any patient might *choose* (or be chosen) to be treated at home as against in hospital. These were the family resources at the individual's disposal, and the type of disease from which they were suffering, and whether or not it was adjudged 'curable' or 'chronic'.¹⁸ She argues that growing patient numbers indicated in charity reports is strong evidence of continuing real demand for outpatient and at-home services into the nineteenth century. Helen Jones goes further to argue that 'hospitals remained a last resort' for the working-class and poor to the end of the nineteenth century. This was because admittance could mean lost wages, familial disruption, general inconvenience, intrusion, fear of dying in hospital, travelling costs, stigma, and perhaps even subjection to cruelty. Most contentiously, Jones also suggests that into the Edwardian period treatment offered at home by medical practitioners was anyways 'not so different' from treatment in hospital. She points the wide array of minor surgeries undertook in the home by general practitioners before the First World War. Medical guidebooks of the time aimed at newly qualified medical practitioners include amongst suggested home

¹⁶ Hodgkinson, *Origins of the National Health Service*, p. 59. Evidence of William Lewis Martin, RC Poor Law and Relief of Distress (Cd.4978, 1910), Appendix CII, paragraph 20: 'The only authority or agency that I can conceive as having [the necessary] potentialities [to understand the whole work and duty of medical assistance to the poor] is the Poor Law Authorities owing to their experience in dealing with the poor, their detailed knowledge of the personal histories, home conditions, and home requirements of the poor, and the experience gained by their officers in carrying out the duties which at present devolve upon them.'

¹⁷ Pickstone, *Medicine and industrial society*, p. 54.

¹⁸ Mary E Fissell, *Patients, power, and the poor in eighteenth-century Bristol* (Cambridge: Cambridge University Press, 1991), p. 96.

surgeries a variety of head and face operations; neck operations; and chest, abdomen, genitourinary, rectal and limb operations.¹⁹

Marland's top-down study of medical services for the poor in Wakefield and Huddersfield to 1870 predates and contrasts with Fissell's bottom-up approach. Marland suggests that even if preferred, home visits were being eschewed by the 1870s by practitioners who increasingly came to favour dispensary consultations as the preferred form of outdoor treatment (at least in England and the towns studied). Less time, she says, was wasted in dispensary consultations; the dispensary allowed medical men to exert greater control over the increasingly technical consultation process; and dispensaries came to house better facilities and equipment than a medical practitioner might hope to carry in his case.²⁰ Time, control and technical issues are crucial points.

The issue of site of treatment and control also animates Fissell's study. In the unfamiliar hospital setting, Fissell argues, the sick-poor patient more easily lost control over the process of interpretation and management of their own illness. The hospital served to 'make, test and reinforce' social boundaries. In effect, there was a shift in the institution in control towards the provider. One obvious corollary is that one reason why a patient into the nineteenth century might continue to seek treatment outside the institution and at home was that such influence over treatment as the patient might expect to be able to wield was retained. Dingwall's recent history of Scottish medicine follows the Fissell line to conceptualise the rise of the hospital and the decline of the home within a broader analytical framework.²¹ Lawrence has also argued that the hospital meant new restrictions too being imposed on the independent powers of the medical practitioner. The practitioner, operating in the changed setting of the public arena of the hospital ward rather than in the private world of the home or own consulting rooms, found that his behaviour and decision making exposed to the scrutiny of peers in a way that they never really were when alone in private practice

¹⁹ Helen Jones, *Health and Society in Twentieth Century Britain* (London: Longman 1994), pp. 20-1. Edred M. Corner and H. Irvine Pinches, *The Operations of General Practice* (London: Oxford University Press, 1907), p. 276f.

²⁰ Marland, *Medicine and society*, pp. 100-1.

²¹ Helen M. Dingwall, *A History of Scottish Medicine* (Edinburgh University Press, 2003), p. 9. Dingwall refers to J. Habermas, *The Structural Transformation of the Public Sphere. An Inquiry into a Category of Bourgeois Society*, trans. T. Burger (Cambridge, 1989).

and outside institutional structures.²² There is evidence supporting this view. When the state began to express its desire to become more involved in organising medical provision for the masses, during discussions with medical profession bodies leading to the introduction of national insurance after 1911, treatment in the home was defended by the B.M.A. as the leitmotif of independent general medical practice. Domiciliary care symbolised the integrity of the individual medical practitioner in the identification, management and treatment of their patient's disease. Thus through the period under study, the home was an arena of power for the practitioner every bit as much as for the patient.²³

The fact that practitioners increasingly felt limited during home visits in terms of the new equipment they could carry was a point bemoaned, for example, in November 1873 by Glasgow medical practitioner David McVail. After witnessing a demonstration of latest techniques applied to the study of the larynx by a fellow at a meeting Glasgow's Medico-Chirurgical Society, McVail pointed out to his colleagues the telling point that 'for general practitioners, the elaborate instruments exhibited that evening were unsuitable... [for] the bulk of the profession the pocket laryngoscope must suffice.'²⁴

Time mattered. Most medical men were masters of time management. 'Economy and rapidity' were key watchwords for successful general practice amongst the poor.²⁵ Practitioners employed in busy dispensary work amidst the poor both metaphorically and literally learned to work to the bell.²⁶ Medical practitioners set visiting hours in an attempt to routinise otherwise chaotic daily rounds and unpredictable medical responsibilities. Appointment schedules were metronomic although some cases could

²² Susan C. Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth Century London* (Cambridge: Cambridge University Press, 1996).

²³ A. S. Comyns Carr, W. H. Stuart Garnett and J. H. Taylor, *National Insurance* (3rd ed.) (London: 1912), pp. 57-8. Looking at the background to the introduction of national insurance in Britain after 1911, Carr et al argued that a key bone of contention for the B.M.A. regarding the RC Poor Law Minority Report proposals in 1909 for the introduction of a unified, full time public health service was that the medical profession (quote): 'in general was opposed to any system that gave the Medical Officer of Health anything like a controlling influence in a service which would be largely concerned with domiciliary medical attendance.'

²⁴ GMJ, v. 6 (1874), p. 138.

²⁵ W.G. Sutherland, *Dispensing Made Easy* (Bristol: John Wright & Co., 1906), p. 3: 'Economy, as well as rapidity in dispensing, is necessary in club and parish practice.'

²⁶ W. Thomson Crabbe, 'Medical Missions: The Importance of Individual Dealing', in *Medical Missions at Home and Abroad: the Quarterly Magazine of the Medical Missionary Association*, first volume (London: 1880), pp.147-8.

be difficult to contain within preordained timeslots. Evidence of just how carefully Scottish medical practitioners calibrated the time they planned to spend on each visit is apparent from the scale of tariffs of recommended fees for home visits circulated between 1880 and 1900 amongst members of the Glasgow Southern Medical Society. All tariffs were based on an estimation that each and every normal visit and consultation should take no more than twenty minutes. Daily visiting rounds were therefore spliced into series of one-third hours. Bills (for paying patients) were calculated and quantified on these twenty-minute timeslots. Any additional charge for out-of-hour service and travel time was also calculated in equivalent, additional twenty minute segments. Poor law work, undertaken by men accustomed in private practice to scheduling their days in packets of twenty minutes, was naturally disruptive. Emergencies and out-of-hour services are and were the destructor of routine.²⁷

In her study of British general practice before 1920, Digby builds on previous points to make six observations: firstly, that the nature and severity of complaints meant some patients absolutely required home visits if they were to be treated at all; second, that medical charities recognised home visits to be both ‘the greatest pressure of [the] business’, and the most time-consuming element of dispensary work; third, that such visits required of the practitioner a particularly bedside manner in order to exert and maintain authority over patient; fourth, that ‘domiciliary visits alerted the medical profession to the full enormity of the public health problems posed by urbanisation’; fifth, that this process of the identification of the nature and scale of the problem faced by industrial society fed into the development of specialist approaches (testimony to one of the ways that home visits served as a handmaiden to broader medical and scientific developments); and sixth that it was recognised that where and when utilised, domiciliary visits helped earlier detection of infectious diseases, and thus had a broader public utility in that they prevented spread of such diseases.²⁸ Digby’s observation about the general treatment of the poor, both as in- and out-patients,

²⁷ *Appendix to Historical Sketch of Glasgow Southern Medical Society* (Glasgow, 1900), pp. 11-12, reprinted in Olive Checkland & Margaret Lamb, *Health Care as Social History: The Glasgow Case* (Aberdeen University Press, 1982), pp. 232-3, appendix III. On the GSMS see Jacqueline Jenkinson, *Scottish Medical Societies 1731-1939, Their History and Records* (Edinburgh: Edinburgh University Press, 1993), p. 168.

²⁸ Anne Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), p. 241.

repeated below, carried additional weight in the home setting, where the medical practitioner was both fully stretched and less subject to direct supervision.

In reality, the day-to-day experience of poor patients varied with the individual medical staff with whom they came into contact... [The poor were] dependent on a sense of professional propriety and honour. Some doctors undoubtedly treated the poor with as much care, attentiveness and skill, as they did their private patients... [some] were less disinterested.²⁹

Two diverse recent Scottish studies - on midwifery in Edinburgh, and on the poor law in Glasgow - raise further points. Nuttall looks at the Edinburgh Royal Maternity Hospital and other maternity charities in Edinburgh over the late nineteenth and early twentieth century and like Marland takes a supply-side approach to this specific instance of the broader question of home versus hospital. She points to capacity, local environment, legislation, and to moral considerations as key factors in determining the site of a treatment. Capacity allowing, the shift in preference away from outdoor domiciliary deliveries after 1912, Nuttall suggests, was connected with perceived problems of urban overcrowding and the general poor structure of low rent housing in the city (which militated against any successful medical treatments). The changing demography of Edinburgh meant after the war many poor people had been relocated away from the old slums and therefore came to reside at a distance from the medical charity dispensaries, lessening the possibility for them to maintain a viable visitation service. Also at issue in the drift away from the home as site of treatment were the practical problems of operating a home delivery service including the particular difficulty of locating houses in emergencies, growing public health concerns, and a changing sense of the moral stigma of the hospital.³⁰ Blackden, looking at Glasgow, argues that all doctors found the act of visiting the sick-poor a universally demanding and challenging experience. Low standards of hygiene and cleanliness in particular meant few medical men 'could be fastidious'.³¹ Oppressive and incessant noise and dirt in overcrowded and unhygienic tenement or basement homes presented great

²⁹ Digby, *Making a medical living*, p. 239.

³⁰ Alison Nuttall, 'Passive Trust or Active Application: Changes in the Management of Difficult Childbirth and the Edinburgh Royal Maternity Hospital, 1850-1890' in *Medical History*, 50 (3) (July 2006), pp. 351-372.

³¹ Stephanie Blackden, 'The Board of Supervision and the Scottish Parochial Medical Service, 1845-95' in *Medical History*, 30 (Wellcome Institute: 1986), p. 162.

obstacles to treatment regimens where best practice for treatment and recovery was normally premised on orderliness, cleanliness and quiet rest.³²

Many forms of domiciliary medical charity that took hold in the late-nineteenth century developed out of the experience of general home visiting societies that proliferated from the later part of the eighteenth century across Britain. Marland notes that these were embedded in the evangelical movement.³³ Kidd notes that visiting was a landmark of Victorian philanthropy.³⁴ Kidd contends that much evangelical revivalist literature of the nineteenth century stressed the importance of personal commitment, of action, and of 'investigation and discrimination' in making visits. Home visitation was crucial to evangelical enterprise; and commitment was the key to home visits. Trevelyan had noted much the same thing, quoting of the second half of the nineteenth century that 'evangelicalism was the religion of the home.'³⁵ Kidd points to the influence on Victorian evangelical visitation of the welfare ministration ideas of Thomas Chalmers. Chalmers was a Scottish minister and ecclesiastical reformer. He championed an experimental approach to charity in Glasgow based on a systematic and aggressive home visitation ministry built on 'the principle of locality'.³⁶ Chalmers developed his ideas about visitation of the sick-poor after a personal conversion. It was after being invited to speak at a fund-raising dinner for the Edinburgh Society for the Relief of the Destitute Sick (Destitute Sick Society, or EDSS), in April 1813 that he became convinced that home visitation was central to tackling both poverty and sickness. Thus he was both influenced by, as well as an influence on, the development of sick visitation agencies in Scotland.³⁷ Kidd points to Chalmers and therefore the particular Scottish influence that lay behind many of the ideas that underlay charitable visitation across Britain over the nineteenth century. Chalmers' system was based on older Presbyterian principles of local burgh

³² Corner and Pinches, *The Operations of General Practice*, pp. 271-6, suggest rooms used in the home for treatment and recovery should in ideal circumstances be large, airy, light, private, dust-free, have a place to sterilize instruments and access to clean water (all largely impractical in the homes of the poor).

³³ Marland, *Medicine and society*, p. 25.

³⁴ Kidd, *State, Society and the Poor*, pp. 79-84.

³⁵ Canon Charles Smyth quoted in G.M Trevelyan, *English Social History: A survey of six centuries, Chaucer to Queen Victoria* (London: Longmans, Green and co., 1946), p. 578.

³⁶ A.C. Cheyne (ed.), *The Practical and the Pious: Essays on Thomas Chalmers* (Edinburgh: Saint Andrew Press, 1985), p. 18.

³⁷ Stewart J. Brown, *Thomas Chalmers and the Godly Commonwealth in Scotland* (Oxford University Press, 1982), introduction pp. xv – xvi and p. 77. John Roxburgh, *Thomas Chalmers, Enthusiast for Mission* (Edinburgh: Paternoster Press, 1988), pp. 60-1.

administrative organisation; of targeted, informed, localised investigation and careful knowledge gathering; of discrimination in determining extent and cause in particular cases through case study; of the importance of making of one's influence felt during a visit; of encouraging familial and neighbourly responsibility; and of enforcing disciplined (or acceptable) forms of behaviour.³⁸ These aspects of district visitation were reflected in domiciliary medical visits amongst the poor by a host of different agencies explored in this thesis, including (and especially) the Scottish poor law.

Attitudes changed over the four decades to 1911. Concerns over national efficiency in the Edwardian period manifest in new forms of medical home visitation activity.³⁹

Domiciliary medical intervention was re-valued. Visitation became central to tuberculosis and mother and child services. Speaking from an American context, echoing British developments, Apple has recently argued that domiciliary public health intervention became the most pro-active form of medicine at this time. Home visits enabled public bodies to detect problems and find patients before they presented themselves; they were therefore vital tools of health investigation.⁴⁰ The recent work of Ferguson et al on the Infant Milk Depot public health movement in Glasgow demonstrates how, from around the turn of the twentieth century, new scientifically and statistically informed concerns regarding the waning efficiency of the nation centred locally in large cities like Glasgow upon concern for infant welfare, diet and especially (and ultimately) 'contact' and 'communication' *with*, access *to*, and 'influence' *over* mothers. Domiciliary intervention was a central component drawing together diffuse modes of work and different interest groups, and the various

³⁸ On Thomas Chalmers and the parochial system see also R.A. Cage, *The Scottish Poor Law 1745-1845* (Edinburgh: Scottish Academic Press, 1981), chapter 6; Cheyne (ed.), *The Practical and the Pious*; Brown, Thomas Chalmers and the Godly Commonwealth, p. 70; and Rev. D. MacColl, *Among the Masses; or, Work in the Wynds* (London: 1867), p. 85.

³⁹ G.R. Searle, *The Quest for National Efficiency: a study in British politics and political thought, 1899-1914* (Oxford: Blackwell, 1971); E.P. Hennock, *British Social Reform and German Precedents: The Case of Social Insurance 1880-1914* (Oxford: Clarendon Press 1987); and Jim Tomlinson, *Government and the enterprise since 1900: the changing problem of efficiency* (Oxford: Clarendon Press 1994).

⁴⁰ Rima Apple, 'The Best Job in the World': The Politics of Public Health' (unpublished lecture paper at the University of Glasgow, 31st January 2006), and Rima D. Apple, 'Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries', *Social History of Medicine*, 8, no.2 (1995), pp.161-78.

approaches and experiences of doctors, politicians, charities, charity think-tanks like the Charity Organisation Society, and local government.⁴¹

Frawley takes an alternative overview of medical home visitation in nineteenth century Britain, exploring it through the experience and social role of the invalid, or the person visited. Visitation of the sick, she says, was seen as a Christian duty, and duties attached both to the visitors and the visited. Frawley argues that the identification of sickness and the issuing of medical certification were more about social categorisation and validating the status of sickness than it was about medical diagnosis of ‘real’ disease.⁴² This is a salient if not unique insight. Certification of disability was one of the most important home visitation tasks undertaken by PMOs, or by medical practitioners called to certify illness for charity aid societies like the Edinburgh Destitute Sick Society. In earlier work, Harvard quotes Glasgow medical practitioner and professor of jurisprudence John Glaister. Glaister in the 1890s claimed that most certification processes were perfunctory and that they were always about facilitation rather than accurate diagnosis.⁴³

Frawley argues that Victorian British society was completely preoccupied with visiting the sick: this obsession, she suggests, was connected with the primary value that Victorians placed on work, which was the antipathy of invalidism, of debility.⁴⁴ Again, reflecting here on the poor law in Scotland, the value placed on work as normal function of adulthood helped define the disability rule that determined pauper status.

This look at what were predominantly male medical practitioners traversing between what has been termed the ‘separate spheres’ of the public, masculine world of work and the private, feminine world of the home, raises a number of considerations that

⁴¹ Angus H. Ferguson, Lawrence T. Weaver, and Malcolm Nicolson, ‘The Glasgow Corporation Milk Depot 1904-1910 and its Role in Infant Welfare: An End or a Means?’ in *Social History of Medicine* (Oxford University Press, December 2006).

⁴² Maria H. Frawley, *Invalidism and Identity in Nineteenth Century Britain* (Chicago and London: University of Chicago Press, 2004), p. 21.

⁴³ J.D.J. Harvard, *The Detection of Secret Homicide* (London: Macmillan & Co, 1960), p. 147, quoting evidence by Professor John Glaister before the Select Committee on Death Certification (1893-4).

⁴⁴ Frawley, *Invalidism and Identity*, p. 37.

gender historians have explored.⁴⁵ For example, in visiting patients, the extent to which a successful practitioner was required to adopt what many Victorians might have seen as essentially 'female' character traits of sensitivity and tactfulness is informing. One can reflect upon the extent to which male medical practitioners engaged in charitable endeavour also depended upon a slew of predominantly middle class female auxiliaries who served in gender assigned roles to complete and complement the doctors' tasks, be it as nursing staff, bible nurses, as lady collectors, or as almoners. The ideological notion that the home was essentially a private sphere and a female domain opens the question of the extent to which a visiting medical practitioner, where a man, represented a direct challenge or threat to social norms, perceived or real. There was genuine sensitivity over the issue of medical practitioners being alone with women in their home. Generally, the medical practitioner belonged to that rare and select group of Victorian-Edwardian males with the ability to enter this female world of the home without chaperone and largely unimpeded. There are numerous reasons why charities by the last decade of the nineteenth century were beginning to employ newly qualified female medical practitioners to visitation roles, and sensitivity and suitability were two justifications. Literary and artistic images of the work of generalist medical practitioners back to the early nineteenth century have made great play of the importance for the new breed of generalist practitioner of winning the confidence of the women in the homes they visited.⁴⁶

⁴⁵ This brief reflection on issues that are significant to gender approaches to history informed by Amanda Vickery, 'Golden Age to Separate Spheres? A Review of the Categories and Chronology of English Women's History' in *The Historical Journal*, Vol. 36, No. 2 (June, 1993), pp. 383-414.

⁴⁶ For example, much flirting can be seen in the lithographs from the 1830s of Charles Philippon. The attitudes of female characters are vitally important in the success of Doctor Lydgate as the new style generalist practitioner in George Eliot, *Middlemarch* (1871), and can be said also, for example, to shape the experiences of Thackeray's *Pendennis*. See W. M. Thackeray, *The works of William Makepeace Thackeray, Vol. II of XIII 'The History of Pendennis'* (London, 1903).

1.2 The homes of the poor of Glasgow and Edinburgh

From the 1870s the cityscapes of Glasgow and Edinburgh were irrevocably changing. Both were reshaped by demographic and territorial growth, by City Improvement schemes, and by fast-expanding transport services. With immigration slowing, much of the physical growth occurred as the two cities spread outwards into suburbs.⁴⁷ City Improvement not only relocated pockets of poor, it changed the dynamic of demand for different medical services, and added to suspicion of the authorities (a potential problem stored up for any future medical practitioner engaging on a treatment visit).⁴⁸

Railways companies in particular played a major role in helping reshape the urban environment, either through land speculation or through the building of new downtown termini. Such building had direct impact on poor neighbourhoods and a knock-on effect on the range of medical services, with the expansion of some services directly financed through gains made selling land to railway interests.⁴⁹ Tram services made available new modes of travel making traversing the city for practitioners (during visits) and other residents (for consultations) a little easier.⁵⁰

Between the Census of 1871 and 1911 the population of Glasgow grew by over two-thirds. As the population grew demand for services grew. Surveys like McDowall's *The People's History of Glasgow* (1899) make much of the institutional development of the city around the mid-1870s, from the relocation of the University in 1874, to the building of the Christian Institute in 1879.⁵¹

⁴⁷ Edinburgh City Improvement Act of 1867 demolished some of the Old Towns poorest and most densely populated areas, like Todricks Wynd and Blackfriars Wynd. Glasgow City Improvement Trust was constituted a year earlier, in 1866. Irene Maver, *Glasgow* (Edinburgh: Edinburgh University Press, 2000), p. 171; and John R. Kellett, *Glasgow: A Concise History* (London: Blond 1967), p. 22.

⁴⁸ See *The Scotsman* (30 Jan, 1893), p. 6. James Burn Russell on the impact of Glasgow Improvement Trust in *Glasgow Medical Journal* (Glasgow: April 1876), pp. 235-246: 'People of that class are very suspicious...' Per *The Scotsman* (29 Jan, 1872), p. 6, Mr John Walker, ERPD Honorary Secretary, noted at the 1872 annual meeting of the dispensary managers: 'Owing to the City improvements of late years, the displaced population had flocked into the neighbouring streets, and the Dispensary is accordingly now situated in the poorest and most populous district of the city...'

⁴⁹ See Earl of Rosebery's speech quoted in *The Scotsman* (10 Dec, 1872), p. 3. See also John R. Kellett, *The impact of railways on Victorian cities* (London: Routledge & K. Paul, 1969).

⁵⁰ Glasgow's first horse-drawn tram service was introduced in 1872..

⁵¹ John K. McDowall, *The People's History of Glasgow* (Glasgow & London: Hay Nisbet & Co, 1899).

Whilst Glasgow epitomised Scotland's new industrial economy, Edinburgh, as the professional, legal and administrative hub of Scotland, and 'a residential, not industrial city,' developed along different economic lines.⁵² Describing a city under half the size of Glasgow with around 400,000 persons in 1907, Edinburgh Inspector of Poor James Kyd noted: 'the Edinburgh population consists to a very large extent of the professional class – legal, actuarial, medical, educational. It has a very large (retired) residential population... It is not an industrial city to any large extent.'⁵³ Local parish councillor, Robert Cumming, described Edinburgh as 'somewhat peculiar,' in that it was a parish of contrasts, with its high number of professionals as well as a high number of unemployed unskilled labourers.⁵⁴ Cumming's description carries strong echo of Robert Louis Stevenson's *picturesque*.⁵⁵ As in Glasgow, the 1870s saw significant expansion of charity services in Edinburgh including the relocation of the Royal Infirmary. In August 1890 the AICP 'Charities of Edinburgh' report concluded that since a similar report in the 1860s 'there has been a large expansion in the direction of dispensary work,' and a 'great multiplication of agencies'.⁵⁶

Despite differences there were commonalities. Rodger's study of employment and poverty in Scotland cities, 1841-1914, indicates, for example, a gradual but noteworthy convergence of the structure of the economies of Glasgow and Edinburgh over the decades to 1911. From 1871 to 1911 the professional occupations sector represented a rising percentage of workforce within Glasgow whilst the industrial sector represented a falling percentage; conversely, the professional occupational sector accounted for a less steeply growing percentage of occupations in Edinburgh whilst its industrial sector was gradually rising. Despite Glasgow's size and fame for overcrowding, the population of the two cities between 1875 and 1911 had grown at

⁵² Richard W, Huie, RC Poor Law and Relief of Distress (Cd.4978), Appendix LXX.

⁵³ James Kyd, RC Poor Law and Relief of Distress (Cd.4978), Evidence 61371/8.

⁵⁴ Robert Cumming, RC Poor Law and Relief of Distress (Cd.4978), Appendix XXXVI.

⁵⁵ Robert Louis Stevenson, *Edinburgh: Picturesque Notes & Further Memories* (London: Waverley book Co., 1925, 1st published 1879), pp. 15-16. John Lowe *Medical Missions: Their Place and Power* (London: Fisher Unwin 1886), p. 253.

⁵⁶ Published in two parts in *The Scotsman* (9 Aug, 1890), p. 6 and (11 Aug, 1890), p. 7.

much the same rate; and proportionally, it was Edinburgh's working population that had, in fact, grown faster.⁵⁷ Edinburgh shared Glasgow's social problems.

The heart of darkness metaphor was ubiquitous in descriptions of the denizens of Scotland's urban landscapes from the mid-nineteenth century. Smout, for example, quotes Lord Cockburn, who in 1848 saw a simile between the growing demands of the urban masses and a great darkening shadow over the country.⁵⁸ The centenary history of the Glasgow City Mission describes how it had discovered 'dark continents... up the Glasgow closes'.⁵⁹ Darkness was both metaphoric and literal in the city's tight, ill-lit streets. John Tweed's tourist guide of Glasgow, 1872, warned that the city, before electric light, was a play of shadows, criss-crossed with 'dark and filthy closes, the abodes of the poor': electric lighting was only introduced in Edinburgh from 1881, and municipal electric lighting in Glasgow only after 1896.⁶⁰ In Edinburgh, an editorial in the EMMS journal in May 1879 pointed out of the poor: 'Living, as they do, in small, ill-ventilated rooms, the common stair of the tenement leading into a dirty, narrow close or alley, into which a streak of sunlight never enters...'⁶¹ At the 1891 Annual Meeting of the EMMS, Rev. George Davidson, that:

'We hear a great deal of 'Darkest Africa' and Darkest England,' and we are apt to be carried away with the picture, and have our eyes turned away from that which is nearest to that which is distant; and we forget often that there is a 'Darkest Cowgate' and that there is work just as heroic being done down in the slums of our city...'⁶²

In the older tenements or "lands" the passages are often dark, narrow and foul-smelling. Some passages are T-shaped, and at the further end it is necessary to light a match in daytime in order to distinguish the doors. The doors and the partitions are so poorly constructed that there is no privacy even within the houses.

In other cases there is a single long passage traversing the tenement with doors on either side... [and] with this arrangement through ventilation is impossible.

⁵⁷ Richard Rodger, 'Employment, wages and poverty in the Scottish Cities 1841-1914,' in George Gordon (ed.), *Perspectives of the Scottish City* (Aberdeen University Press, 1985), p. 29, table 1: 'Occupational Structure in Scottish Cities 1841-1911' and footnote 17, p. 59.

⁵⁸ See C.W. Hill, *Edwardian Scotland* (Edinburgh: Scottish Academic Press, 1976), p. 98. Joseph Conrad, *Heart of Darkness*, published 1902, tapped into familiar sentiments. T.C. Smout, *A Century of the Scottish People, 1830-1950* (Collins, London 1986), pp. 7-8.

⁵⁹ *The Glasgow City Mission: A Short History* (Glasgow: 1926), p. 8.

⁶⁰ *Tweed's guide to Glasgow: "A facsimile of a section of Tweed's Guide to Glasgow and the Clyde first published by John Tweed in 1872. The remainder is published in The Clyde a hundred years ago"* (Glasgow: Molindar press, 1973), p. 1. *The Scotsman* (18th Nov, 1881), p. 3, and (31 Jan, 1896), p. 4.

⁶¹ *Quarterly Papers of the Edinburgh Medical Missionary Society* [EMMS Quarterly] vol. 3, pp. 17-18

⁶² EMMS Quarterly, Vol. 5 (May 1887-Feb 1891), p.372.

...one witness [speaking of Anderston district in Glasgow] described the area as follows:- “The sunk flat houses even in a hot dry summer remain damp and unwholesome. The stairs down to these houses are almost invariably dark and dirty, the passages pitch dark on the brightest day, so that only by feeling the walls can one discover the doors...”

Miss Rutherford, RC Housing of the Industrial Population of Scotland (1917) ⁶³

The parlous condition of the home of the poor in the period is well enough known. The image of visitors to the closes and tenements in Glasgow and Edinburgh – including medical practitioners - as late as 1915 still requiring to grope there way along dark, dank corridors in order to identify an entrance, even at midday, is still an evocative one. Miss Rutherford, quoted here in the Royal Commission on the Housing of the Industrial Population of Scotland (RCHS) Report (commissioned in 1912 and finally concluded in 1917), was familiar with her topic and with medical visitation of the poor, being both a member of Govan Parish Council and Warden of Queen Margaret Settlement in Anderston.

The RCHS Report gives much evidence on housing conditions (with much supplied by medical practitioners as sanitary officials). ⁶⁴ In both cities, for example, a night's lodgings might still be had in 1915 for sixpence. The poorer districts of both cities were synonymous with a 'floating population' who moved in and out of these lodgings. In Glasgow and Govan in 1911 the report recorded that 13.8% of the people still lived in one roomed accommodation, 48.4% in two rooms, and over half of the city in houses with a density of more than two occupants per room. Only 7.1% of one roomed houses and 38.1% of two roomed houses in Glasgow had there own water closet facility (although by 1911 nearly all had there own sink). In Edinburgh, over one-third of the population lived in homes of two rooms or less (with 5.8% in one room). Although less overcrowded than was typically the case in Glasgow, those that lived in one-roomed homes in Edinburgh commonly had fewer amenities: only 57%

⁶³ Opening section of the *Royal Commission on the Housing of the Industrial Population of Scotland Rural and Urban* [Royal Commission on Housing in Scotland (RCHS)] (PP Cd.8731, 1917), para. 28, p. 4. see also *The Scotsman* (10 Dec, 1872), p. 3; and *First Report of the Proceedings of the Brotherhood of St Vincent de Paul in Glasgow, From its Establishment, 23rd August 1848, till 30th June 1852* attached to *Report of the Superior Council of the Society of St Vincent de Paul in the Archdiocese of Glasgow* [SVDP Annual Report] (Glasgow: 1909).

⁶⁴ The Royal Commission on Housing in Scotland (Cd.8731), 1917, followed the publication of the RC Poor Law Report on Scotland in 1910 and emanated out of an inquiry into Miner's Housing. Although interrupted by war and only finally publishing in 1917 the evidence in the RCHS Report very much reflects conditions before World War One, with the original consideration for the report laying with the Secretary for Scotland in November 1911, the warrant for the inquiry issued in 1912.

of one roomed homes in the city had a sink, and 6.2% a water closet. Leith, compared to the rest of Edinburgh and Glasgow, was adjudged 'remarkably free from overcrowding'. This was surprising given that it was largely a working-class area. It had just 5.4% of its population in one roomed accommodation and 44.5% in two rooms. One could conclude that although Edinburgh might have had less poor, the poor it had were typically very poor indeed. Municipal rates for rent per one roomed accommodation, circa 1911, averaged around two to three shillings across Edinburgh and Glasgow, and three to four shillings for two-roomed accommodation (with Leith most expensive). Rents, typically, had increased but little since the start of the 1870s (although generally this period saw no overall inflation across Britain). The RCHS Report made much of the inadequacy of one-roomed family life, with its lack of privacy, decency and morality. Problems were especially acute in times of crisis like birth, sickness or death, with extracts describing confined or sick women in beds pushed up tight against other beds occupied by lodgers; and nowhere to sleep for the rest of the family, left with no choice but to try to carry on moving around the confined or dead body laid out the room. John Burn Russell's famous paper on the subject is much quoted.⁶⁵

If the home was physical structure it was also family. Study of *the home* is intrinsically study of *the family*. In its conclusion the RCHS Report (1917) states simply the point that: 'a healthy family [requires] a healthy home'.⁶⁶ Much of the government's commitment to an interwar housing programme was built on this notion. The family – an important unit of focus of modern welfare politics – has been subject to intense historical interest since the 1970s. Harding noted this, reminding that both concepts 'elude simple definitions'.⁶⁷ Whilst this thesis is not an exploration that seeks to add to this study of the sociology of the family it is nonetheless important to keep in mind the interplay of family, home and public policy in the process of medical visitation of the poor. Domiciliary medical care under the Scottish poor law, for example, provided a key area of interaction between the family and the state. All medical interventions in the homes of the poor – regardless of visitation

⁶⁵ Royal Commission on Housing in Scotland (Cd.8731, 1917): p. 44, para. 650-653; p. 92, para. 674; p. 95; chapter XII; p. 100; and Minority Report, p. 363, para. 51. John Burn Russell, *Life In One Room* (1888, published 1905) and reproduced in Edna Robertson, *Glasgow's Doctor: James Burn Russell 1837-1904* (East Lothian: Tuckwell Press, 1998), appendix.

⁶⁶ Royal Commission on Housing in Scotland (Cd.8731, 1917), p. 348.

⁶⁷ Lorraine Fox Harding, *Family, State and Social Policy* (Basingstoke: Macmillan, 1996), Intro.

agency – were intrusions into the family life of the poor and would have been welcomed or resisted as such.⁶⁸ ‘Hierarchies of communication’ existed amongst families. In different circumstances certain ‘privileged’ family members are empowered to speak for the family collective. How during visits into family homes of the poor medical men managed to direct discussion between patients and other ‘privileged’ householders would have been significant for medical outcomes.⁶⁹

A ‘well-ordered home life,’ Harris claims, was considered a touchstone of working-class respectability in British society before World War One. Conversely, disorder, disassociation, and dissatisfaction with domestic arrangements were prime indicators of poverty and the urban poor. The Victorian-Edwardian concept of the family, Harris argues, was reinforced functionally, through internal ‘patriarchal’ divisions of labour, and socially, through reinforcement of the ideal of the respectable family. Harris pre-empted Harding (quoted above) arguing that external reinforcement of family function amongst the British poor was mediated both by state and philanthropic intervention in the home - that is, by various home visitation agencies of the type explored by Behlmer (below) - and by the legal codification of familial responsibilities. An example of this type of mediation is the poor law in Scotland. This enshrined a wide definition of familial legal responsibility in order to keep down costs (although how practically enforceable this responsibility was found to be given public resistance to it is open to question). The family, under the Scottish poor law, and until children reached puberty and working-age and were ‘forisfamiliarated’ in their own right, were treated as a single unit under a head of household for relief purposes.⁷⁰

George K. Behlmer’s *The Friends of the Family* (1998) has become a touchstone in the socio-historical study of family and visitation. It explores visitation in the context of what he refers to as the Victorian ‘cult of domesticity’. Different forms of district

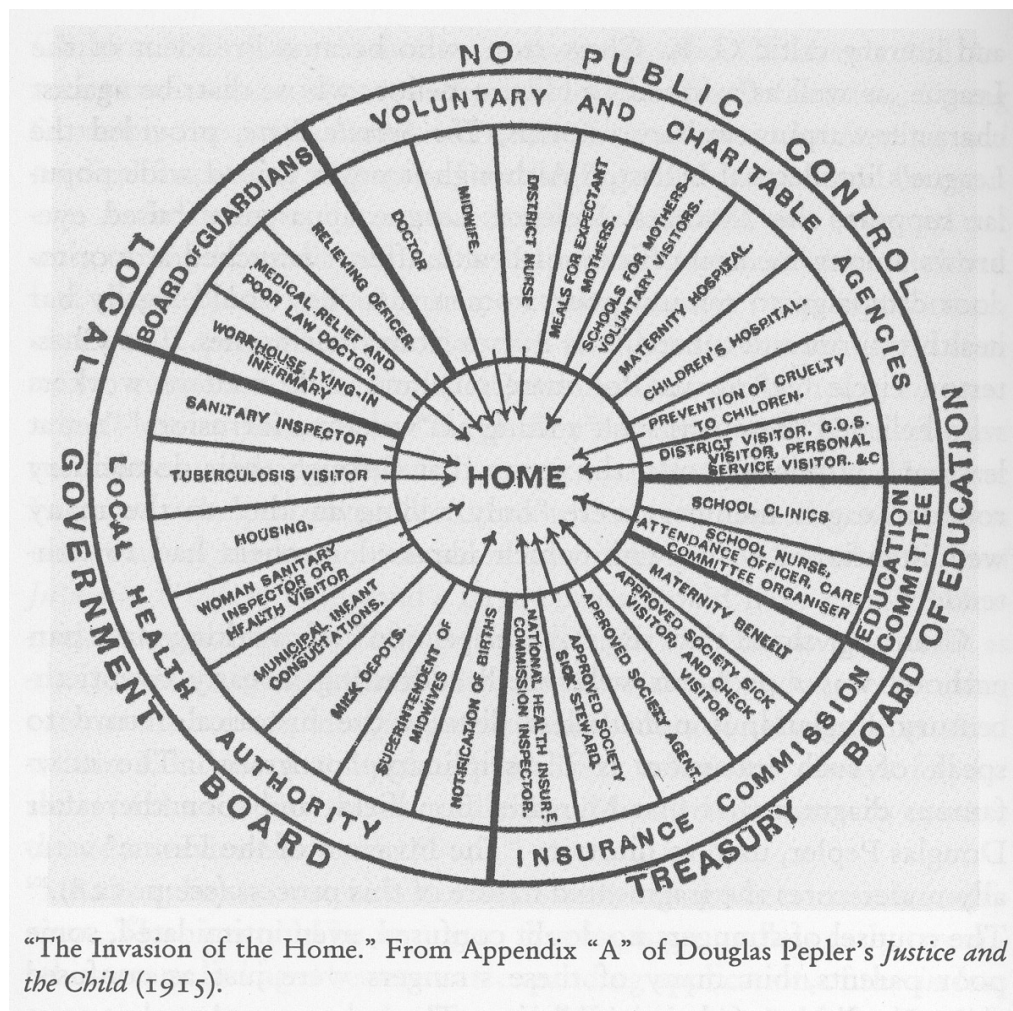
⁶⁸ Thomas Ferguson, *Scottish social welfare, 1864-1914* (Edinburgh: 1958), pp.12-13.

⁶⁹ John J. Rodger, *Family Life and Social Control: A Sociological Perspective* (Basingstoke: Macmillan, 1996), p. 16. See also Lisa W. Smith, ‘Reassessing the role of the family: women’s medical care in eighteenth century England,’ in *Social History of Medicine* vol. 16 no. 3 (December 2003).

⁷⁰ Harris, *Private Lives, Public Spirit*, chapter 3. Harding, *Family, State and Social Policy*, p. 107. Many of the rights and obligations of family under the Scottish poor law were determined by precedents set in test legal cases (i.e. at Court of Session), by House of Lords judgement, or by arbitration of the Board of Supervision (later the Local Government Board). See, for example, J. Edward Graham, K.C., *The Law relating to the Poor and to Parish Councils* (Edinburgh and London: William Hodge & Co., 1922).

visiting, Behlmer argues, developed on the evangelical model. All ‘policing of family life’ centred on the actual physical act of visitation. ‘Gaining access to a home – being invited across its threshold’ was key.⁷¹

Figure 1.1: ‘The Invasion of the Home’



“The Invasion of the Home.” From Appendix “A” of Douglas Pepler’s *Justice and the Child* (1915).

Source: George K. Behlmer, *Friends of the Family: The English Home and its Guardians, 1850-1940* (Stanford University Press, California 1998), p.128, and reproduced from Douglas Pepler, *Justice and the Child* (1915), Appendix A.

Behlmer looks at how homes ‘came under attack’ from a ‘[bewildering] array of home-centred philanthropy’ in the decades prior to World War One. Upwards to 200,000 persons were involved in home visitation amongst the poor before 1914 in

⁷¹ George K. Behlmer, *Friends of the Family: The English Home and its Guardians, 1850-1940* (California: Stanford University Press, 1998), p. 2.

Britain.⁷² Figure 1.1 reproduced from a 1915 publication graphically presents the many and various public and private agencies sending agents to the home of the poor in England: a diagram of Scotland would have looked much the same or be it that designations for specific roles differ. Visitors north and south included public health authorities, sanitation and housing officials and parochial officers; insurance agents; child protection officers and education authorities; missionaries, maternity and child health officials; charity agents and district visitors of the Charity Organisation Society; the police; doctors, nurses and midwives. What might have added is that medical practitioners acted in many of the guises identified.⁷³ For Behlmer the homes of the poor in the period of interest here were ‘contested ground’. Access to the homes was ‘negotiated’. As he points out, it is necessary to try to understand people’s relationship to the physical space around them in order to understand their reaction. For the poor this means understanding both their immediate home space (which they might or might not have had strong emotional and territorial attachment to) and their wider sense of neighbourhood territoriality, or home turf. Behlmer also makes the point that it is hard to avoid a top-down analysis of the visitation process for it is very difficult from the surviving records to judge the attitude or extent of resistance the visitors faced. Whilst (until recently) the ubiquitous black bag might provide some sort of visitor’s passport for the doctor, the personality of the agent was essential. District visitation required multiple sets of skills: commitment, fitness, energy, tact, sensitivity, perseverance and adept skills of ‘linguistic manipulation’.

Recent work by J.J. Smyth has given much thought to Glasgow’s slums in the half century to 1911. As he makes clear, it was the medical practitioners engaged either in private practice or in public roles as agents of different agencies, *familiar through visitation*, who did most to publicize conditions in the homes of the poor.⁷⁴

⁷² Behlmer, *Friends of the Family*, p. 34.

⁷³ Behlmer, *Friends of the Family*, p. 34 and p. 128, republished from Douglas Pepler, *Justice and the Child* (1915), Appendix A.

⁷⁴ J.J. Smyth, ‘Lodging houses, public health and moral hygiene: Glasgow 1850-1911,’ paper presented at the European Network on Housing Research Conference, Cambridge, July 2nd-6th 2004, available online < <http://www.enhr2004.org/files/papers/Smyth> > [accessed 18/2/2005].

CHAPTER 2

PUBLIC PROVISION - THE POOR LAW MEDICAL SERVICES

2.1 Medical relief and the Poor Law Act (Scotland) of 1845

Charity never did, and never can, meet the needs of the poor.

David Nairn, Montrose Parish Council (1907)¹

Since the decision of the House of Lords that an able-bodied person is not entitled to parochial relief, the Medical Officer has become an essential part of the [Scottish] Poor Law system, as, in the majority of cases, it requires a medical man to decide whether an applicant is or is not able-bodied.

Quotes from George A. Mackay (1907)²

Medical relief was a key addition to existing public relief services in Scotland from the 1840s. In 1843 Scottish Poor Law Commissioners were appointed to make inquiry into the existing provision for relief for the poor in Scotland. Their report in 1844 outlined in pragmatic terms arguments for more targeted provision of poor law medical relief in Scotland. For a small and discrete original outlay, it concluded, provision of ‘prompt and efficient’ medical treatment *might* prevent larger than necessary numbers of poor persons suffering from temporary, treatable conditions from becoming permanent burdens dependent on the parish. The logic was simple enough for prospective ratepayers to comprehend: a little spending today might mean less expense tomorrow. Although in discussions surrounding the publication of the report in 1844 William Pulteney Alison, University of Edinburgh Professor of Medicine, had vigorously pressed the moral case for parochial medical provision, it was ultimately carried on economic and pragmatic reasons as much as moral reasons.³

Whilst marked by continuity in terms of pauper status, in creating what Ian Levitt has described as Scotland’s first centrally coordinated welfare system, the Act of 1845: ‘*For the Amendment and better Administration of the Laws relating to the Relief of the Poor in Scotland*’ (hereafter the Poor Law (Amendment) Act (Scotland) of 1845)

¹ David Nairn, *(Royal Commission) Poor Law and Relief of Distress, Appendix Vol.VI.: Minutes of Evidence, 95th to 110th Days, and 139th and 149th Days, with Appendix* [RC Poor Laws and Relief of Distress] (PP Cd.4978, 1910), Appendix CIX.

² George A. Mackay, *Practice of the Scottish Poor Law* (Edinburgh: 1907), p.100 & 110.

³ See recommendations of the *Report of the Scottish Poor Law Commissioners* (1844) quoted by Dr. W. Leslie Mackenzie, RC Poor Law and Relief of Distress (Cd.4978), Evidence 56605/3.

was to fundamentally alter the concept of poor relief in that country. As well as provision of medical relief, the 1845 Act introduced the first national framework of civil administration and compulsorily assessed poor relief provision; further codified the concept of settlement in determining legal responsibility for funding relief in any given case; and introduced the notion that for some relief should be rather be a matter of right rather than of charity.⁴ Importantly, an element of what Audrey Paterson refers to as ‘flexibility of interpretation’ was built into the new relief system (as it was with much Victorian legislation).⁵ Thus, although a non-elected central Board of Supervision was created to supervise poor relief nationally, it was deliberately invested with few direct powers of compulsion; and at first parishes also retained the right to opt out of compulsory rating (though few did so over time). For these and other reasons local discretionary standards of relief remained. Despite greater availability of central funds after 1848, revenue streams were uneven amongst parishes because finances were mainly based on rate levels, and these varied by scale and wealth of local parish. This naturally resulted in uneven developments of medical relief service. Attempts by the new central body to increase its powers of influence over the parochial boards, whilst constant, were constantly resisted at local level. Forestalling proposed attempts to increase the powers of the Board of Supervision in an address as serving President of the Society of Inspectors of Poor of Scotland in 1878, Andrew Wallace, Govan Inspector of Poor, pointed out that the Scottish Poor Law: ‘has always been considered as more discretionary than that which obtains in the sister kingdoms, and has been more than theirs an outcome of the life and habits of the people’: The Poor Law Amendment Bill of 1876, whilst never enacted, had proposed a greater increase in the powers of the Board of Supervision, something that local parish inspectors keenly opposed.⁶

From the beginning the idea of relief for the unemployed, medical or otherwise, was anathema to the Scottish concept of public relief provision. Concepts of *jus naturæ* - self-help and ‘familial self-responsibility’ - underlay principles long enshrined in

⁴ Ian Levitt (ed.), *Government and Social Conditions in Scotland 1845-1919* (Edinburgh: Social History Society, 1988), Introduction.

⁵ Audrey Paterson, ‘The New Poor Law in Nineteenth-Century Scotland’, in Derek Fraser (ed.), *The New Poor Law in the Nineteenth Century* (Macmillan, 1976), pp. 171-93.

⁶ *Poor Law Magazine*, Vol. VI (Edinburgh: 1878), p.22.

Scottish parochial law.⁷ That the deserving poor did not include those deemed able-bodied and therefore ‘able’ to earn an independent income was a long established principle. It was given further longevity after 1845 through the Act’s failure to redefine the traditional concept of the pauper in Scotland. The accepted definition of a pauper therefore remained by default: “*crukit folk, blind folk, impotent folk, and waik folk*”.⁸ Thus, after 1845, the determination of *disability* remained of paramount importance, and as a consequence the medical practitioner appointed found himself the central figure in the practical exercise of the Scottish poor law. Locally he was as important as the inspector of poor in determining relief entitlement, since Scottish parishes required a man with medical expertise to determine disability⁹.

A series of legal judgements between 1845 and the late 1870s confirmed that destitution alone was not sufficient to enable a person to seek poor relief. In 1852 the House of Lords began eroding some of the existing local discretionary powers of the Scottish Act by ruling that: ‘the able bodied had no right to demand parochial relief, whatever the cause of their necessities might be’.¹⁰ In 1866, in a further judicial decision over the correct interpretation of the Act (*Isdaile v. Jack*), the House of Lords also ruled that: ‘the right to give and receive relief were correlative, and if their was no right to demand relief there was no right to give relief’.¹¹ This built on Section 68 of the Poor Law Act that had originally insisted: ‘...nothing herein contained [in this Act] shall be held to confer a right to demand relief on able-bodied persons out of employment’.¹² The Select Committee into the Scottish Poor Law, (1869-71), further clarified the situation, affirming the now established principle that: ‘the persons entitled to parochial relief are those who are either wholly or partially disabled on account of age or infirmity, so as to be incapable of working or earning for themselves a sufficient maintenance’.¹³

⁷ William George Black, *A handbook of Scottish parochial law: other than ecclesiastical* (Edinburgh, 1893), pp. 129-32.

⁸ Ewan Macpherson, RC Poor Law and Relief of Distress (Cd.4978), Evidence no. 53068. The point about the failure to define the ‘pauper’ was made by Macpherson, legal member of the LGBS, in evidence, and was picked up on by Paterson, *The New Poor Law*, p. 171.

⁹ On relationship between PMOs and Inspectors of Poor see below, section on ‘Parochial workloads; locum tenens; and relations between PMOs and the Inspectors of Poor’.

¹⁰ Lamond, *The Scottish Poor Laws*, p.239.

¹¹ Macpherson, RC Poor Law and Relief of Distress (Cd.4978), Evidence no. 53068/90.

¹² *An Act for the Amendment and better Administration of the Laws relating to the Relief of the Poor in Scotland*, 1845, Vict. 8&9, c.83 (August 1845) [Poor Law (Scotland) Act], Section 68.

¹³ Quoted by reviewer in *Poor Law Magazine* 1870-71 (Glasgow, 1871), p.30.

Behind the hard-line taken regarding relief provision for the able-bodied lay the perennial resentment of ratepayers, as well as the tacit assumption that periods of unemployment would be short for the willing to work. Initially, for those able to work, physical disability was taken as the only factor in whether a person could work and endemic industrial and manufacturing unemployment was not foreseen. The beginnings of a shift in attitude towards outdoor medical assistance for the able-bodied poor in Scotland can be seen in a number of peripheral decisions cementing the central role and status of medical officers from the 1870s and 1880s. In particular, in January 1878, during a period of severe depression in the Scottish economy, Sheriff Spens of Glasgow decreed that the 'Isdaile v. Jack' judgement had disallowed only able-bodied men from relief. A woman could be judged on a different criterion, he stated, based on her duty of care for her children. This opened medical and other forms of destitution relief for some that might otherwise be dismissed as able-bodied.¹⁴ Of more particular significance was a Board of Supervision Circular dated December 1878. In this, against a backdrop of a severe winter and mounting unemployment, local parochial boards across Scotland were 'advised' by the central board to err towards a liberal interpretation of what 'able-bodied' meant. The Circular insisted that the able-bodied principle should not be taken to extremities, and that: '...It is obvious that if a person is really destitute, no long period would elapse before he also became disabled from want of food'.¹⁵

The effect of this circular and the Spens judgement in 1878 was to informally open the possibility of access to medical care under the poor law to some who might otherwise previously have been considered able-bodied (at the discretion of the local parochial board, and more pertinently, at the judgement of the medical officers), as well as to the 'collaterally poor,' the families and dependents of applicants. In effect, however, policies instigated from central authorities reflected rather than directed change in large urban parishes. For example, Glasgow City parish records that between 1870 and 1875, whilst a total of 34,764 different individuals had been given

¹⁴ See *Poor Law Magazine* 1878 (Glasgow, June 1878), p. 281f: editorial; and p. 304f: 'Spens Judgement', Bryson v. Beattie, 17/1/1878.

¹⁵ Quoted in Ewan Macpherson and Dr. Leslie Mackenzie, RC Poor Law and Relief of Distress (Cd.4978), Evidence no. 53156 and 56605/22f, from the 'Circular and Minute Respecting Able-Bodied Persons out of Employment' (12th Dec., 1878). Also quoted by Levitt, *Poverty & Welfare*, p. 11.

medical relief by it, of these fully 19,485 were technically non-paupers.¹⁶ Despite changes in interpretation of the law in the 1870s, the right of medical access of dependents was to remain a sensitive issue into the 1930s and 1940s.

The Medical Relief Disqualification Act, 1885 – a national piece of legislation affecting both Scotland and England - built on the implications of the 1878 circular and signalled a further shift in official attitudes over the problems inherent in the interconnection between medical relief and pauperisation. Under the Disqualification Act a legal distinction was made between regular paupers and those simply seeking short-term medical assistance. Persons applying to the parish and subsequently being granted outdoor medical relief only were no longer to be disenfranchised. They were, however, disqualified from acting as a parish guardian or councillor. The distinction between the pauper and the medical relief recipient under the poor law was suitably subtle to allow for an element of ongoing local interpretation.

Whilst much of the Scottish Poor Law Act of 1845 had emphasised the development of institutional provision through poorhouse construction, outdoor assistance was an obligatory aspect of pauper relief under the Act. Two sections of the 1845 Act outlined the *new* legal obligations of parishes for outdoor medical relief. The first, Section 67, permitted parochial boards to contribute public funds to support local charitable agencies where such was considered expedient. The second and most important, Section 69 of the Act, placed dietary alongside medicine treatment at the heart of the medical responsibility of parochial boards. It stated:

And be it enacted...Parochial Board[s]...are hereby required, out of the funds raised for the relief of the poor, to provide for medicines, medical attendance, nutritious diet, cordials, and clothing for such poor, in such manner and to such extent as may seem equitable and expedient...¹⁷

¹⁶ Glasgow City Parochial Board Medical Committee Reports (Glasgow City Archives) ref: GCA D-HEW 1/5/3 (May 1876). *The Scotsman* (28 Jun, 1876), p. 6: Barony Parochial Board, in June 1876, produced a report on 'medical relief to persons a grade above pauperism' where it was made clear that (in Barony, as in Glasgow City parish) broader cross-sections of the poor were routinely given un-penalised access to parochial medical services.

¹⁷ Poor Law (Scotland) Act (August 1845), Section 69. Section 67 permitted parochial boards to contribute or subscribe: '...Such Sums of Money as to them may seem reasonable and expedient...to any public Infirmary, Dispensary, or Lying-in-Hospital, or the any Lunatic Asylum, or Asylum for the Blind or Deaf and Dumb'.

Though the use of town medical officers to care for the parish sick had eighteenth century origins in Glasgow and Edinburgh, no provision in the new law specified the formal structure that outdoor medical assistance was to take and neither the appointment nor the duties of outdoor medical officers were directly prescribed. Indeed, the role of the parochial medical officer (PMO) was not mentioned at all. The Act thus left a number of matters open that would become major points of contention for the medical practitioners later contracted: 'How were Parochial Medical Officers to be appointed, and how paid, and what services were they to provide?'¹⁸

Despite the fact that the Act of 1845 made no mention of their employment, very quickly the appointment of part-time medical officers became the expedient, accepted way by which a parish met its new obligations. The 'First Report of the Board of Supervision for the Relief of the Poor in Scotland' published in 1847 noted that the most immediate effects of 1845 Act was that 'in a considerable number of parishes a medical officer with a fixed salary, has been appointed'.¹⁹ The appointment of medical practitioners to these roles became an imperative condition imposed upon any parish wishing to participate in the Government Medical Relief Grant scheme established in 1848. Through the scheme the government sought to offset the cost of the new outdoor medical relief obligation and instil a level of national uniformity. It provided a fixed sum of relief of £10,000 for outdoor medical costs for all Scotland. This was increased to £20,000 from 1883 in recognition of the growing cost of the medical service, and as an attempt to encourage and supplement the training of poorhouse sick-nurses. From 1876 a Lunacy Grant of £50,000 designed to meet the cost of asylum provision was added, as the provision of asylums for the insane was grafted onto the existing poor law system. The Medical Relief Grant enabled parishes to defer a large percentage of total 'outdoor' medical costs incurred (especially after 1883) although for Glasgow and Edinburgh parishes the monies claimed represented a small percentage of total outlay on parochial relief. For example, in 1883-84, Glasgow City parish received £6,352 as a share of the grant to offset both medical expenditure of £2,449 and expenditure on the insane of £10,391.

¹⁸ Ferguson, *Scottish Social Welfare*, p. 436. Claim for eighteenth century origins in *The Lancet* (1900), vol. 1, p. 45.

¹⁹ *The Scotsman* (13th Feb, 1847), p. 2. The new Board of Supervision, in October 1845, issued instructions to all the newly appointed inspectors of poor reminding them of the responsibility of each parish to provide 'immediate medical and surgical assistance' to all entitled to parochial relief.

Whilst total poor law receipts into Glasgow Parish Council between 1899/1900 and 1911/12 rose from £158,021 to £324,520, the amount of this represented by claims on the Medical Relief Grant scheme never exceeded £5,212 in any year. 82.1% of income over this period was from local rates, and only 1.6% came from the grant. In Govan, Edinburgh, and Glasgow, after 1883 when the grant was doubled, typically each year just over one-half of all outdoor medical relief expenditure was being claimed back as part of the Medical Relief Grant scheme in these parishes.²⁰

The Medical Relief Grant was widely if not always immediately taken up. Barony parochial board in Glasgow, for example, initially declined to participate; whilst the neighbouring City parochial board agreed, but only after seeking out the opinions of its staff of PMOs: this is clear evidence that the board respected its medical officers' views. Having studied conditions carefully and noted that accepting Medical Relief Grant money imposed few conditions and no unacceptable burdens upon them, after their initial reluctance all the larger parishes participated. Thus in order to participate Glasgow City parochial board had to agree to clear '£200 of debts owing by the Board in connection with the Medical Department'; it had to comply with a new vaccination procedure; and it had to agree to produce promptly annual and monthly statistical returns relating to the sick poor in each district.²¹ By 1875, 736 out of Scotland's 886 parishes were participating including those in Glasgow and Edinburgh. By the mid-1900s 99% of all Scottish people lived in parishes that were covered.²²

²⁰ James Nicol, *Vital Social and Economic Statistics of the City of Glasgow, 1881-1885* (Glasgow: 1885), pp. 237 to 242. 'Glasgow, Barony and Govan Parish Abstracts of Accounts 1877-1925', GCA D-HEW 6/1. For example, in the accounting year to May 1905, Govan Parish Council spent £1205 18s on outdoor medical relief, and was able to claim back from the Medical Relief Grant £607 2s (50.3%) excluding that portion of the grant paid towards the development of indoor poorhouse sick nursing services; Glasgow Parish Council spent £4068 18s, claiming back £2613 1s (64.2%) excluding that for indoor nursing services; and Edinburgh Parish Council spent £1254 12s, claiming back a total including what was claimed for indoor nursing services of £1166, 19s.

²¹ Barony Parochial Board Minutes, GCA D-HEW 2/1/1 (13th June 1848). City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (4th June 1849).

²² Poor Law Medical Relief (Scotland) Report (PP. Cd. 2022 Edinburgh, 1904), Vol. II, appendix LVI: '[In parishes] which represent a population of 4,432,873 out of a total of 4,472,103, according to the 1901 census, medical relief to the poor is administered systematically and under official regulations [as laid out as rules for participation in the Medical Relief Grant scheme]'.

Amongst conditions for participation in the grant issued by the Board of Supervision in 1856, the following outlined the duties of the outdoor medical officers to be employed:

Every Medical Officer appointed by the Parochial Board to any such parish, or to a district of any such parish, shall duly and punctually attend upon and prescribe for all poor persons requiring medical or surgical assistance within the parish or district to which he is appointed, whenever he shall be thereunto required, by a written or printed order from the Parochial Board or the Inspector of the Poor; or, in cases of sudden and urgent necessity, from a member of the Parochial Board; or by the production, on the part of any poor person, of [a] ticket....²³

The Board of Supervision imposed a host of rules and recommendations in its attempt to make more uniform outdoor medical relief of the poor across Scotland. These were periodically updated after approval by the Secretary of State for Scotland and by the 1890s numbered eighteen. These are shown in Appendix VI and serve as demonstration of how a minimalist statement of statutory outdoor medical provision under the Act flowered as it was interpreted thereafter. The rules asserted that all Scotland's paupers were entitled to be 'duly and punctually attended by a competent medical practitioner' charged with supplying 'medicines and medical and surgical appliances of such quality and to such an extent as may be necessary for the proper medical or surgical treatment'. The first measure of competency was registered qualification. The rules detailed the conditions under which a PMO was expected to work, as well as the circumstances under which he might come to be dismissed or compelled to tender his resignation: 'if any medical officer shall fail or neglect or refuse to perform the duties of his office, or shall be found unfit or incompetent to discharge them'.²⁴

Evidence from the Medical Committee Minutes for Glasgow City parish shows that each newly appointed PMO was issued the same standard contract in the form of a 'Duties' handbook that was originally drafted in November 1854. Local and national

²³ Peter Beattie, *Barony Parish Parochial Law* (2 vol.s) (Glasgow, 1881), Vol.1 p. 150, 'rule 10'.

²⁴ 'Rules framed by the Board of Supervision, under the Statute 8 and 9 Vict. Cap. 83, as to Medical Relief of the Poor' in *Report of the Departmental Committee appointed by the Local Government Board for Scotland to enquire in the system of Poor Law medical relief and in the rules and regulations for the management of poorhouses*, vol. II (Edinburgh, 1904 Cd. 2022), Appendix LXVI, pp. 283-4. These rules are printed out in full in Appendix VI of this paper.

guidelines were interwoven. Other parochial boards would have issued similar contracts. For those employed after 1875 these duties read:

1. To attend within his District all poor persons who stand in need of medical or surgical assistance, including patients during cholera and other epidemics, whenever required, by a written or printed order from the Inspector. The same services to be given in the case of poor persons having claims on Glasgow Parish, but residing in the Parishes of Barony, Govan, or Gorbals, contiguous to his district.
2. To perform the above duties to all persons without a written or printed order from the Inspector, whenever the Parochial Board shall deem it fit to suspend that part of the above Rule ...
3. To attend all aged and infirm persons permanently disabled, who are in receipt of Parochial relief, and residing within his District, on producing to him a Ticket furnished to them by the Parochial Board. A list of the names of such persons will be furnished to the Surgeon from time to time for his guidance.
4. [Scored out – concerned previous vaccination responsibilities].
5. To transmit to the Inspector, whenever required, a written report of the state of health and fitness for work of any person applying for relief.
6. To give under his hand a certificate in the case of Lunatics, or of any other poor person, whenever required by the Inspector.
7. To enter in a regular and complete manner in the book provided for that purpose, the names and other particulars of illness, and attendance...of all persons receiving at his hands Parochial Relief.
8. To make monthly returns of the sick poor to the Parochial Board, and an annual return...to the Board of Supervision...
9. In keeping the books...to employ...the terms used or recommended in the regulations and statistical nosology of the Registrar-General.
10. To attend when required any meeting of the Parochial Board, or of its Committee.
11. To furnish the Inspector with the name of a duly qualified medical Practitioner, for whose diligence he will be held responsible, and who will perform his duties in case of his absence from home, or other unavoidable hindrance to his personal attendance.
12. To obey all present and future Rules and Regulations...
13. His salary for these services shall be £55 per annum, without other fee or emolument.²⁵

From this list the actual medical duties expected of the medical practitioner being appointed are not detailed beyond the use of the loose phrase ‘to attend... [and provide] medical and surgical assistance’. The administrative duties connected to the appointment are more specific. The demand that the ‘district surgeon’ or PMO be familiar with the ‘statistical nosology of the Registrar-General’ is testament to the

²⁵ For example, see ‘Duties of the District Surgeons’ guidelines issued to, and signed by, John Falconer Murison in City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/5 (April 1897).

burgeoning sophistication of national and civil administrative record keeping, and the growing importance of statistical investigation in medicine in the second half of the nineteenth century.

Levitt dates a clear demarcation between medical work of the poor law authorities and the voluntary charity services to the period covered by this thesis, arguing: 'During the 1870s, a clear demarcation in the structure of medical welfare had evolved. Voluntary hospitals were freed from the necessity of dealing with the infirm, the chronically ill, the insane and those affected with infectious diseases and so could turn their attention to acute illnesses and the newer horizons of surgical medicine'.²⁶ Despite historical criticisms, the parochial contracts in Scotland encompassed a much wider view of healthcare provision than doctoring in the narrow sense. The medical duties were essentially threefold. First, PMOs were employed to visit paupers, normally within twenty-four hours of being requested to do so), to facilitate and provide necessary medical treatment and advice, and fill medical prescriptions. Under the terms of the 1845 Act with its onus on parish boards to 'provide for medicines, medical attendance, nutritious diet, cordials, and clothing' - it was common for the practitioners to find that as much of their time was spent on considerations of diet as on any other specific form of medical treatment. Faced with the hungry sick, food carried medicinal status. PMOs who gave evidence regarding their work to the Royal Commission in 1907 all described supplying medicine and supplying food 'stimulants' in the same breath. Detailing the work of its members in February 1878, the Scottish Poor Law Medical Officers' Association made it clear that in its members' eyes: '[parochial] medical treatment consists quite as much in the administration of a sufficient and appropriate diet as in the exhibition of drugs.'²⁷

The nutritional aspect of medical care was one that posed a functional dilemma for some PMOs and for parish boards alike. Ironically, given that his son would go on to become a pioneer in the study of poverty and childhood nutrition, responsibility for prescribing food provision was seen by at least one Glasgow PMO as anomalous to

²⁶ Ian Levitt, *Poverty & Welfare in Scotland, 1890-1948* (Edinburgh: Edinburgh University Press, 1988), p. 14.

²⁷ *The Poor Law Magazine*, vol. VI (Edinburgh: 1878), p. 75.

what he perceived as the pure practice of medicine. In February 1891, William Findlay bemoaned to the Medical sub-Committee of City parish that he was frequently expected to prescribe food as part of his duties, and that:

Cases [were] coming before him where paupers applied for cordials and nourishing food, and...that he considered that such was work more in connection with the Inspector's Department than the District Surgeon's...²⁸

Secondly, Scottish PMOs were employed to assess disability (the criterion of relief entitlement), with all applicants being examined and certified. Thirdly, a medical officer had ad hoc additional responsibilities or 'extras' to perform, including at various times, vaccination, the certification of suspected lunatics and, from 1877, the reporting accidents and suspicious deaths.²⁹

'In the administration of the Poor Law [in Scotland] a parish medical officer is as necessary in a parish as an inspector of poor. In addition to the benefit of having a recognised official to attend the sick, it must not be overlooked that in Scotland, no able-bodied person is eligible for poor relief, and that the parish medical officer must necessarily be the ultimate, if not also the primary, judge of the physical condition of an applicant for relief.'

From Findings of the Poor Law Medical Relief (Scotland) 1904³⁰

It was the duty of medical examination and certification that made the PMO the fulcrum of the Scottish poor relief system: entitlement to relief for most hung on this process, as too often did the decision whether a pauper was likely to be treated at home or in the poorhouse.³¹ In examining an applicant for relief, Dr W. Leslie Mackenzie, medical member of the LGBS, pointed out that PMOs regularly took both physical and psychological factors into consideration. Medical judgement was

²⁸ Glasgow City Parochial Board Medical Committee Minutes, GCA D-HEW 1/5/4 (19th February 1891). William Findlay was the father of Glasgow child-health specialist, Leonard Findlay, M.D., D.Sc. See, for example, D. Noel Paton and Leonard Findlay, *Poverty, Nutrition and Growth: Studies of Child Life in Cities and Rural Districts of Scotland* (Special Report Series, No. 101, Medical Research Council) (London: HMSO, 1926). Much of this report based on home visit investigations carried out amongst the poor of Glasgow, Edinburgh and Dundee.

²⁹ Contemporary witnesses from both Glasgow and Edinburgh largely concurred when asked to sum up the medical work. For example, see Dr W. L. Martin, Edinburgh PMO, RC Poor Laws and Relief of Distress (Cd.4978), Appendix CIII; James Erskine, Glasgow Parish Councillor and later PMO, RC Poor Laws and Relief of Distress (Cd.4978), Appendix LII; and John Veitch Wallace, Govan PMO, Parish Councillor and later PMO, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 60312/1.

³⁰ Poor Law Medical Relief (Scotland) 1904 (Cd. 2008), vol. 1, part V, p. 69. This assessment almost exactly echoed in Thomas Jones' Interim Report, RC Poor Law and Relief of Distress (Cd.4690), Appendix XVII, part II, p. 279.

³¹ See Dr. W. Leslie Mackenzie, RC Poor Law and Relief of Distress (Cd.4978), Evidence 56626 and 56675; and James Devon, RC Poor Laws and Relief of Distress (Cd.4978), Appendix XLI.

paramount. For Mackenzie, the skill and dedication of the PMOs was one of the five key factors that influenced poor law medical work. Also important, he said, was the level of contemporary medical understanding; the equipment and drugs provided by the parishes; the nature of the diseases of applicants; and the overall aims of poor law policy.³²

Due to its importance to the Scottish system, examination and certification came under intense scrutiny in the early years of the twentieth century and was thoroughly criticised by the commissioners of the Large Towns Parishes in Scotland Report of 1905. The commissioners had witnessed proceedings at first hand during morning sessions of medical examinations carried out in the set-aside rooms of various parishes' council offices (although not in homes), and noted:

As a rule, all applicants are medically examined before relief is granted.... The examining medical officer is furnished with a copy of the application form, showing the name of applicant, age, alleged disability, and kind of relief asked for. The examination is [then] made either at the applicant's home or at the Parish Council Office... [with] homeless cases examined at the Parish Council Office.³³

With the growing utilisation of set aside facilities from the 1890s it was estimated that half of all applicants by the 1900s were examined in the parish chambers: half were still examined at home. Tens of thousands applied for relief in Edinburgh and Glasgow each year, with an average of 65 fresh applications per day to Glasgow Parish Council in 1904, and 20 per day to Govan. Allowing for examinations taking place at the council chambers by the PMO on duty, although parish districts varied, these figures suggest that each PMO thus would have expected an average of one to three new examination assignments each day that required a home visit, as well as the normal workload of home visits for those already on the pauper roll.³⁴

Despite the efforts of the central authorities in Edinburgh to regularise provision, urban PMOs were largely left to act as they would have routinely done in independent general practice, with little direct daily control or interference. PMOs were expected

³² Dr. W. Leslie Mackenzie, RC Poor Law and Relief of Distress (Cd.4978), Evidence no. 56605/20.

³³ LGBS Large Towns Report, 1905 (Cd. 2524), p. x. Exceptions to the medical examination rule included deserted women and children or applicants for educational support.

³⁴ LGBS Large Towns Report, 1905 (Cd. 2524), reports 23,650 applications during 1904 to Glasgow Parish Council, and 7,358 to Govan Parish Council.

to treat the poor in a manner consistent with their ordinary practice, as demonstrated in the following summary in the records of Glasgow City parochial board in October 1895:

...The state of health of *every* applicant for admission to Poorhouse must be certified by a medical man before admission... *The system of consultation and visitation is identical with that pursued generally throughout Glasgow in ordinary private practice.* The cards supplied to all persons on the outdoor poor roll authorise them to procure the services of the medical officers to themselves or their dependents [as required].³⁵

An area of potential disadvantage of poor law service was the medical officers' supposedly fractious relationship with local, lay Inspectors of Poor. It was the mixing of these roles that for some symbolised the confusion of medical relief and poor relief.³⁶ In contrast to some well-rehearsed debates over the relationship between the medical officer and the relieving officer in England, there is less evidence to suggest similar tensions in Scotland, where PMOs and Inspectors of Poor mainly enjoyed an amicable and largely *symbiotic* relationship. Though the medical officer theoretically worked under the authority of the Inspector of Poor for the parish, the two most often worked in unison.³⁷ Whilst some PMOs might complain of interference (primarily over the disputed ground of provision of what were known as 'medical extras' – namely dietaries, clothing, and 'non-essential' medical appliances), it was a foolish or foolhardy inspector who risked ignoring the advice of his PMO. The legal obligation to grant medical relief provision ultimately lay with the inspector; and in cases where failed applicants for relief subsequently died, if it was found that he had failed to heed the PMO's advice and grant particular forms of relief, the inspector was directly legally liable. The medical member of the LGBS, W. Leslie Mackenzie, summarised the distinction of responsibility between the inspector and his PMO thus: 'the inspector of poor is really the person responsible for the applicant, and the medical officer comes in as a certifying adviser, so to speak.' Although 'the doctor is not the principal in the case,' Mackenzie clarified that his word was, in fact, supreme.³⁸ Edinburgh's Inspector of Poor was even clearer on where the ultimate power in the relationship lay:

³⁵ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (11th October 1895).

³⁶ Kidd, *State, Society and the Poor*, p. 41, quoted in the Introduction of this thesis.

³⁷ See rules issued to PMOs in Appendix VI

³⁸ Dr. W. Leslie Mackenzie, *RC Poor Law and Relief of Distress* (Cd.4978), Evidence 56630.

[2595] I call your attention to No. 4 of the rules as to medical relief of the poor... if the inspector refuses or fails to furnish that relief he will be held accountable for such refusal or failure.'

[2596] ...The moment the doctor says, 'I recommend and order a patient to get such and such,' then I say that I [as the Inspector] am bound to supply it without consulting my board. The doctor must take the responsibility.

[2600] In fact the doctor is supreme? – Yes, he is supreme in everything affecting the health and condition of the patient. If anything were to happen to a patient or a pauper through the inspector refusing to give what was ordered by the doctor, then it would be a very serious position for the inspector to be placed in.³⁹

PMOs in Scotland's large, urban parishes were as categorical when also asked to comment at the start of the twentieth century:

All the medical officers that I have any acquaintance with never complain about interference in ordering their extra diet and other things for the paupers. That is in the Glasgow or the Govan parish. They are allowed a free hand.⁴⁰

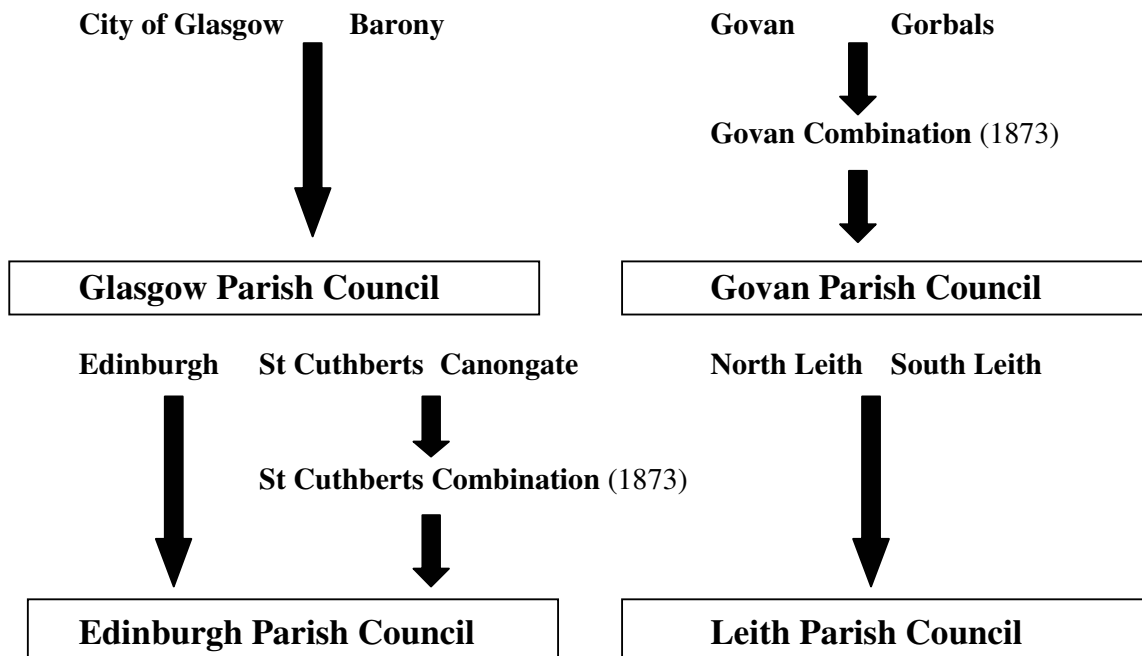
³⁹ Mr A. Ferrier, Edinburgh Inspector of Poor, Poor Law Medical Relief (Scotland) Report 1904 (Cd. 2022), Vol. II, Evidence 2469-2741.

⁴⁰ William Limont Muir, Poor Law Medical Relief (Scotland) Report 1904 (Cd. 2022), Vol. II, Evidence 999 and 1029. Edinburgh PMOs denied interference from Inspectors of Poor too. See Dr W.L.Martin, Edinburgh PMO, RC Poor Law and Relief of Distress (Cd.4978), Appendix CIII.

2.2 The outdoor parochial medical services of Glasgow and Edinburgh

The focus here is the outdoor parochial medical services of the urban parishes that made up what by 1911 consisted of Glasgow, Govan, Edinburgh and Leith Parish Councils (Figure 2.1).

Figure 2.1: The parochial boards that became Glasgow, Govan, Edinburgh and Leith Parish Councils after the Local Government (Scotland) Act, 1894



Under the new Poor Law (Scotland) Act of 1845 a new administrative structure had been imposed upon Scotland by which the country was divided into 840 parishes based on historic Kirk-based areas. As Figure 2.1 demonstrates, there were initially four main parochial boards in Glasgow (north and south of the river). Voluntary combinations of parishes were possible in order to pool resources, and Govan absorbed Gorbals in 1873. This left three parishes in Glasgow consisting of Glasgow City, Barony (Glasgow's landward parish) and Govan Combination. Glasgow City had originally the biggest density of poor, although many were displaced by the 1870s; Barony was Scotland's most populated parish with the biggest parochial board; and Govan was Scotland's fastest growing parish in terms of population. From

1898, after combination of Barony and City, these became reduced to two, Glasgow Parish Council and Govan Parish Council. Edinburgh (including the parishes of the port area of Burgh of Leith) consisted of four parishes by 1875: City of Edinburgh, St Cuthberts-Canongate (combined in 1873, following the opening of a joint poorhouse at Craiglieth in 1868), and North and South Leith. The demography of Edinburgh City parish, like Glasgow City parish, was impacted upon by redevelopment. St Cuthberts was Edinburgh's most populous parish, having doubled in size over 40 years to a population of 176,434 in 1881. From 1895 these also became two, Edinburgh Parish Council and Leith Parish Council. The parish councils, established by the Local Government (Scotland) Act of 1894, remained the main administrative unit until replaced under the Local Government (Scotland) Act of 1929.⁴¹ By the 1900s, by burgh population, Glasgow, Edinburgh, Govan and Leith were the first, second, fifth and seventh most populous places in Scotland.⁴²

Dimensions of the parochial service in Glasgow and Govan compared to Edinburgh and Leith are shown in Tables 2.1 and 2.2. Population density per PMO varied between cities and over time (Table 2.1). In Edinburgh and Leith the ratio of PMOs to population changed from 1:17,680 circa 1880 to 1:30,424 persons in 1910. In Glasgow and Govan the ratio changed from 1:24,177 in 1880 to 1:33,553 in 1910. Differences between cities can be seen to have closed by the turn of the century. These changes were in line with what was happening everywhere: Webb, for example, noted three of the poor law districts of Birmingham exceed 120,000 in population.⁴³ Changes reflected the changing ability of medical practitioners to take on more patients, particularly as transport systems improved.

⁴¹ The Local Government (Scotland) Act (1894) was more fully The Local Government (Scotland) Act [57 & 58 Vict., c.58]. Under it parish councils replaced parochial boards, and a Local Government Board replaced the Board of Supervision. Former property qualifications regulations were swept aside under the Act. On this see J. Edward Graham, *Manual of the acts relating to parish councils in Scotland* (Edinburgh: 1897).

⁴² *Journal of the Royal Statistical Society*, Vol. 74 No. 6 (May, 1911), p. 663: Glasgow burgh population 784,455; Edinburgh 320,315; Dundee 165,002; Aberdeen 163,084; Govan 89,723; Paisley 84,477; Leith 80,489. On discussions over combination of Govan and Gorbals see Govan Parochial Board Minutes, GCA D-HEW 2/8.

⁴³ Webb, *The State and the Doctor*, p. 17. In England and Wales at this time the limits of each Poor Law medical district was theoretically set at '15,000 acres in extent – equivalent to a radius of nearly 2¾ miles from a central point – or 15,000 in population': in practice, these population limits were widely discarded.

Table 2.1: Number of PMOs and local medical practitioners and proportion of these to the total population of parishes in Edinburgh and Leith and Glasgow and Govan, 1880-1910.

	Parishes	PMOs	Population	Population per PMO	local medical practitioners	population per Practitioner	% of practitioners serving as PMOs
Edinburgh & Leith:							
circa 1880	4	14	247,524	17,680	207	1,196	6.8%
1890	4	12	297,270	24,773	286	1,039	4.2%
1900	2	12	338,114	28,176	362	934	3.3%
1910	2	13	393,146	30,242	366	1,074	3.6%
Glasgow & Govan:							
1880	3	23	556,070	24,177	294	1,891	7.8%
1890	3	22	669,100	30,414	390	1,716	5.6%
1900	2	27	756,325	28,012	558	1,355	4.8%
1910	2	27	905,931	33,553	538	1,684	5.0%

Source: Population data from Medical Directories. For 1900 and 1910 the Burgh population is given instead of the sum population of the individual parishes. The number of 'medical practitioners' as listed in the Edinburgh and Leith Post Office Directory and 'physicians and surgeons' listed in the Glasgow Post Office Directory for Glasgow and Govan for the years 1880-1, 1890-1, 1900-1, and 1909-10 (for Glasgow) and 1910-11 (for Edinburgh).⁴⁴

Table 2.2: Comparison of ratio of indoor versus outdoor relief as administered in Edinburgh and Glasgow in 1896 and 1906

Burghs	Area (acres)	Pop'n	Gross Rental Valuation (£)	No. of paupers plus dependents				Ratio outdoor to indoor	Paupers as % of pop.
				Indoor	Outdoor	Lunatic	Total		
1896									
Glasgow, Govan, Kinning Park and Partick	25,724	789,426	£4,882,088	3,153	13,773	2,095	19,021	4.4 to one	2.41%
Edinburgh and Leith	23,512	353,641	£2,898,550	1,199	5,475	989	7,663	4.6 to one	2.17%
1906									
Glasgow, Govan, Kinning Park and Partick	24,743	941,423	£6,812,514	5,209	17,583	3,169	25,961	3.4 to one	2.76%
Edinburgh and Leith	23,124	404,784	£3,833,900	1,669	6,075	1,384	9,128	3.6 to one	2.26%

Source: Copy of paper handed in by Local Government Board for Scotland, *Poor Law and Relief of Distress (Royal Commission)*, Appendix Vol.VI.: *Minutes of Evidence*, 95th to 110th Days, and 139th and 149th Days, with Appendix (Cd.4978, 1910), app. no. CLXXXIX

⁴⁴ The of medical practitioners from local post office directories (recorded here) is significantly less than the number listed at these times in the Medical Directory for the two cities. For example, in 1910, the Medical Directory lists 646 qualified practitioners living in the Edinburgh area and 789 in the Glasgow area. The Post Office Directory data is used because this better presents the number of practitioners who were, at these times, actively working in general practice (rather than men who were specialists, teaching, not yet established in practice and/or retired).

The burghs (and parishes) of Glasgow and of Edinburgh covered very similar acreage although the population of Glasgow was consistently more than double that of Edinburgh.⁴⁵ Differences in population are reflected in differences in the numbers of paupers (and dependents) in each city. Although Table 2.2 shows a higher percentage of paupers in Glasgow than in Edinburgh, typically between 2% and 3% of all persons across Scotland were registered as paupers at any one time. Per Table 2.1, Glasgow-Govan together grew nearly two-thirds between 1880 and 1910; and the Edinburgh-Leith population a little less (at 58.8%). All parishes were centres of much urban-cross migration activity amongst the poor. St Cuthberts Combination on 14th May 1880, for example, had 1,985 paupers on the parish roll, including persons who had residency established with 56 other parishes across Scotland (including Glasgow, Aberdeen and Dundee).⁴⁶

Different sub-districts within each parish – often coinciding with locally familiar and established suburbs – each had their own elected parochial board representatives. By local arrangement, each of these sub-districts was usually recognised as its own relief district with its own PMO.⁴⁷ Before 1911, these districts in Glasgow and Edinburgh were all served by men. Such a territorial approach, which had roots in the Kirk-based responsibility for welfare, suited the medical practitioners employed, who by the nature of their business sought to carve out local influence and who also had made it clear that they wanted a clear demarcation of their sphere of parochial responsibility. The territoriality of parochial medical work was emphasised by the PMO James Maxwell Adams in his study of Glasgow Cholera in 1849:

The thirteenth medical district [Adams's district] comprises that central portion of the city which is bounded on the upper or north side by George Street; by the west side of High Street to Stirling Street; by Stirling Street to

⁴⁵ There is some difference between the burgh and the parish as administrative units. Burgh data is used here to give an approximate comparison of parishes.

⁴⁶ St Cuthberts Parochial Board Annual Reports (Edinburgh: Edinburgh City Archives (ECA)) ref: SL/10/16 (14th May 1880).

⁴⁷ The medical district structure of Glasgow parishes is shown in Appendix IX. For example, Glasgow City – which was originally sub-divided into twelve districts - from 1878 was divided into the eight districts of Central, Whitevale, Broomielaw, Mile-End, St. Rollox, Townhead, Garngad and Garscube. Each was assigned a PMO. Barony was sub-divided into nine districts: Parkhead-Camlachie, Anderston, Springburn, Blythswood-Sandyford, Calton-Bridgeton, Maryhill, Dennistoun, Woodside-Keppoch-Cowcaddens, Anderston, and Finnieston. After combination of City and Barony, as Glasgow grew outwards, from 1899 new districts of Possilpark-Lambhill, Shettleston-Tollcross, and Rockvilla were added to what became Glasgow Parish Council, again each with its own PMO. By the 1900s Govan Parish Council was sub-divided into seven medical districts, Edinburgh nine medical districts, and Leith two medical districts.

Candleriggs; thence to Argyle Street; by Argyle Street to Buchanan Street, and thence to George Street. It forms pretty nearly an oblong quadrangle, running from east to west, half a mile in length, by a quarter in breadth. The population of the entire district can scarcely be under 14,000; and of this number I consider that about 5,000 are of that class who avail themselves of the services of the parochial surgeon.⁴⁸

As city centres altered and the population density of different parts of Glasgow and Edinburgh changed, representatives of the different local parochial boards occasionally found they had to reconfigure the medical districts of each PMO. With reorganisation sometimes instigated by the PMOs and other times by parochial board members, changes also took into account changes in different PMO workloads. These changes did not occur very often. They were time-consuming exercises and always stirred controversy. After an agreement was reached between the three parishes of Glasgow regarding reciprocity in medical relief provision for non-settled paupers in October 1876, the City parish board considered (but ultimately rejected) plans to redraw the internal parish boundaries of the medical districts. The process of deciding whether to carry out internal restructuring of districts included an audit calculation of *the average number of cases per month that each serving medical officer in City parish was required to treat 'to conclusion' and the average number of medical certificates issued by each during the year to the end of May 1876.*⁴⁹

Table 2.2 shows differences in ratios of indoor to outdoor paupers in Glasgow, Govan, Edinburgh and Leith. Sustained greater numbers of outdoor poor in Glasgow into the 1900s was in spite of significant investment in poorhouse medical facilities. In September 1904, Glasgow Parish Council formally opened three new parish hospitals, at Stobhill, Duke Street and Oakbank. The cost of the project was given at almost £500,000. This was a huge sum given average expenditure of medical relief across Scotland at this time (Table 2.4).⁵⁰ Despite the promotion of its new-built

⁴⁸ Extract from James Maxwell Adams, *Observations on the Epidemic Cholera of 1848-9, chiefly as it prevailed in the 13th Medical District of City Parish Glasgow* (Edinburgh: 1849), available on-line at: <http://www.nls.uk/scotlandspages/timeline/1848.html#label> [viewed 23rd June, 2008].

⁴⁹ Glasgow City Medical Committee Reports (6th November 1876), GCA D-HEW 1/5/3.

⁵⁰ *The Scotsman* (16 Sep, 1904), p. 7. Stobhill, with original accommodation for 1600 inmates, was originally meant for treatment of 'the infirm poor and children'; the Eastern District Hospital in Duke Street, with 250 beds, had separate wards for 'probationary and isolation cases', and for mental, medical, surgical, skin and maternity cases; the Western district Hospital at Oakbank had accommodation for 200 beds, and pavilions for surgical, medical, maternity and skin diseases. The new

hospitals, and despite the fact that its indoor services by this time were much superior to those of Edinburgh, poorhouse inmate numbers remained severely limited in terms of bed capacity through to the end of 1911.⁵¹ Total annual spending on outdoor relief in Glasgow remained significantly higher. The greater burden on Glasgow parishes in terms of number of paupers was reflected in greater annual expenditure of medical services (Table 2.3). Also reflected in Table 2.3 is the difference in emphasis between Edinburgh and Glasgow in the development of parish dispensaries.

Table 2.3: Average total annual expenditure on outdoor medical relief by Edinburgh, Glasgow and Govan Parish Councils, per annual accounts, 1899-00 to 1911-12.

Av. recorded total annual expenditure for years from 1899/00 to 1911/12	Edinburgh		Glasgow		Govan	
	av. (£)	%	av.	%	av.	%
<i>on...</i>						
PMO salaries	751	60.9%	1751	42.3%	491	37.5%
Medicines & appliances*	169	13.7%	578	14.0%	354	27.1%
dispensary services costs	0	0.0%	608	14.7%	377	28.8%
subscriptions (hospitals, nursing etc)	128	10.4%	318	7.7%	86	6.6%
Children, lunatics, invalids boarded out	164	13.3%	768	18.6%		
non-resident poor/paid to other parishes	15	1.2%	113	2.7%		
other/ad hoc	6	0.5%				
Total for medical relief (outdoor)...	1234		4136		1308	

Source: *listed in Glasgow Parish accounts instead as 'medical attendance and medicines'.
Data calculated from annual account returns in 'Glasgow, Barony and Govan Parish Abstracts of Accounts 1877-1925', in Glasgow City Archives (GCA) D-HEW 6/1.

Total spending on parochial medical relief across Scotland – whilst overall remaining a small proportion of total relief spending throughout the history of the poor law – rose considerably. In 1875 medical relief expenditure on indoor and outdoor treatment combined, across Scotland, accounted for £34,771 (4.3%) of total parochial relief spending of £804,916. By 1905 expenditure had risen 91.7% and accounted for £66,651 (5.2%) of a total of £1,285,721 (Table 2.4). This doubling in expenditure was during a period recent government research suggests was otherwise marked by an

complex of hospitals in Glasgow pre-empted the findings of the Royal Commission to signal, in Glasgow, the formal separation of the sick from the remaining pauper inmates.

⁵¹ RC Poor Laws and Relief of Distress (Cd.4978), Appendix CLXI (A): *Paper handed in by Dr W. Leslie Mackenzie*. Mackenzie recorded the average daily number of inmates – sick or otherwise - for all poorhouses across Scotland with trained sick nursing staff. For Glasgow this was 4,138 (Barnhill 1,976; Stobhill 1,734; Western 181; and Eastern 247); for Edinburgh 1,322 (split between Craiglockhart and Craigleith); for Leith, 451; and for Govan, 1,275 inmates.

overall price deflation across the British economy (Figure 2.2).⁵² The proportion of total relief expenditure on medical relief varied between parishes although each was loosely in line with national statistics: for example, 2.9% of expenditure was on medical relief in Barony in 1883-4, and 3.7% in Govan. Of £40,757 claimable medical relief expenditure by all Scottish parishes in 1880, medical relief expenditure was £2,625 for Glasgow City parish, £3,038 for Barony, £1,223 for Govan, £863 for Edinburgh City, £858 for St Cuthberts, £309 for South Leith, and £167 for North Leith.⁵³

Table 2.4: Parochial medical relief expenditure in Scotland as a percentage of total poor law relief expenditure, per claims returns by parishes to the LGBS as a condition of participation in the Medical Relief Grant, for year 1875-1911

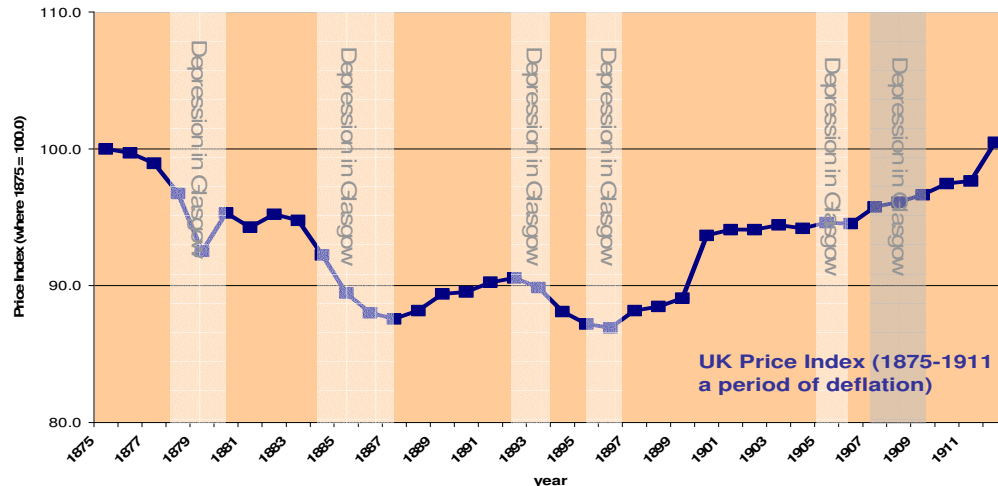
Year	medical relief expenditure (MR) (£)	total relief expenditure (£)	MR as % of total:
1875	34,771	804,916	4.3%
1880	40,757	849,064	4.8%
1885	39,578	830,641	4.8%
1890	42,311	841,952	5.0%
1895	48,091	926,759	5.2%
1900	53,468	1,056,964	5.1%
1905	66,651	1,285,721	5.2%
Growth	91.7%	59.7%	

Source: Data table originally published as ‘Relief Figures for all Scotland’ in RC Poor Law and Relief of Distress (Cd.4978, 1910), appendix CLIX (C) Table No. 6.

⁵² Per Robert Twigger, *Inflation: the Value of the Pound 1750-1918*, Economic Policy and Statistics Section of House of Commons Library (London: House of Commons Research Paper 99/20, 23 February 1999), available on-line at [<http://www.parliament.uk/commons/lib/research/rp99/rp99-020.pdf>]: at no time to 1911 was the pound worth less in U.K. than in either 1854 or 1875. The mid 1870s to mid 1880s was a period of gradual deflation in Britain; the late 1880s to the 1890s, a period of largely stable prices in Britain (with 1896 price index 14.1% lower than 1875); the 1900s, a period of gradual price recovery to 1875 levels (with 1912 price index just 0.5% higher than 1875).

⁵³ James Nicol, *Vital Social and Economic Statistics of the City of Glasgow, 1881-1885* (Glasgow: 1885), pp. 237-42, published ‘Expenditure Tables’ on Glasgow’s three parishes – City, Barony, and Govan.

Figure 2.2: Recently estimated U.K. price index showing levels of inflation, 1875 to 1911, with periods of depression in the Glasgow economy highlighted (identified by years when relief works opened in Glasgow by Glasgow Town Council)⁵⁴



Source: Robert Twigger, *Inflation: the Value of the Pound 1750-1918*, Economic Policy and Statistics Section of House of Commons Library (London: House of Commons Research Paper 99/20, 23 February 1999).

Poor law medicine in Scotland was separately arranged, organised and funded to that elsewhere in Britain. These differences produced natural inequalities. Scotland had a separate legal system (although legislation lay with Westminster) and an independent religious culture. Scottish welfare traditions meant the parish was the prime unit of relief provision.⁵⁵ Whereas a central concern of the 1834 poor law in England was to discourage people out of work from applying, in Scotland the issue of ‘disability,’ defined as the inability to work, was at the heart of its poor law. Central in Scotland

⁵⁴ Evidence of James Bell, Glasgow Lord Provost, Select Committee on Distress from Want of Employment (1895, Third Report, PP 365), 7811f: Bell claimed seven major periods of economic distress in the Glasgow economy between 1845 and 1895: relief works were used by the Town Council during winters of 1878-9 and 1879-80 (blamed by Bell on the collapse of the City of Glasgow bank); 1884-5; 1885-6; 1886-7 (due to ‘great commercial depression’); 1892-3 (blamed on a periodic downturn in the iron and shipbuilding industries); 1895 (blamed on severe bad weather and commercial depression); 1902-3; 1904; and 1905. Per SC on Want of Employment, 1895 (PP 365), Appendix 32, Edinburgh municipal authorities also established make-work schemes in difficult economic years: in 1895, the municipal authorities employed labourers on roads and cleaning duties.

⁵⁵ *The Scotsman* (24 Feb, 1876), p. 4: At the start of the period of interest here, in February 1876, it was reported that a delegation of Scottish M.P.s had approached the Home Secretary in London with a view to seeking an increase in government expenditure commitment on parochial medical relief in Scotland. The delegation sought what they referred to as ‘equality with England,’ and were duly informed that the cost of such equality would be greater central control over the parishes of Scotland, and ‘a re-opening’ of the question of the need for a separate parochial system in Scotland at all. The sacrificing of Scottish legislative independence was evidently a price too high for equality, and the claim dropped.

therefore was the need to determine functional capacity through medical examination, followed by the provision of medicines and medical attendance.⁵⁶ Commissioned in the first decade of the twentieth century to make comparison between the English and Welsh system and the Scottish system, Thomas Jones especially noted a number of differences, particularly the importance of outdoor relief in Scotland.⁵⁷ Outdoor, or domiciliary, relief was a defining characteristic of the Scottish poor law. Most medical examinations and provision of medical relief continued to be carried on in the home, despite the establishment of dedicated if rudimentary facilities at City Chambers - in Glasgow and Govan, Edinburgh and Leith - and the growing propensity of the medical practitioners to establish district shop-surgeries where they might see patients.

An anti-outdoor relief movement had swept Britain from the end of the 1860s.⁵⁸ At this time the nation faced deepening, social and economic challenges of entrenched poverty and of industrial unemployment. Anti-outdoor relief and anti-public charity campaigns became manifestations of the desire to reduce the overall cost of pauperism to the public purse. All forms of outdoor poor law service – including the medical service - were targeted. Scotland too felt the residual influence of developments in the poor law south of the border. In particular there was an ideological crusade waged against outdoor relief being claimed by the unemployed led from London.⁵⁹ In the face of rising costs, competing relief ideologies resurfaced. Battle lines were drawn in Scotland between those like Dr. Alexander Wood and the organisation known as the Edinburgh Association for Improving the Condition of the

⁵⁶ Traditionally, whereas the three defining characteristics of the English poor law have been said to be its centralising framework, the workhouse test, and the guiding principle of less eligibility, the Scottish poor law was characterised by its localism, a preference for outdoor relief, and the disability rule. On this see, for example, Audrey Paterson, 'The New Poor Law in Nineteenth-Century Scotland', in Derek Fraser (ed.), *The New Poor Law in the Nineteenth Century* (Macmillan, 1976), pp. 171-93. For Sir George Nicholls, *A history of the Scotch poor law, in connexion with the condition of the people*. (London, 1856), p. 112: 'The chief characteristic of Scottish Poor Law administration, as contrasted with that of England, is the pertinacity with which all claim to relief on behalf of the able-bodied poor has been resisted.'

⁵⁷ (*Royal Commission*) *Poor Law and Relief of Distress* (Cd.4690, 1909), appendix XVII: 'Report by Miss Constance Williams and Mr Thomas Jones on The Effect of Outdoor Relief on Wages and the Conditions of Employment', 'Interim Report No. 5, by Mr. Thomas Jones of inquiry into the effect of outdoor relief on wages and the conditions of employment in certain parishes in Scotland', part I, p. 237f., and part II, p. 259f.

⁵⁸ Andrew Wallace, 'Outdoor and Indoor Relief' in *The Poor Law Magazine and Parochial Journal*, vol. VI (Edinburgh: 1878), p. 116f..

⁵⁹ See editorial comment reprinted from *the Local Government Chronicle* in *The Poor Law Magazine and Parochial Journal*, vol. V (Edinburgh: 1877), p. 19.

Poor [AICP], that maintained that indiscriminate relief was anathema to social efficiency and to Victorian values of self-help, and those who rather felt the ‘positive necessity’ of compulsory assessment. Although unsuccessful in changing law, the rise in charity organisation movements throughout Britain’s cities was a direct consequence. There was little change wrought, for example, by the House of Commons Select Committee Inquiry into the Scottish Poor Laws, 1869-71, chaired by Eduard Crauford.⁶⁰ As a result the Scottish parochial medical service, into the 1870s and in the decades thereafter, continued largely unchanged as an outdoor service.

Paterson has pointed out that a simple explanation for the preference for outdoor relief in Scotland was that it was ‘cheaper and easier to organise than residential care’. This held obvious appeal, although costs were never the sole consideration in determining whether outdoor or indoor relief was granted in a particular instance.⁶¹ In 1904 a LGBS departmental committee report found that although over twice as much was being spent across Scotland on outdoor medical relief as on indoor parochial medical relief, the actual per capita cost of providing medical relief outdoors was less than half that of medical relief in the poorhouse: it calculated treatment costs per head around two and a half times higher for indoor treatment than any domiciliary treatment. In 1890, indoor medical relief expenditure for Scotland was £11,749; with 9,182 provided indoor medical relief this equated to an annual expenditure per pauper of £1 5s 7d. In 1890 outdoor medical relief expenditure was £30,562; with 76,768 cases treated (eight times as many as indoors), the average cost was 8s. By 1902 indoor medical relief expenditure for Scotland had risen 54% to £18,091; with 12,004 paupers treated indoors, the average cost of treatment per head had risen to £1 10s 6d (an 18% increase). In 1902, total outdoor medical relief expenditure had also increased, to £38,651 (a 26% increase); and with 78,772 paupers treated outdoors this equated to 9s 10d spent per pauper.⁶² In the same year that Glasgow’s much lauded

⁶⁰ Robert Peel Lamond, *The Scottish Poor Laws* (Glasgow: 1892), p. 12. Lamond was scathing of the Crauford Select Committee: ‘the promoters of the inquiry had no definite notion of what they wanted to inquire into... the whole appears to be an irregular, unmethodical, disconnected hotch-potch of poor law information.’

⁶¹ Paterson, *The New Poor Law*, p.187. In towns like Glasgow and Edinburgh religious background was always important in the type of relief granted, with statistics confirming that Catholics were always more likely than Protestants to be offered the poorhouse. See, for example, *RC Poor Law and Relief of Distress* (Cd.4978), Appendix CLXIV.

⁶² *Poor Law Medical Relief (Scotland) 1904* (Cd. 2008), vol. 1, part III, pp. 18-19, and *Poor Law Medical Relief (Scotland) 1904* (Cd. 2022), vol. 2, appendix LVII.

model poor law hospital at Stobhill opened, Glasgow Parish Council spent more than double on outdoor medical relief than it did on indoor medical relief (not including additional substantial investment in buildings). Six times as many people were treated outdoors than in its new poorhouse infirmaries over the year.⁶³

Outdoor relief in all its forms was something that was preferred, in the main, by the recipients of relief. Speaking in 1878 about the relative merits of indoor and outdoor parochial relief systems, the Govan Inspector of Poor, Andrew Wallace, gave four reasons why in his experience the poorhouse was ‘so irksome and hateful to so many of our paupers’: it imposed a ‘restriction of personal liberty,’ he said; it removed the pauper from general society; it deprived him of the pleasures and advantages and intercourse of that society; and being sent to the poorhouse was ‘abhorred’ because ‘it brings them into contact with the vicious, the dissipated, the low and degraded’.⁶⁴

Both poorhouses and hospitals carried long-standing stigma and prejudices, with popular associations of death and autopsy. Ingrained impressions were but slowly changed, with a lag between the standard of services and common perceptions of them.⁶⁵ In both Glasgow and Edinburgh the poor retained their aversion to the poorhouse wards into the early twentieth century, seeking treatment at home (amongst the family) when possible.⁶⁶ Providing evidence to the Royal Commission in 1907, one of the four General Superintendents of Poor of the LGBS, Alexander Stuart, noted very practical reasons why some of the sick-poor eschewed the poorhouse. Many, he argued, suffered from phthisis. They feared being sent to the poorhouse for treatment, choosing instead to seek medical help outside the parochial services in the early stages of disease, because they were concerned that poorhouse treatment would lead to their condition becoming common knowledge and make them effectively unemployable.⁶⁷

⁶³ RC Poor Law and Relief of Distress (Cd.4922), Part II, p. 7: ‘No less than 84.9 per cent of the persons [in Scotland] in receipt of relief on a given day are in receipt of outdoor relief’.

⁶⁴ Andrew Wallace, ‘Outdoor and Indoor Relief’, *The Poor Law Magazine and Parochial Journal*, vol. VI (Edinburgh: 1878), p. 118.

⁶⁵ William Core and J. McCubbin Johnston, Poor Law Medical Relief (Scotland) 1904 (Cd. 2022), vol. 2, Evidence 292-489 and 533-538.

⁶⁶ Stephanie Blackden, ‘The Poor Law and Health: A Survey of Parochial Medical Aid in Glasgow, 1845-1900’ in T. C. Smout, *The Search For Wealth and Stability* (Macmillan, 1979), p. 262 & 250.

⁶⁷ Alexander Stuart, RC Poor Law and Relief of Distress (Cd.4978), Evidence 55344.

Little of right so as to interfere they [the medical officers] have none. And although poor, some people retain some feeling of independence and it is questionable whether they should be submitted to importunings which those in better circumstances cannot be submitted to.⁶⁸

The issue of the compulsory treatment and compulsory removal of the poor for medical relief purposes was a live one around the turn of the twentieth century. Whilst elements of compulsion were accepted by the authorities in some circumstances, based on the utilitarian principle of broader public interest, compulsion was seen to test the limits of both a medical practitioner's power and the liberty of free-born British persons. A crucial question was how far an individual gave up their rights when they accepted public charity. In this case the rights of those receiving public charity (deemed to be a necessity) differed fundamentally from those seeking private charity (a *voluntarily* impulse). One area of difference is shown in the fact that, in Scotland, poorhouse wards and outdoor pauper-patients were never used in the medical training of students.⁶⁹ Parochial authorities lacked any powers of compulsion to compel admittance to poorhouses of the non-infectious sick, a point much complained of in medical circles. Informed sections of the poor, adept at finding their way around any service, used local intelligence regarding parochial relief to exercise some choice by refusing to go to hospital once initial contact with a PMO had been secured (they understood the authorities could then legally withdraw relief once the poor house had been offered). Priming the Royal Commissioners on Scottish conventions, Special Commissioner Thomas Jones argued that:

Inspectors of Poor and others complained that the habit of regarding out-relief as a right... was spreading. A competent social worker in Glasgow stated that to the people there is a world of difference between the poorhouse and out-relief. They think it is not discreditable to receive the latter. The Edinburgh inspector stated that members of the same family are often unwilling to support each other. They readily obtain advice as to their precise liability from the legal columns of the weekly newspapers.⁷⁰

⁶⁸ David Walker, Glasgow City PMO and Vaccinator, City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/3 (2nd April 1877). Emphasis is in the original.

⁶⁹ Dr John McCubbin Johnston, 'State Provision for the Care of the Destitute Sick', presented at the Glasgow Eastern Medical Society (7th March, 1900) and reproduced in the Poor Law Medical Relief (Scotland) 1904 (Cd. 2022), vol. 2, app. III, p.226: 'Legally [poorhouses] cannot be used for teaching purposes, because the patients are in the poorhouse hospital through necessity, and not of their own free will...[yet] There is at present a vast amount of clinical material lying unused.'

⁷⁰ Interim Report No. 5, by Thomas Jones, RC Poor Laws and Relief of Distress (Cd.4690), Appendix XVII. See J.T. Johnstone, Vice Chairman of Edinburgh Parish Council, RC Poor Laws and Relief of Distress (Cd.4978), Appendix LXXV; James Stark, missionary, RC Poor Laws and Relief of Distress (Cd.4978), Appendix CXXIX; and Poor Law Medical Relief (Scotland) 1904 (Cd. 2008), vol. 1, part V, p. 84.

There were also straightforward practical problems. In some cases the condition of patients made transit to the medical wards of the poorhouse risky. Ambulance services were developing in this period but remained rudimentary, and the risk of deaths in transit on difficult roads and in horse-drawn wagons was a real one.⁷¹ In some cases, removal from even the most desperate domestic circumstances might cause potentially fatal deterioration. The PMOs were directly responsible for certifying whether a pauper was ‘fit for removal,’ so in many cases, they chose to err on the side of caution and recommend that care continued at home. An additional attendant risk of transit to hospital was that paupers were routinely removed in wagons without accompanying nursing supervision. This, it was suggested, was because the type of work was unattractive to nurses. As a witness to the 1902 inquiry argued: ‘Try and put yourself in the place of a nurse, and imagine an ambulance van with three or four cases being removed at once – these cases are unwashed, and with all their rags and vermin on them. I don’t think you would get many nurses to do it.’⁷²

⁷¹ Scotland’s first ambulance service, consisting of covered pull-carts, was established in Edinburgh in the 1770s. St. Andrews Ambulance Association was only found in Glasgow in 1882. To 1905, when motorised transportations were introduced, horse drawn carriages were used.

⁷² Dr. Johnston, Poor Law Medical Relief (Scotland) 1904 (Cd. 2022), vol. 2, evidence 924.

2.3 Local management and the medical sub-committee (MSC)

There is no central medical inspection of outdoor medical relief.⁷³

The first full-time medical member of the LGBS, Doctor W. Leslie Mackenzie (quoted above), bemoaned the absence of any central supervisory body to oversee domiciliary aspects of poor law medical relief in Scotland. Without such an apparatus to check the daily work of visitation, examination and treatment of the sick-poor by PMOs, the central authorities found that ultimately they could do little to shape local services. LGBS rules were circumvented to fit local circumstances.⁷⁴ The local management and supervisory structures established by the parochial boards were therefore crucial in the development of outdoor medical relief services. The main agents of local management in Glasgow and Edinburgh were the variously named medical sub-committees (MSCs), whose work will be examined in this section. These were sub-committees of board members and parish councillors selected annually to take charge of the outdoor parochial medical services.

In many regards the MSCs discussed here were the untold story of parochial medical care in Scotland. Little has been written about them (with the exception of Blackden) even though these committees did most to organise and drive forward standards of outdoor medical care in Scotland's main urban parishes from the earliest years of the new poor law. The MSCs were always rather enigmatic bodies, their role not only overlooked but also not always properly understood even by some contemporaries working under their management. Thus when asked about arrangements for the dispensing of medicine for pauper-patients in Glasgow, Dr. McCubbin Johnston of the Towns Hospital explained that, like the other outdoor PMOs of the parish, all medicines prescribed by him were made up by the same qualified chemist who worked: 'directly under the [control of] the Medical Committee' of the parish. Asked next to clarify exactly what this Medical Committee's duties were, Johnston had to admit: 'I am not quite sure...'⁷⁵

⁷³ W. Leslie Mackenzie, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 56605/51:

⁷⁴ Mr A. Ferrier, Poor Law Medical Relief (Scotland) 1904 (Cd. 2008), Vol. 1, Evidence 2469-2741

⁷⁵ J. McCubbin Johnston, Poor Law Medical Relief (Scotland) 1904 (Cd.2022), Vol. 2, Evidence 744-748.

The larger parochial boards in Scotland soon adopted the habit of subdividing duties amongst their board members and councillors. Selection processes are not clear but members of boards, re-elected yearly, probably gravitated towards issues of specific personal interest. Doctors elected onto parochial boards were often selected to oversee medical matters, and many members served for years on particular committees. Education, poorhouse provision, legal matters, asylum management, financial affairs, relief decisions, the dispensation of 'extras' like clothing and fuel, and the management of medical affairs were each overseen by its own sub-committee. Whilst only the largest urban parishes had sufficient manpower to appoint a sub-committee to each of these tasks, in Glasgow and Edinburgh such committees emerged by the end of the 1840s.

Five handwritten volumes survive in Glasgow documenting in substantial detail the monthly meetings of City Parochial Board MSC between inception of the committee in 1849 and amalgamation of the parish with Barony in 1898. Additionally, a single volume dedicated to the operations of Barony MSC during the years 1853-58 also survives. This ledger echoes in style and level of detail of debate the more complete series of records that survive for City parochial board, suggesting that the MSCs of the two main Glasgow parishes came into being and operated along broadly similar lines. For St Cuthberts Parochial Board, Edinburgh, less detailed, summative printed minutes relating to the work of its MSC also survive for 1850-80. Whilst without the same level of detail they also confirm that similar processes were undertaken in Scotland's capital city. A few parish records survive to also confirm the existence of equivalent bodies for the parishes of Govan, City of Edinburgh, and South Leith.⁷⁶

The surviving volumes of Glasgow City MSC tell us much about the processes of management and operation of parochial medicine in Scotland and provide valuable

⁷⁶ The five-volume ledger series is kept at the Mitchell Library, Glasgow and referenced Glasgow City Archives (GCA), D-HEW 1/5, City Parochial Board Medical Committee Minutes (handwritten series). The three series of Barony parish records that provided details of the activities of the Medical Committee in Barony are Glasgow City Archives (GCA), D-HEW 2/2, Barony Parochial Board Minutes (printed series), 1875-1898 (22 volumes); D-HEW 2/1, Barony Parochial Board Minutes, 1844-1894 (9 volumes); and D-HEW 2/13, Sub-Committee on Medical Relief and Sanitary measures, 1853-8 (1 volumes). Records held at Edinburgh City Archives (ECA) and that detail the work of St Cuthberts Medical committee include St Cuthberts Parochial Board Annual Reports (ECA), ref: SL/10/16; and St Cuthberts Parochial Board Minutes of Medical Relief Committee 1850-1880 (ECA), SL 10/12/10.

evidence on all aspects of the outdoor medical service. The records of early meetings are the most detailed. They reveal, for example, the important initial steps taken by that parochial board to establish medical services under the 1845 Act, and the process by which MSCs fixed salaries for medical work and codified outdoor medical duties. They reveal also the development and gradual professionalization of supporting dispensary services under the watchful eye of board members. They detail the appointment process and show how the responsibilities and workload of PMOs were assigned. The MSC records touch on the dichotomy felt, at times, amongst different practitioners, between parochial duties and private practice. They detail the handling of directives from the administration in Edinburgh and therefore reveal something of the relations between parochial boards and central authorities. They reveal how complaints received from the general public in cases of suspected medical negligence were handled and how PMOs were subsequently interrogated and, if necessary, brought to task. They shed light on the local organisation of medical practice by those employed as PMO's, providing details of the arrangements made in various surgery-shops across the city. They provide evidence too on the extent of the use of assistants and locums by practitioners in Glasgow, on the role of ancillary staff, and on the operation of markets for the supply and distribution of medicines and medical products. They provide details on the process by which medical contracts were awarded and the types of medicine and foodstuffs procured. The surviving volumes also give details regarding the relationship between the parochial medical relief service and other (visitation) agencies in the city, such as the Charity Organisation Society. Importantly, they also tell us much about the persons who undertook the 'lay' management of domiciliary medicine in Scotland. They detail decision making processes regarding changes periodically carried out to the structure of services; and they reveal the attitude of the parochial authorities to innovations in medical practice. As an example of this, with developments at Glasgow Royal Infirmary at the forefront internationally, an awareness of current advances in surgical procedure and apparatus led the City MSC, in April 1879, to request the parish poorhouse medical officer Alexander Robertson to report on the prospect of an introduction of new treatment methods in the parish poorhouse hospital wards. Robertson asserted his 'high opinion' of the efficacy of new antiseptic procedure (being pioneered by his friend and Glasgow PMO colleague, William Macewen). However Robertson advised that: 'considering this is a Parochial Establishment he has not thought himself justified in

ordering the more expensive apparatus and appliances employed in many general hospitals in the use of that class of agents.’ In response the minutes of the MSC record a comment to the effect that their priority was not cost but efficiency:

...that if a somewhat more expensive mode of treatment of the cases coming under Dr Robertson’s charge would result in greater benefit to the sick poor, they trust this will not prevent him from adopting the course of treatment he thinks will best attain that end.⁷⁷

As time passed, the minutes of Glasgow City MSC become more organized and perfunctory. By the 1860s the committee had established a set routine. This need not be read as a sign of growing diffidence but rather as evidence of the maturation of the process of medical relief administration. Meetings of the medical committee by 1875 consisted of four standard pieces of business. At each monthly meeting, the accounts were examined and docqueted for remittance to the Finance, Law and Assessment Committee of the parish. Secondly the ‘stock book of cordials’, a ledger of spirits and cordials held at the dispensary to combat adulteration and improve accounting procedure, was checked. Thirdly the PMO report books and ‘Abstract of Returns’, compiled in compliance with the terms of the Medical Relief Grant, were checked. Fourthly, members’ detailed monthly visitations conducted to parish dispensaries and (less frequently) to PMO surgeries.

To understand the MSCs and how they came to shape parochial medical services it is necessary to understand their origins. As Blackden’s work reveals, the structures for managing and supervising both public health and outdoor medical parochial services, across Scotland’s main parishes, grew out of a particular medical emergency: the cholera epidemic of 1848-9. This was Scotland’s second epidemic of the disease during the nineteenth century and was a particularly testing time for city authorities and the new poor law services in both Glasgow and Edinburgh. Whilst fewer people were infected, the 1848-9 epidemic killed more people in Glasgow than had the previous epidemic of 1832. More pertinently, in terms of motivation for a more constructive response, the 1848-9 epidemic was found to be ‘not limited to the city’s poor’.⁷⁸ A broader civic emergency required a broader civic response. In Glasgow a

⁷⁷ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/3 (8th April 1879).

⁷⁸ Quote from Werner Troesken, *The Great Lead Water Pipe Disaster* (Massachusetts: MIT Press, 2006), p. 176. The significance of cholera for helping establish public medical structures was recognised early on. For example, F.S.B. Francois de Chaumont, *Lectures on State Medicine* (London,

Sanitary Committee of the City Parochial Board (as it was originally styled) was established in January 1849. It was given an initial remit to take full responsibility for ‘the management of all matters in relation to cholera prevention etc’. From this position of fairly specialised authority the committee quickly assumed permanence in its supervision over all medical aspects relating to the parishes’ outdoor medico-legal responsibilities towards sick paupers, and once cholera had abated the Glasgow City MSC quickly set about reorganising the PMO domiciliary service. In the absence of alternative public health services at this time, as a sub-committee of the main board it had an initial remit wide enough to give it full supervisory control over both the curative and ameliorative (or medical) as well as the preventative (or public health) aspects of parish medical relief. Over time, as Glasgow’s sanitary affairs became more organised and were separated into a distinct set of services by local Police Acts, the focus and scope of the committee narrowed onto its prime concern, the outdoor medical service. The re-naming of the committee reflected this process. By successive stages it restyled itself the Medical and Sanitary Committee of the Parochial Board, in March 1863, and finally just the Medical Committee, in August 1874. In 1862 Edinburgh became the first local authority in Scotland to appoint a Medical Officer of Health, followed shortly by Glasgow. Thus whilst it was the Local Government (Scotland) Act of 1889 that formally divorced sanitary concerns from the poor law structure throughout the rest of Scotland, the distinction between poor law and public health services had been firmly established in Glasgow and Edinburgh by the mid-1870s.⁷⁹ In its origins and its structure the City parish MSC serves as an example of similar committees established in Glasgow and Edinburgh’s other main parishes: in Barony in 1848; in St Cuthberts and in Edinburgh City Parish also prior to 1850; in South Leith, in 1853 (another cholera year); and in Govan (following combination with Gorbals Parish) in 1873.

1875) reviewed in *Glasgow Medical Journal* (April 1876) pp.229-233. Stephanie Blackden, ‘The Poor Law and Health: A Survey of Parochial Medical Aid in Glasgow, 1845-1900’ in T. C. Smout, *The Search For Wealth and Stability* (Macmillan, 1979), pp. 255-256.

⁷⁹ Separate and distinct public health or sanitary departments in both Glasgow and Edinburgh both effectively date from the early 1870s. In Glasgow the key moment was the appointment of a chief sanitary inspector (about the time of the second name-change of the parish committee) and Glasgow’s first full-time Medical Officer of Health, James Burn Russell. On this see Edna Robertson, *Glasgow’s Doctor: James Burn Russell 1837-1904* (East Lothian: Tuckwell Press, 1998). The 1862 Glasgow Police Act marked the beginnings of a distinct public health framework in the city and saw the appointment of Professor William T. Gairdner to what at the time was a part-time post. The PMOs were called upon to deal with infectious pauper cases before this time, although ultimate responsibility lay with the Town Council and the police service. See City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/2 (2nd July 1860).

The most important managerial work of the MSC in Glasgow City parish was established in the early years. In the inaugural meetings of this MSC in January 1849 the important and courageous domiciliary interventionist work of the PMO was roundly praised. The General Board of Health had noted the immediate success of the extended visitation system in City parish to combat cholera for which the PMOs had a series of temporary lay-assistants.⁸⁰ One City PMO and two Barony PMOs died during the epidemic.⁸¹ At the meeting of the new committee on 15 February each PMO was voted a sum of 'forty pounds exclusive of their usual salary' for his troubles during the epidemic. Fearing that a precedent might be set, rather astutely the MSC at the same time took the opportunity of the abatement of the epidemic and the goodwill engendered by the reward of additional sums of money to fix the future remuneration of its medical employees. It set the salary of all the PMOs in the parish at: 'fifty guineas per annum each, it being distinctly understood that no extra allowance will be made in future on account of any additional labour which the District Surgeon may be called on to perform during the existence of any epidemic'.⁸² On the same date the MSC also established another significant feature of the future medical relief system in the parish by further recommending the establishment of 'a dispensary, or dispensaries' for the provision of medicine for all its paupers. This newly inaugurated parish dispensary service was quickly extended, and more localised outlets quickly followed in the wake of a new wave of cholera epidemics towards the end of 1853. Dispensing duties had been taken from the hands of the doctors. Within six months of its establishment the PMOs of City parish began receiving specific directives from the MSC regarding practices for the prescription of medicines and medicinal cordials.⁸³ The MSC also decided to fix the number of PMOs employed. Having reviewed the situation for one year, in February 1850 the MSC re-evaluated medical staffing requirements and resolved on twelve PMOs for twelve redrawn districts as the ideal number: these twelve districts 'appearing to the Committee quite sufficient [in size] to occupy the time of the surgeon in the proper discharge of his duty'. The twelve-district structure drawn up in 1850 remained largely unaltered for the next fifty years, although the number of serving PMOs for

⁸⁰ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (26th January 1849).

⁸¹ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (19th February 1849).

⁸² City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (15th February 1849).

⁸³ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (3rd July, 1849).

these parish districts was reduced to nine after 1874, and then to eight, as the demographic landscape of certain parts of the city altered. In order to formalise the new arrangements, in June 1850, the serving practitioners were all given notice to quit and asked to reapply for the new district posts. These were locally re-advertised. Salaries were reset at this time at the annual sum of £45 inclusive. An additional stipulation was added as a pre-condition of future employment, that each PMO: 'shall have either his dwelling House, or place of business, within one hundred yards of the District of which he has the charge'.⁸⁴ The first written, fixed set of *Rules and Regulations for the District Surgeons* was drafted later in the same month, and all newly appointed PMOs were expected to sign as another precondition of appointment.⁸⁵

Thus was the outline of the outdoor parochial medical service in Glasgow City parish as it was to operate for much of the next sixty years (and through to the end of the period 1875-1911) given its shape under the guidance of the MSC, with much of the supervisory apparatus put into place in the first year or so of its existence. These moves made by City MSC pre-empted regulations imposed under the Medical Relief Grant, for the parish did not join in the grant scheme until after 1851. In other developments the MSC quickly assumed control over requisitions. By the early months of 1850 the minutes record tenders for foodstuffs, alcohol, medical and fixture supplies being received and evaluated at MSC meetings. In February 1850, for example, tenders were being received for the contract to refit the newly established dispensary, and samples of wine, whisky and porter sent in by prospective suppliers were being tested by board members at the committee meeting!⁸⁶ MSC minutes show that the handful of wholesale drugs suppliers that were pitching to the parochial authorities were the same as were also supplying medicines to other medical charities like the Glasgow Central Dispensary. These drug wholesalers linked together

⁸⁴ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (12th March 1850 and 18th June 1850). By November 1854 the salary had been set at £55 per annum.

⁸⁵ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (1st July 1850). The terms by which medical practitioners accepted the new contracts of employment in June 1850 were detailed in the Minutes as follows: 'I hereby accept of the appointment to that Medical District of the City Parish of Glasgow which has been allocated to me, and I agree to perform the duties pertaining to said office, on the terms specified by the Parochial Board in the printed Rules and Regulations for the District Surgeons, a copy of which has been signed by me of this date, as relative hereto, it being distinctly understood that I am to hold office during the pleasure of the Board'.

⁸⁶ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (4th and 15th February 1850).

different aspects of the medical market, through their supply networks, and by acting as go-betweens in the sale of practices.⁸⁷ The MSC also took early control over the compilation of medical statistical data for the parish, agreeing an appointment for that purpose in March 1849.⁸⁸ The development of statistical returns – whilst it added to workloads – appeared to carry the endorsement of PMOs who saw the returns as the cutting edge of medical scientific endeavour at this time.⁸⁹ From June 1850 the MSC arranged to convene monthly; this was an arrangement that persisted. These monthly meetings were the vehicle for the exercise of parochial board control over the domiciliary medical service of the parish. PMOs were called to appear from time to time. Any complained of practitioners were quickly called to account for their actions. The threat of dismissal for slack performance was very real (if infrequently actuated in the main town parishes) and, as serving practitioners well realised, discharge from public office carried serious ramifications for future career prospects.

The structure and composition of the MSCs of the different parishes of Glasgow and Edinburgh were largely consistent. Medical practitioners as private ratepayers were entitled to seek election. An elected medical presence on the parochial board was norm rather than the exception. Medical practitioners – like Thomas Drysdale Buchanan in Barony, and Thomas Lapraik in Glasgow City Parish - became local driving forces in the development of outdoor medical services. PMOs were not solely therefore under lay management. St Cuthberts MSC in Edinburgh – between 1867 and 1883 - had eighteen members of the parochial board: between two and five of these board members each year was qualified medical practitioners.⁹⁰ Edinburgh Parish Council, after 1895, consisted of 31 elected members of whom between thirteen and fifteen were chosen to serve on its MSC. Although members were re-elected each

⁸⁷ See, for example, Glasgow Central Dispensary Minutes (29th November 1907) (GGHB Archives) Ref: HB48/1/1. Suppliers of drugs to Glasgow Parishes per contracts tendered included the New Apothecaries Company, W & R Hattrick & Company, Brown Brothers, Peter Harrower, James Taylor, the Glasgow Apothecaries Company, and Francis Spite & Company Ltd. Medical wholesalers such as James Taylor in Glasgow also played a significant role in the selling on of the medical practices of the deceased. On this see *The Scotsman* (29 Nov, 1898), p. 9. Similar drug companies operating in Edinburgh included Messrs. Duncan Flockhart & Company.

⁸⁸ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (12th March 1849).

⁸⁹ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/1 (29th May 1849). A Letter to the Committee from PMO Alexander Maxwell Adams read: 'I am gratified at the interest evinced by the Board in their scientific records and I have no doubt when the present Books are contrasted in the nosological arrangement and scientific nomenclature will be duly appreciated'.

⁹⁰ Per St Cuthberts Parochial Board Annual Reports, ECA SL/10/16.

year, turnover on the committee was actually quite small, at between one and five members from year to year (or 18.8% per year over this period). There was again a consistence medical presence amongst elected councillors in Edinburgh, including John Lyon Wilson (MSC convenor 1900-1), and John Macrae (MSC convenor from 1905). For one year sampled, Barony MSC in 1888-9 consisted of twelve members including two Glasgow medical practitioners.

Thomas Drysdale Buchanan first stood for parish election alongside fellow medical practitioner Douglas Spiers, in Barony, in 1874. Both at first failed to get elected. Spiers had previously served as a Barony PMO. Buchanan was elected second time around, in December 1875. He was immediately chosen to serve on the MSC. In January 1876, in his first month on the committee, Thomas Drysdale Buchanan's son - also named Thomas - was appointed to serve the parish as the Anderston district PMO. When his son was awarded extended sick leave in 1883, Buchanan senior - then the chairman of the Barony MSC - covered the Anderston district. Patronage had its limits. In 1885, still under the chairmanship of Buchanan senior, Barony MSC made Thomas resign after two years of ill health and absenteeism.⁹¹ In the first months that Buchanan served on it, Barony MSC conducted a full review of its existing outdoor medical services and took the extraordinary (and unrepeated) step of appointing a first full-time PMO in Scotland. More radically yet, it planned for the extension of its parish dispensary services to the non-pauper poor until persuaded otherwise, along the lines of what (it said) had been observed in Ireland. PMO Murdoch Cameron made reference to the board's role in driving new proposals during discussion of treatment of the sick-poor in Glasgow in February 1876.

Dr Murdoch Cameron said that, as one of the district medical officers of the Barony Parish, he had attended a meeting of medical officers called at the instance of the Board in regard to affording medical relief to the class just above paupers.⁹²

In Govan, the MSC – which doubled as a Medical Relief *and* Clothing and Appeal Committee – consisted of between eight and sixteen members annually between 1877 and 1911. Different qualified medical practitioners again served on it, including

⁹¹ Barony Parochial Board Medical Committee Reports, GCA D-HEW 2/2/9 (3rd November, 1885).

⁹² See *The Scotsman* (28th June, 1876), p. 6) and GMJ, vol. 8 (April 1876), pp. 273-6.

Patrick Aloysius Smith, a leading figure in Glasgow's Irish Catholic community and one of Glasgow's few Catholic medical practitioners at this time. On average, the 112 men and women who served on Govan MSC between 1877 and 1911 served for more than four years each.⁹³

In Glasgow City parish, annually, ten parochial board members served the MSC. It had a quorum of five required for each meeting. The annual turnover of some members – whilst small – put the MSC as at a temporary disadvantage; each intake took time to learn the operations of the medical relief service in the parish. The minutes for December 1890 record that all new annually elected members to the committee were formally welcomed and orientated to the business of the medical committee by the chairman.⁹⁴ Members of the City MSC in the mid-1870s were drawn, as usual, from the merchant and manufacturing classes. Most had business addresses in city centre, with residences on the outskirts of Glasgow, in wealthy suburbs like Lenzie, Helensburgh, Kirkintilloch and Bellahouston.⁹⁵ Until amalgamation in 1898, at the core of City MSC was a three-man Purchasing-sub Committee led by the MSC chairman. This was where the real power on the committee lay and was responsible for overseeing of the operations of the dispensaries, medical supplies, acquisitions, and awarding contracts. As suburban-dwelling merchants and manufacturing industrialists, the profile of the men on City MSC differed from those on Barony MSC in 1875. These differences reflected the economic profile of parishes at this time. In Barony, the presence of two farmers and two house-factors amongst members of the MSC reflected the former rural and now-urbanising nature of the parish.⁹⁶

⁹³ See 'Glasgow, Barony and Govan Parish Abstracts of Accounts 1877-1925', GCA D-HEW 6/1. On Patrick Aloysius Smith see obituary, GMJ, v.174 (1910), p. 140.

⁹⁴ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (18th December 1890).

⁹⁵ Robert Lochore – the MSC chairman in 1875 – was described in the 1874 Post Office Directory as having a 'place of call' on Argyle Street in Glasgow, with a residential home at Minerva Lodge in Lenzie. The City parish minute books describe him as a merchant. West Nile Street was the business residence of the Cramb Brothers photographic studios. John Cramb resided at Larch Villa in Helensburgh. James Brown – boot and shoe merchant – was of 313 Argyle St. He had a house in Sandyford. Thomas Brown of 118 Queen Street was a commission merchant and manufacturer of Scotch bonnets, with a residence at Bellahouston Hill. James Wright of 114 John Street was owner or director of the City Calendering and Finishing Works. He had a residence in Kirkintilloch. James Beith – the serving parochial board chairman – was an ironfounder with his main residence, like Lochore, in Lenzie.

⁹⁶ Barony parish MSC as at January 1875 consisted of ten members: Bailie John Young, convener, had a bakery business; Robert Mather, sub-convener, was a farmer, as was James Murdoch junior; Robert

Historians have a tendency to dichotomise this period of public welfare in terms of public medical servants and lay managers: this is an overly simple approach that presumes that medical men were not to be found amongst management structures. In Edinburgh and in Glasgow, as seen, this was not the case. Through the period from 1875 to 1898 qualified medical presence on the City MSC culminated in June 1890 with the election to convener of the medical committee of Glasgow medical heavyweight, Doctor Thomas Lapraik. In the 1890s Lapraik was also the treasurer of the Faculty of Physicians and Surgeons of Glasgow, a director of the Lock Hospital, served as a governor of Anderson's Medical College, and with James Burn Russell was also co-manager of the newly erected Western Infirmary.

Macdougall and Hugh Reid were house factors. The five other members were Alexander McLaren, upholsterer and proprietor; Donald Fisher, writer; James Murdoch, senior; George J. Miller; and William Hamilton, printer and publisher.

2.4 Re-profiling the Parochial Medical Officer (PMO)

Whilst the Webbs have cast a long shadow over the history of the poor law, much contemporary evidence also contains inescapable biases. Whereas practitioners in parochial employment might have been reluctant to criticise the system, those outside who were ratepayers, unsuccessful in application to become PMOs or campaign for election, or former employees, were wont to mix assessment of the poor law with elements of self-interest or personal grievance.⁹⁷

To reappraise the traditional picture of the PMOs a database of two multi-tabled relational datasets was constructed. These datasets allow for more precise statistical assessment of a range of important ‘profile’ issues, including: the individual and collective standing and social status of the medical men that provided poor law outdoor medical services; their background and mentalities; their network of local connections; their education and medical abilities (measured by publications, prestige and accumulation of posts); and their professional and social activities and interests (important markers of the self-identification of serving medical practitioners).

The two datasets created are for Glasgow and for Edinburgh PMOs. They adopt the approach of a prosopographical study and are identically modelled.⁹⁸ A range of different information was collected including professional, personal and demographic details. The structure of the database datasets is diagrammatically represented in Appendix VIII. The data has been drawn from a wide range of sources, including: parish board records, Post Office Directories, the *Poor Law Magazine*, the *Medical Directory*, the *Medical Register*, local and Scottish national newspapers, medical journals, censuses, and Calendar of Confirmations inventory data. Information on Glasgow practitioners has been far more thoroughly assembled because the poor law records are better preserved than those for Edinburgh, but sufficient information has

⁹⁷ On this see debate surrounding Strethill H. Wright, ‘Some Remarks on the Treatment of the Sick Poor’, paper given in February 1876 before the Glasgow Medico-Chirurgical Society, in GMJ (April 1876), pp. 272-276.

⁹⁸ Per Katharine Keats-Rohan, *History and Computing* 12, 1, p. 2: ‘Prosopography is about what the analysis of the sum of data about many individuals can tell us about the different types of connexion between them, and hence about how they operated within and upon the institutions - social, political, legal, economic, intellectual - of their time.’

been collated on the medical practitioners who served in Edinburgh to allow longitudinal study of parochial employment patterns in both cities.

The parameters of the datasets are as follows. The Glasgow (and Govan) dataset consists of details on 135 PMOs who worked in Glasgow before 1911, including all 72 PMOs that served from 1875 to 1911. For Edinburgh (and Leith) and its parishes, the dataset consists of details relating to 38 PMOs. These are all who are known to have served as PMOs between 1874 and 1909. The names and service details of the combined 110 PMOs identified for Glasgow 1875 to 1911 and Edinburgh 1874 to 1909 are listed in Appendix IV. Together the Glasgow and Edinburgh datasets provide a fairly robust analytical tool for exploring supply-side issues relating to the parochial medical encounter in Scotland's main two cities. This approach has enabled a historical reassessment that argues from the disaggregated profile of the individual towards a general case, rather than one that seeks to account for the individual in the general (a more typical approach to the topic of describing PMOs).

Using the datasets a new profile of the PMO emerges. The tables in Appendix II and III list the names of all the PMOs that were employed in Glasgow and Edinburgh in mid-1875. There were nine PMOs employed by Glasgow City, twelve by Barony, and five by Govan (Appendix II). In Edinburgh in 1875 City parish employed five, St Cuthberts-Combination six, South Leith two, and the smallest parish of North Leith one (Appendix III). All 26 Glasgow PMOs and all 14 Edinburgh PMOs were part-time. The number of PMOs employed across Glasgow varied from 22 and 28 from the mid-1870s to 1911. The number employed in Edinburgh fell to twelve in 1884 (when City of Edinburgh medical districts were redrawn), before climbing back to thirteen after the creation of Edinburgh Parish Council. The 40 PMOs employed in Glasgow and Edinburgh in 1875 equate to around one-fifth of all PMOs employed at this time across Scotland.

The age at which 36 of the 40 men serving as PMOs in Glasgow and Edinburgh in 1875 qualified to practice medicine has been calculated; for 23 of the PMOs, the age at which they were appointed is also known. In Glasgow and Govan, where no new appointment had been made since 1873, the average age of the PMOs in 1875 was 41 years. Most of these PMOs were in their 30s or 40s, with the eldest at this time aged

64. In identified cases, the average aged at appointment of these men was 30.6 years old, and the average period since qualification for appointees was six years. Govan had the youngest set of PMOs in 1875, with an average age of 37. This relative youthfulness is somewhat misleading for a number of new appointments had been made over the previous couple of years following combination of the parochial board with Gorbals parish and the expansion of the service. Most new Govan PMOs continued to each serve for several decades after appointment.

For Edinburgh and Leith, two of the fourteen PMOs were newly appointed in May 1875. This followed the death, in close succession, of Edinburgh City PMOs, William Hammond and Thomas Cairns. Cairns had been an experienced practitioner who shared with numerous fellow PMOs a specialist interest in midwifery. He had acquired his M.D. in 1862, and had been a Fellow of the Royal College of Surgeons of Edinburgh since 1864, having also been employed as physician-accoucheur at the most prestigious general dispensary in Edinburgh, the Edinburgh Royal Public Dispensary, in the years before his death. He had published widely on different aspects of midwifery. William Hammond, aged 43, had died just one month after being appointed, having contracted typhus during the course of discharging his parochial duties. His death was a salutary reminder of the dangers that faced all medical practitioners during the execution of their duties amongst the poor at this time.⁹⁹ The average age of the remaining Edinburgh and Leith PMOs in 1875 was a little higher than in Glasgow, at 46.8 years; the six whose appointment date is known commenced parochial work when aged anywhere from 25 years old to 65 years old, and typically only after several years being qualified.

The general profile of the men employed as PMOs in Glasgow and Edinburgh in 1875 would be that they were mainly Scots, and locally educated.¹⁰⁰ Their qualifications were not inferior to rank and file practitioners, with 79.5% of 39 whose qualifications have been identified having taken their M.D.s, and with all but one acquiring it before appointment. They had mainly qualified in their mid-20s; had not gained an appointment as a PMO until into their 30s after several years of private practice; and,

⁹⁹ Both deaths were recorded in the pages of *The Scotsman* during May 1875. *The Scotsman* (29/4/1875), p. 4, carried Hammond's obituary.

¹⁰⁰ Of those identified and employed as PMOs in 1875, only one was not born in Scotland, although he was educated there.

in 1875, were likely to be men in their 40s. This is a profile unlike the historical stereotype. A more comprehensive analysis of all the practitioners serving as PMOs in Glasgow and Edinburgh between 1875 and 1911 will further qualify this new profile.

Historical judgement on the men (and women) that served as medical officers under the poor law tends to point towards a coterie of young, inexperienced lowly professionals of a type supposedly preferred by parochial boards for their malleability. Study of appointments and appointment processes in Glasgow and Edinburgh quickly debunks this impression. Using appointment records it is possible to determine the ages and point in their career at which medical practitioners were employed; their experience and background; and the probable reasons why they were chosen. All PMOs in Scotland were employed directly by the parish. Selected and elected poor law board members and parish councillors liked to assert their independence, and the appointment process was one arena through which real power, and application of that power, could be exercised by the MSCs.

Table 2.5: Summary of the number of known applicants for each of the 39 PMO vacancies in Glasgow parishes, 1875-1911

Number of Applicants:	1875-1898 <i>City Parish</i>	1875-1898 <i>Barony Parish</i>	1898-1911 <i>Glasgow P.C.</i>	Total
5 or fewer	28.6%	16.7%	46.2%	30.8%
6 to 10	57.1%	33.3%	30.8%	41.0%
11 to 15	14.3%	25.0%	23.1%	20.5%
16 or over	0.0%	25.0%	0.0%	7.7%
<i>of these, vacancies attracting between 4 and 12 applicants...</i>				77.0%
av. no. of applicants	6.5	14	6.8	9.0
appointments made...	14	12	13	39

In the main, outdoor parochial medical positions in Glasgow were highly contested. Vacancies occurred only occasionally – once a year or less in either Glasgow or Edinburgh - and attracted strong numbers of applicants. Table 2.5 summaries the applications that were considered by Glasgow parochial boards for 39 vacancies between 1875 and 1911. Across Glasgow, parish vacancies were handled in-house rather than farmed out to one of the medical appointment agencies that were springing

up.¹⁰¹ Positions were advertised both locally and nationally. Applicants were typically whittled down to a short list of two or three by the MSC before a final appointment was ratified (usually at the next full meeting of the board). Two-thirds of Glasgow vacancies attracted six or more applications; 77% attracted between four and twelve applications; and there was an average of nine applicants per post. Aged 44 years, Robert Langmuir was the last medical practitioner appointed by Glasgow Parish Council in this period. Langmuir replaced George Bell Todd in the Garscube district in June 1911. Todd was professor of zoology in Anderson's College at this time but was removed from his parish post because he faced crown prosecution in unrelated matters. He was the last of only five PMOs dismissed from service in Glasgow and Govan over five decades stretching back to 1860. Langmuir was one of twelve applicants. All twelve were Glasgow educated and Glasgow based, ten of them in general practice within the surrounding district of Garscube. The youngest was aged 29 years, and the oldest was 56, being one of four applicants over 50 years old. In his testimonials, Langmuir provided evidence of the longest presence in the Garscube area of all the applicants, having been in general practice there for eighteen years.¹⁰²

Hodgkinson points out that the Provincial Medical and Surgical Association advocated as early as 1840 that the poor law authorities adopt three basic appointment criteria: all PMOs, it said, should be 'doubly qualified' in both medicine and surgery; all practitioners appointed have a minimum two years general practice experience; and all have 'a thorough knowledge of the locality and the inhabitants' of the district they are to serve.¹⁰³ Whilst the criteria were not rigid, the 'right' age and experience; local knowledge and an established presence in the district; the location of the practice; evidence of a good or high standard of medical qualifications and awards; evidence of practical experience amongst the poor via medical charity or other public appointments (such as the police or sanitary services); and evidence of solid medical and parochial connections through strong testimonies were important in a successful application to any of the parishes in Glasgow and Edinburgh. When considering a replacement for Daniel McLean who had died aged 64 in July 1889, Barony parochial

¹⁰¹ For example, *University Medical Agency*, George Street, Edinburgh, and the *Scottish Medical Agency*, Bath Street, Glasgow, were both acting as a clearinghouse for medical appointments by the 1890s.

¹⁰² On Langmuir appointment see Glasgow Parish Parochial Board Minutes, GCA D-HEW 1/2.

¹⁰³ Hodgkinson, *Origins of the National Health Service*, pp. 68-9, 84-106:

board received eleven applications for the post. Each member of the MSC charged with deciding between candidates was provided with a list with the following points highlighted for each applicant before interview: whether he was already established in the district; what public appointments he had served; and his age. These were evidently therefore key criteria. John Oliver Chisholm, the successful practitioner, was the eldest of the candidates; although qualified in Edinburgh, he had been at practice in Glasgow nine years before applying.¹⁰⁴

Despite accusations of parsimony, cost management was never the sole motive in making appointments. Given the volume of applications that each vacancy attracted parochial boards (and later parish councils) were in a position to drive a hard bargain had they chosen to do so. Amongst the candidates when Chisholm was appointed was a William Leighton Ross, M.B., C.M.. Ross was 27 years old and had recently returned to Glasgow after two years serving as PMO in Alva. Although not chosen, he had offered to take the post without salary for the first year if he were appointed!

Similar processes were followed in Edinburgh, where the boards demonstrated similar preferences. For example, *The Scotsman* records that in October 1880, James Carmichael aged 37 was appointed to the City of Edinburgh Parish in preference to Arthur Douglas Webster aged 25 (at that time the serving Assistant Medical Officer at the Poorhouse). All board members were balloted, with the chairman opting for Carmichael on a split vote. Webster was more successful when the next vacancy arose. Carmichael got an M.D. in 1864 and had become M.R.C.P.E. in 1874. According to the *Medical Directory*, in the year he applied to become a PMO, he was already serving as a physician at the Royal Hospital for Sick Children; was a lecturer on diseases of children at the extramural School of Medicine in Edinburgh; and a physician at the New Town Dispensary. Formerly Carmichael had been President of the Royal Medical Society in Edinburgh, and MOH in Burntisland. He published widely on infectious diseases in children before and during parochial appointment, and went on to a distinguished career in Edinburgh medical education, becoming Emeritus University Clinical Lecturer on Diseases of Children in the 1890s.¹⁰⁵

¹⁰⁴ Details of appointment of John Oliver Chisholm, Barony Parochial Board Minutes, GCA D-HEW 2/2/13, p. 261.

¹⁰⁵ *The Scotsman* (19th Oct, 1880), p. 6.

Figure 2.3: Age at appointment of Glasgow & Govan PMOs, 1875-1911 (59 of 72 PMOs where both date of birth and appointment year are known)

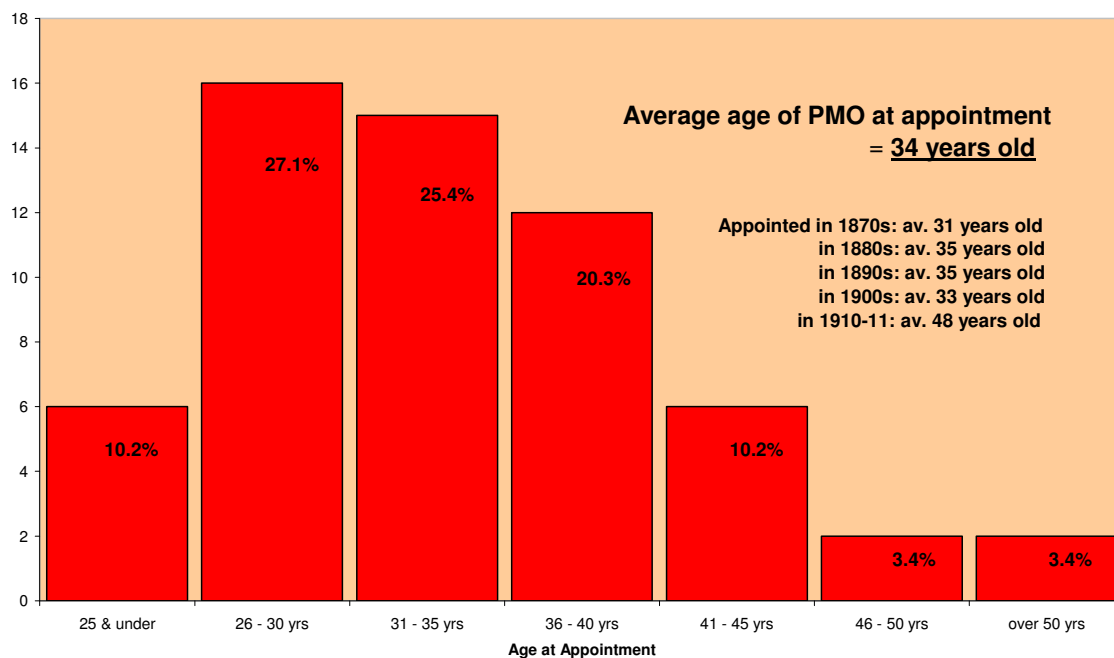


Figure 2.4: Years of experience of newly appointed Glasgow & Govan PMOs, 1875-1911 (calculated as years between qualification and appointment) (62 of 72 PMOs)

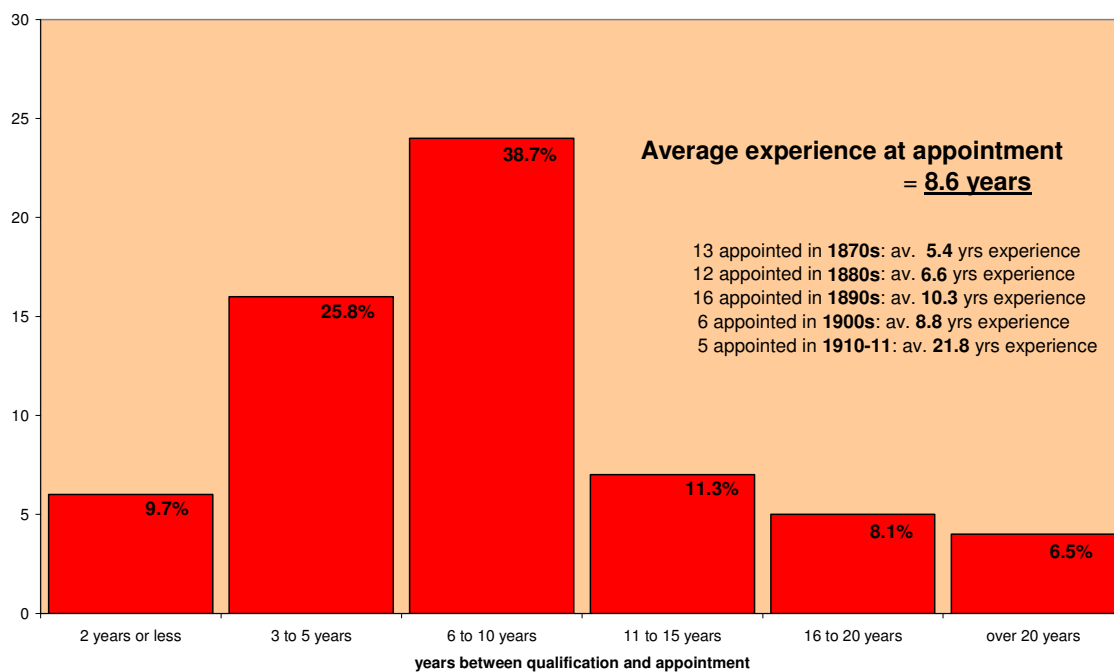


Figure 2.5: Years of experience of newly appointed Edinburgh & Leith PMOs, 1874-1909 (based on approximate appointment date) (26 appointments)

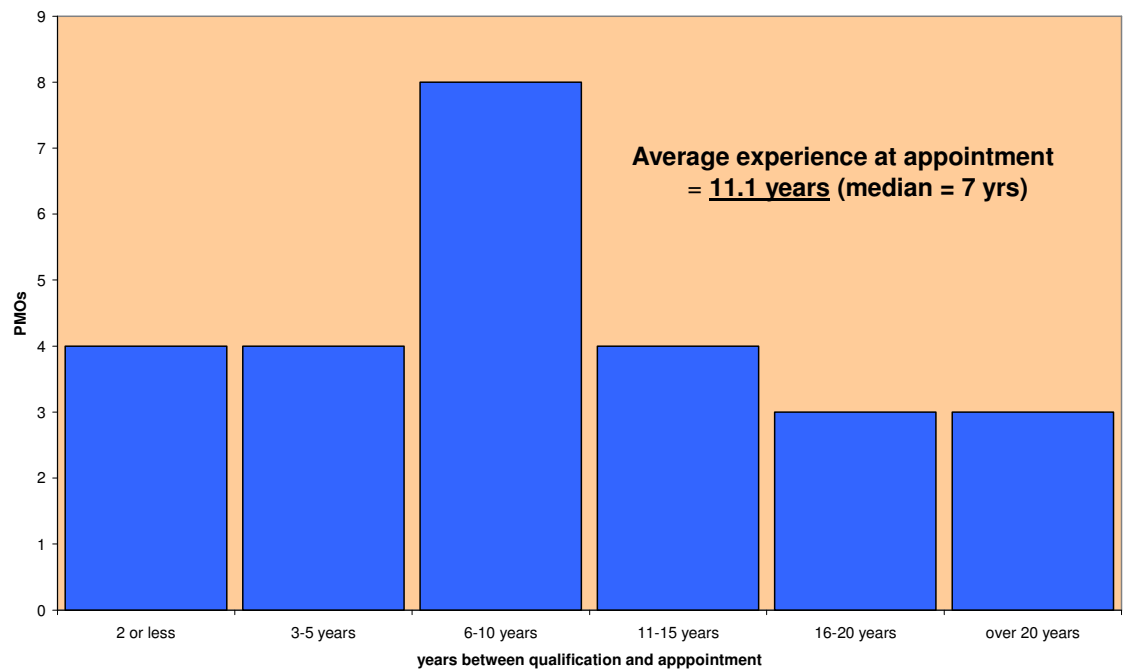


Figure 2.3 expands on information provided previous about those in position in 1875 and shows that the average age of all newly appointed PMOs in Glasgow and Govan between 1875 and 1911 was 34. Only six (10.2%) secured appointment aged 25 or under. Figure 2.4 shows that on average those men appointed in Glasgow and Govan had been qualified to practice medicine for 8.6 years before securing appointment. Figure 2.5 shows that for 26 appointments in Edinburgh, the average length of time between qualification and appointment was even longer, at 11.1 years. In both Edinburgh and Glasgow, a spread of age and experience is observed.

Reflecting that the average age of successful applicants changed, the average number of year's previous practice rose over the decades until it reached over 20 years by the 1910s. One factor in changing applicant profiles was the growth of intra-professional competition amongst general practitioners. As Table 2.1 shows, along with the expansion of the city's boundaries and rising population, the number of physicians and surgeons listed in the Glasgow Post Office Directory also increased significantly from 1870: rising by 28%, then 33%, and then 43% each decade over each of the next three decades. With the goal of an established private practice becoming more difficult (and more expensive), medical graduates by the 1900s would have

contemplated different career trajectories than previous generations. This is in line with Digby's view about changing medical practice in the period.¹⁰⁶

Very few, generally exceptional men secured appointments as PMOs in these cities within a couple of years of graduation. Untypical therefore was the appointment of Daniel McKellar Dewar in November 1886. At this time he had been qualified to practise medicine for only four months. The parish felt compelled to detail in the minutes their justification for this unusual decision, pointing out that amongst the candidates at that time Dewar was most familiar with the area, having been born and brought up there.¹⁰⁷

The requirement that anyone appointed as PMO needed to show a minimum of three years prior practice experience had also earlier been waived for the application of William Macewen. When Macewen was appointed PMO in December 1871 he had been qualified to practise for just two years, and was at this time aged just 23. It must be presumed that he came with glowing testimonials. His subsequent rise to the elite ranks of the profession suggests why, perhaps, he had been appointed over more senior men, and amply demonstrates that one was not necessarily disadvantaged in terms of career development by a period of 'public service' as a PMO in Glasgow. Macewen went on, of course, to become one the great figures in the history of medicine, pioneering new surgical techniques and antiseptic medical practice. He served as a PMO in Glasgow for twelve years, only resigning his post in 1883 when on the verge of becoming an international figure. Though it has been little mentioned in relationship to the development of his career, in biography or elsewhere – being overshadowed by his parallel police surgeon career - the PMO appointment brought contacts, a welcome regular income, as well as other practical advantages he was able to exploit.¹⁰⁸

¹⁰⁶ See Glasgow Post Office Directory (Glasgow: 1870/71, 1880/81, 1890/91, 1900/01, and 1909/10): the number of 'physicians and surgeons listed was 229, 294, 390, 558 and 538 respectively. Anne Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), p. 14.

¹⁰⁷ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (1st December 1886).

¹⁰⁸ A.K. Bowman, *The Life and Teaching of Sir William Macewen* (London, Edinburgh and Glasgow: William Hodge and Co, Ltd, 1942), p. 16: Bowman argues that as a PMO Macewen was brought 'into intimate contact with the work and personnel of the town or parish hospital in Parliamentary Road.'

Locally trained medical practitioners – and therefore local ‘ways of knowing’ – dominated medical practice in Scotland’s cities (Appendix V). That local knowledge or local connections was a crucial criterion in determining PMOs working in both Glasgow and Edinburgh is clear when one looks at the medical qualifications of the men employed. In Glasgow and Govan 77.1% of qualifications acquired by the PMOs employed between 1875 and 1911 were acquired in Glasgow (with the vast majority of the men employed by the parish being university trained). 95.9% of Glasgow PMOs acquired their educational qualifications within Scotland. Amongst Edinburgh and Leith PMOs, 84.2% of their medical qualifications were Edinburgh awards. These were split more equally between university and medical college graduates than in Glasgow, as befits the separate medical educational culture of that city. In Edinburgh, 97% of all PMO qualifications were acquired in Scotland. Comparative figures for all Dundee doctors in general practice in that city before 1911 demonstrate that local medical training was a Scots-wide phenomenon (Appendix V).

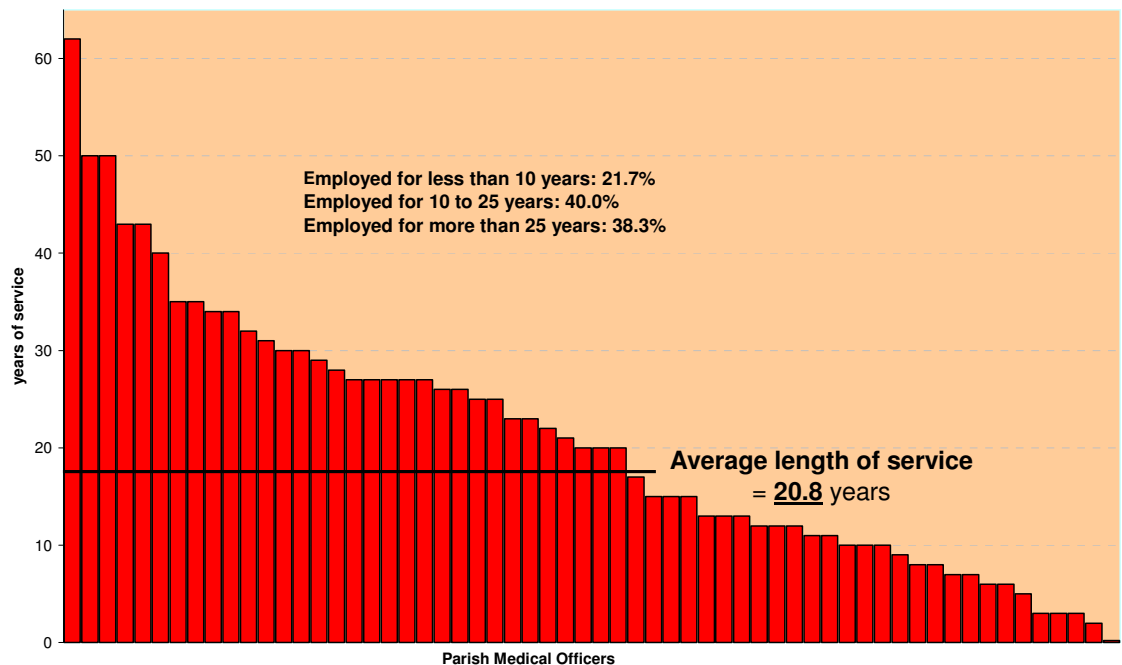
Amongst the issues that most agitated representatives of PMOs such as the Scottish Poor Law Medical Officers’ Association (SPLMOA), and amongst issues that historians have used as an important indicator of a substandard service, was the lack of security of tenure. In readiness for providing evidence to the Royal Commission into the Poor Laws in 1907, the Scottish Committee of the BMA conducted a sub-committee inquiry into conditions of service for all Scotland’s PMOs. It took evidence from 420 Scottish PMOs. In addition to routine complaints over pay, the BMA inquiry found that what was most bemoaned was the lack of security of tenure. This was a security that it said was enjoyed by those equivalently employed under the poor law in England where dismissal could only be made by the central authorities.¹⁰⁹ Unlike the parochial inspectors of the poor in Scotland, the PMOs held their position at the whim of the parochial board.

Feelings of insecurity suggest a great likelihood that one’s tenure could be abruptly and unjustly ended. However, although various medical practitioners at different times were censured or called to account for actions – with pauper complaints taken particularly seriously - it has already been noted that, in fact, only five men were

¹⁰⁹ William Limont Muir, Representative of the B.M.A. and the SPLMOA, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 57922f.

actually dismissed in Glasgow across the five decades after 1860. One dismissal has been mentioned. In 1863 Glasgow's first Irish-Catholic PMO was dismissed following what the MSC recorded as 'inattention' to a pregnant pauper. In November 1871 David Calderwood was dismissed for negligence (with no further explanation offered). In November 1886 Paisley-born PMO John Edmond Fairley was replaced after taking an unauthorised leave of absence, having sailed to America without prior notice, and (according to the parish records) having left a trail of creditors in his wake. In 1906 Thomas Russell was dismissed after repeated friction with Glasgow's parochial board. After Russell's extremely acrimonious dismissal several local practitioners initially agreed to boycott the vacant post (although enough suitable candidates still came forward to scupper the boycott). Russell himself continued his personal battle with the board but from the inside, by seeking and gaining election as Shettleston representative from 1907. Parish records show he was a fractious presence at board meetings for years afterwards!

Figure 2.6: Total years of service of Glasgow & Govan PMOs, 1875-1911 (60 of 72 with exact start and end dates known)



The LGBS, which otherwise sought every opportunity to increase its influence over local parish boards, was, in fact, sceptical that unwarranted or whimsical dismissal of a PMO was a likely occurrence under the established system. In investigations into

standards it found that between 1855 and 1902 only 139 official complaints had been logged against the actions of PMOs across Scotland (an average of not much more than three per year). Of these, only 51 had been upheld, with 28 PMOs censured; twelve forced to resign; and just eleven dismissed. Dismissal of a PMO, the LGBS noted, was often a last resort.¹¹⁰

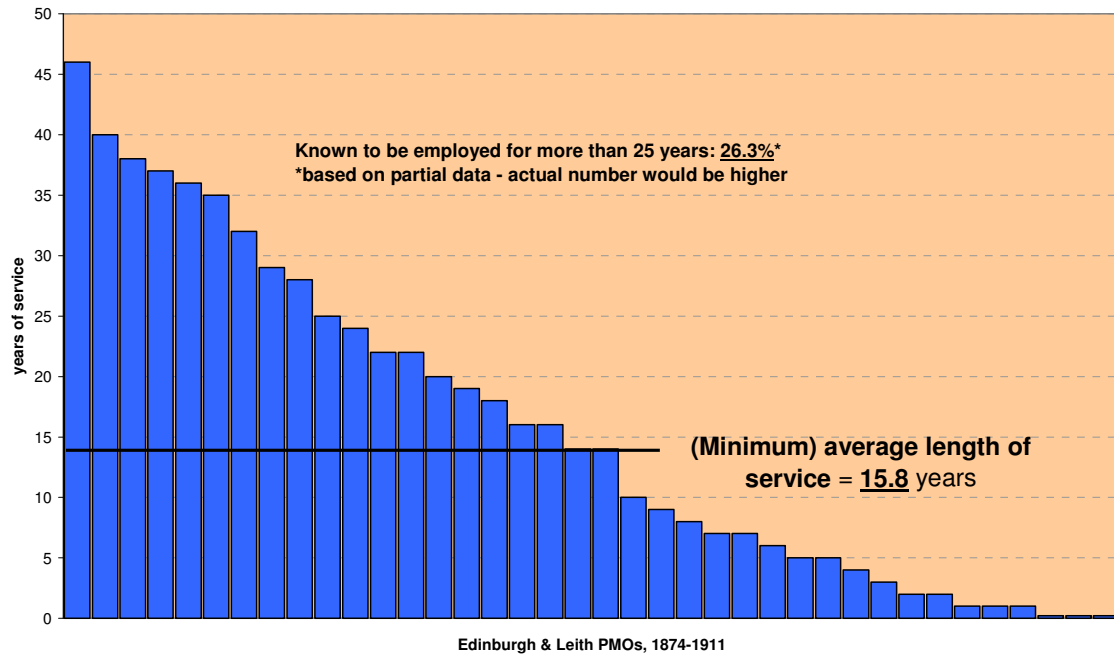
Few PMOs were dismissed; resignations – however PMOs felt about their work – were infrequent; and years of service were usually long. The exact length of service is known for 60 of the PMOs who worked in either Govan or Glasgow parish between 1875 and 1911. Figure 2.6 shows that the average length of service was just over 20 years, with nearly four-fifths of all PMOs remaining in post for more than ten years. Two of the men that were still serving as PMOs in the mid-1880s – William Young and David Walker – had, in fact, originally been appointed as town medical officers before the passing of 1845 Act! Six men are known to have served for 40 years or more.¹¹¹ David Walker retired after 43 years of service aged 76. From 1863 he had also doubled as the parish vaccinator. By his own calculations, through the 1860s and 1870s, Walker was regularly vaccinating over a thousand children each year on top of his district duties.¹¹²

¹¹⁰ Poor Law Medical Relief (Scotland) 1904 (Cd. 2008), vol. 1, part V, p. 74: Without ‘desir[ing] to throw doubt’ on the evidence provided to it by the SPLMOA representative Dr Muir, the LGBS Report expressed the opinion that generally the likelihood that a PMO would be dismissed or threatened with dismissal for suggesting excessive treatments was remote, noting ‘if there be one or two such cases, it is perhaps not unnatural that the grievance should be largely magnified.’

¹¹¹ On list of all PMOs and their years of service see Appendix IV.

¹¹² City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/3 (5th November 1877, 28th November 1878, 18th February and 18th March 1881, and 18th March 1886). Walker advised the medical committee that for the year ending 31st October 1877 he vaccinated 1,144 children at vaccination stations established at the two parish dispensaries; and that for the six months to November 1878 this rate had risen to over 700 children biannually. In 1881 he advised the medical committee: ‘that he had vaccinated between 17,000 and 18,000 children at the vaccination station in Trongate between 1864 & 1879’. In March 1886 PMO James Smellie noted of his newly acquired vaccination duties that: ‘more than one visit is usually required, and that a third is often necessary’. Smellie was paid a flat-rate of two shillings and sixpence per case. This was a more attractive form of payment to practitioners than the fixed sum.

Figure 2.7: Minimum years of service of 38 Edinburgh & Leith PMOs, 1874-1909



As seen in Figure 2.7, whilst exact appointment dates and end dates are harder to trace for Edinburgh PMOs, it has still proven possible to calculate, based on known years of service, that those employed between 1874 and 1909 in Edinburgh or Leith served a minimum of 15.8 years on average, while more than one-quarter of them served more than twenty-five years.

In the parishes of Leith turnover of PMOs was remarkably slow. Robert McNair, M.D., F.R.C.S.E., served as PMO for North Leith Parochial Board for at least sixteen years before moving to Greenock, aged 57, in 1885. His home on Ferry Road in Leith with two resident servants gives an indication of his professional standing. McNair was replaced by George Donald. Donald was unusual for an Edinburgh appointment in that he was educated in Glasgow. He was still serving PMO for Leith Parish Council after 1911, and seems to have served for up to 40 years. Donald had moved to Leith a couple of years before appointment, and acquired his M.D. in 1889. In not untypical fashion, Donald had built up post-graduation experience working as an assurance company medical referee, and working as a surgeon at Coltness Ironworks. The parish of South Leith had two PMOs before combination, with William Black Alexander, highly unusually, working both for the parochial boards of South Leith and St Cuthberts Combination before 1895. Alexander served for 20 years as a PMO

in South Leith; and for over 46 years, before his death in 1922, as PMO for St Cuthberts (and later Edinburgh Parish Council). The second South Leith post was held by Thomas Williamson, M.D., F.R.C.S.E., for over 30 years until his death in 1885. Williamson's work as a PMO fed into other aspects of his medical career, as he published on aspects of both sanitary nuisances and 'origins of disease in large towns' in the *Edinburgh Medical Journal* in 1866. Whilst serving as a PMO Williamson also served as a physician at Leith Hospital and at Sir John Gladstone's Hospital for Incurables. Williamson's replacement was George Minto Johnston. Johnston was appointed five years after graduation and the year following acquisition of his M.D., and after local experience gained by working at Leith Hospital and the Edinburgh Royal Maternity Hospital. He then similarly served for 30 years until World War One, before retiring a J.P. for Leith.

Edinburgh and Leith investigations confirm findings for Glasgow and Govan that overturn the idea that those in position were forever in danger of being 'bowled out' (Appendix I). And whilst length of service might be held to support arguments that PMOs were men without other medical abilities, application vetting processes and analysis of the general activities of PMOs in Scotland's two principal cities demonstrates the opposite. Some of the examples selected here support the idea that some practitioners saw work as a PMO as a springboard to other ventures, although most men stayed with parish work for many years.

William Macewen, already a surgeon of repute when additional workload encouraged him to quit in November 1883, was not the only future Glasgow medical heavyweight operative as a PMO in the period 1875 to 1911. For example, amongst the practitioners serving in Glasgow in 1875 were Barony PMO's William Loudon Reid and Murdoch Cameron. Both were to become significant figures in the development of the specialization of midwifery in Glasgow. Reid, like several other Glasgow PMOs, had been a student under Lister in the 1860s, and served as PMO in the populous and poor Anderston district for seven years to 1877. In the year of his resignation Reid became Fellow of the Faculty of Physician and Surgeons of Glasgow and was appointed outdoor physician-accoucheur to the Glasgow Maternity Hospital. In 1889 he was appointed professor of midwifery and diseases of women and children at the Anderson's College in Glasgow. In 1907 Reid served a term as president of the

Royal College of Physicians and Surgeons.¹¹³ Murdoch Cameron served as a PMO for approximately five years until 1878: ten years later he was appointed visiting physician to the Glasgow Maternity Hospital. It was there that he developed and encouraged the use of Caesarean section operations, which (as his obituary claimed): ‘established the procedure on a sound and scientific basis in this country’. From 1894 to 1927 Cameron was lecturer on midwifery at Glasgow University. A contributor to Cameron’s BMJ obituary noted the debt he had owed in his medical development to the period of time he had spent in practice in the homes of the poor:

His unique experience of difficult obstetrical conditions in the rachitic slum dwellers of Glasgow made him an authority in his subject; in fact, he may be said to have founded a Glasgow school of midwifery...¹¹⁴

When he resigned the poor law post in 1878 Cameron sold his practice to John Glaister, later to become professor of medical jurisprudence at Glasgow University. Any claim that parochial boards were consistently good at talent spotting would be difficult to sustain for in the year he acquired Cameron’s practice Glaister failed in his application for a vacant PMO position in Barony parish. In 1880 he failed again, this time in application for a vacancy to Glasgow, despite in the interim years building relations and experience by filling in as a locum tenens PMO.¹¹⁵ The quality of some of the men that failed to secure appointment represents a kind of ‘hidden history’ of the parochial service and provide another example of the obvious but under-mentioned esteem with which parochial medical services were held in Glasgow: in January 1877, for example, after returning from Africa, the cholera expert James Christie, M.D., was another in a long list who failed to secure parochial appointment.¹¹⁶

Murdoch Cameron and William Loudon Reid were not the only connection between poor law service in Glasgow and the development of midwifery services in the city. In 1886 George Halket, John Stuart Nairne, Robert Park and Thomas McKee established

¹¹³ Obituaries of William Loudon Reid Obituaries in BMJ, v.1 (1932), p. 40; and the GMJ, v.117 (1932), pp. 91-3. Typically, neither makes mention to Reid’s service as a PMO.

¹¹⁴ BMJ, v.1 (1930) p. 930.

¹¹⁵ Within a year of failing to be appointed PMO for City Parochial Board, and as a symbol of his growing status in Glasgow medicine, Glaister had been made, like Reid, a Fellow of the Faculty Physician Surgeons Glasgow. See City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/3 (21st November 1879, and 23rd January and 24th September 1880); and Barony Parochial Board Minutes, GCA D-HEW 2/2/1 to 2/2/22 (June, 1878).

¹¹⁶ On the career of James Christie see forthcoming work of Edna Robertson, University of Glasgow.

a clinic for women that quickly grew into the Royal Samaritan Hospital. Halket served in Anderston as a PMO for Barony from 1877 to 1892; Park served as a City PMO from 1877 to 1894; and Stuart Nairne also served as a PMO in Glasgow, although only for two years before 1874.

That a number of highly competent, prominent medical professionals were employed at different times as PMOs in Glasgow is clearly shown when one looks at how many went on to obtain prominent teaching positions in the city. In Comrie's *History of Scottish Medicine* (1932) there is a list of the few dozen professors and lecturers appointed to the Glasgow Medical Schools – consisting of Glasgow University, Anderson's College, and the Royal Infirmary Medical School (St. Mungo's) – between 1860 and 1900. With the importance of such appointments, it can be argued that this list represents the cream of Glasgow medicine in the late-Victorian period. The list includes Macewen, Cameron, William Loudon Reid, Glaister, and Nairne, already identified as Glasgow PMOs.¹¹⁷ The list of academic medical practitioners also includes the ophthalmologist Thomas Reid, who was appointed to a Waltonian lectureship in 1869, the year he quit as a PMO for Barony parish. Reid was said to be a figure of fascination for the neighbourhood children of the day, his topcoat pockets full of dusty lenses. Men, like Reid, struggling to establish himself in a profession without family money, were keen to take parochial appointment. Work amongst the poor was necessary, although in Reid's case he was also said to have served the poor law due to 'financial circumstances, as well as his own inclination'.¹¹⁸ Listed too is Alexander Lindsay, lecturer in medical jurisprudence at Anderson's College from 1872 to 1887, and for 19 years to 1869 a PMO for City parish; George Bell Todd, a PMO in the Garscube district of Glasgow from 1898 to 1911, and who at the time of his appointment had been for seven years the natural history lecturer at Anderson's College; John Carswell, who from 1891 to 1914 held the chair in mental diseases at Anderson's College, and who for 34 years from 1880 was connected to the outdoor medical service of City parish, beginning first as a PMO in the Finnieston district; and James Erskine, PMO for Blythswood between 1910 and his death in 1922, who was also lecturer on aural surgery in Anderson's College to 1899. Erskine's obituary

¹¹⁷ John D. Comrie, *History of Scottish Medicine in Two Volumes*, v. II (London: Wellcome, 1932), pp. 661-664.

¹¹⁸ A. Maitland-Ramsay, 'An Appreciation' in GMJ, v.9 (1937) pp. 66-73.

records that he was also active in shaping the parochial services in Glasgow, noting that: ‘for some years also he was a member of Glasgow Parish Council, and chairman of the District Hospitals Committee, to which he devoted much time’.¹¹⁹ Erskine was one of several medical men elected to serve as parochial board members and parish councillors, and who represented a bridge between the often dichotomised medical workforce and the ‘lay’ management.

Leith PMOs have been mentioned. Amongst the other 33 Edinburgh PMOs known to have served between 1874 and 1909 are several who also contest the argument that parochial medical services only attracted men of little ability. Several examples suffice. J.J.K Duncanson founder of the Edinburgh Ear Dispensary in 1875 (this was later combined with the Eye Infirmary to form Edinburgh Eye, Ear and Throat Infirmary). He was for a time before giving up general practice and prior to finding the dispensary a City of Edinburgh PMO: he had been appointed around the time of becoming F.R.C.S.E., and this after several years of study in Vienna.¹²⁰ Alexander James Sinclair was appointed PMO circa 1873/4, shortly after acquiring his M.D. and becoming F.R.C.P.E. He was only in his mid-twenties when appointed but had been a prodigious student, his obituary noting that he was too young to be capped on completing his studies and had to wait, and that his M.D. thesis was specially commended. When he died of meningitis in 1889, *The Lancet* noted that he ‘would certainly have become one of the leading members of our profession’. Even allowing for the hagiographic nature of medical obituaries, this is a strong statement.¹²¹

Andrew Smart, M.D., M.R.C.P.E., had only registered to practice medicine when aged 40. He was approaching 50 years old when appointed PMO for St Cuthberts Combination parish. Early in his career in a report requested by the Lord Provost of Edinburgh on the prevention of Rinderpest in 1864, Smart was said to have been one of the first to identify the existence of germs in living tissues. Before ceasing to serve as a PMO, Smart was already an examiner for the Royal College of Physicians of Edinburgh and an honorary physician at the Edinburgh Royal Public Dispensary. In 1883 (approximately two years after ceasing to serve as a PMO) Smart published ‘Germs, Dust and Disease’, becoming subsequently lecturer on clinical medicine in

¹¹⁹ GMJ, v.97 (1922) p. 233.

¹²⁰ Duncanson’s appointment recorded in *The Scotsman* (17/2/1874), p. 6.

¹²¹ Obituaries in EMJ, v. 34/2 (1889), p. 969, and *The Lancet*, v. 1 (1889) p. 454.

the Extra-Academical School of Edinburgh. William Husband was PMO for St Cuthberts Parish for at least 40 years to his death in 1901. He was Scotland's leading expert on vaccination, being credited with introducing 'the method of preserving vaccine lymph in capillary tubes,' and serving as the Superintendent of the Central Vaccine Institution for Scotland.¹²² Stewart Stirling, founder of the Edinburgh Dispensary for Skin Diseases, held an Edinburgh PMO appointment in the early 1880s; as did James Graham, gold medal M.D. thesis winner at the Edinburgh University in 1889, acquired after his return from Sydney, Australia, where he became Mayor and was later knighted by King George V.

¹²² On Husband see obituary in *The Scotsman* (21 Aug, 1901), p. 6.

2.5 Workloads; salaries; and locum tenens

In the towns the medical officer is paid at a very low rate per attendance, and his salary is more like a retaining fee than a payment for work done

William Limont Muir, PMO, BMA and SPLMOA representative (1907)¹²³

It must be assumed, until the contrary can be shown, that a Medical Officer is fulfilling his duties, even though the number of attendances upon patients be relatively smaller than those of a brother officer. In this much will depend upon the *idiosyncrasy* of the individual officer...

Glasgow City MSC Report on PMO workloads (1896)¹²⁴

For the medical practitioners employed under the poor law ‘attendance’ and domiciliary treatment of the poor was the most arduous aspect of the workload. Patients needing monitoring, and ulcers and wounds needed redressing. However, as Glasgow City MSC’s chairman - himself a medical practitioner – claimed, workloads varied by ‘the idiosyncrasy of the individual officer and the individual case’. And as Hodgkinson correctly states of English poor law medical officers, where like their Scottish counterparts free to treat cases as they saw fit, total numbers of visits conducted depended as often on the ‘conscience’ and ‘discretion’ of the practitioner concerned as upon the nature of the case.¹²⁵

PMOs, as Muir stated, were often aggrieved by discrepant workloads for similar pay. This was problem fuelled by constant changes to population in different districts. It was in the interest of both parties that workload bore relation to pay. Given that parochial boards preferred to maintain fixed annual salaries, part of the problem was that not all were equally disadvantaged. Thus PMOs were as likely to press for changes to their salary individually, as collectively. In April 1879, in support of a personal application for a salary increase, Glasgow City Parish PMO James Smellie advised the parish MSC that his particular parochial case load over the previous two years had seen him make: ‘on average per month 220 [home] visits, fill...up 58 certificates, [write] some hundreds of prescriptions, and devote...much time daily to considerations with paupers’. For the month of December 1878, when the Scottish economy was at its most depressed, Smellie calculated that he had averaged twelve home visits a day. Given the time that was routinely set aside for each visit, 20

¹²³ William Limont Muir, RC Poor Laws and Relief of Distress (PP Cd.4978), Evidence 57922/3.

¹²⁴ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (23rd April 1896).

¹²⁵ Hodgkinson, The Origins of the National Health Service, p. 356.

minutes, this would have meant that four hours or more each day were necessarily given over to parochial visitation.¹²⁶

Evidence suggests that Smellie had a legitimate complaint that his workload had become very high. Audited investigations in both October 1876 and again a decade in February 1887, conducted by the City MSC in Glasgow with a view to redraw the internal parish boundaries of the medical districts, found that he was constantly amongst the busiest of the PMOs in the parish in terms of total individual number of cases he was called upon to treat. In 1876 the Medical Committee Minutes recorded:

The Committee in reconsidering this subject [of tying pay to workload] find that the Medical Officers have had during the year ending 31st May 1876 the following average number of each month under their care which they were required *to treat to a conclusion* viz – Dr Leitch 33, Dr Mackay 59, Dr Buchanan 25, Dr Smellie 53, Dr Lothian 9, Dr Mather 27, Dr Macewen 30, Dr Walker 20 and Dr Orr 25: and besides these they were called upon by the Inspector *to fill up Certificates* [my italics] in the following average number of cases, the largest proportion of which were parties applying for parochial relief and who did not as a rule require to be visited at their houses, but were examined by the Medical Officers at their place of business or call viz – Dr Leitch 40, Dr Mackay 128, Dr Buchanan 50, Dr Smellie 47, Dr Lothian 58, Dr Mather 33, Dr Macewen 81, Dr Walker 24 and Dr Orr 24.¹²⁷

In February 1887 a table detailing the number of cases treated in the eight districts of Glasgow City parish, over a three-year period, was again recorded in the medical committee's minutes (reproduced here as Table 2.6).¹²⁸ This time the review of services was instigated not by aggrieved PMOs but by the parochial board. It was the parish inspector that had suggested an investigation into the respective workloads. The new MSC convener, Dr. William Limont Muir, sanctioned the inspector's suggestion. Muir – who later resigned to become a PMO and who has been mentioned already for his work with the SPLMOA - saw in the review the chance to determine whether any changes to salaries were needed. Muir served as a PMO in Glasgow from 1889 to 1923.

¹²⁶ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/3 (8th April 1879).

¹²⁷ City Parochial Board Medical Committee Report, GCA D-HEW 1/5/3 (6th November 1876).

¹²⁸ City Parochial Board Medical Committee Report, GCA D-HEW 1/5/4 (17th February 1887).

Table 2.6: Number of cases attended and medical certificates issued per PMO in Glasgow City parish, 1884 to 1886.

Salary p.a.	PMO	Parish district	1884			1885			1886		
			cases	Certfctes	total	Cases	certfctes	total	cases	certfctes	total
£55	Dr. Leitch	1	344	973	1317	378	921	1299	385	924	1309
£80	Dr. Findlay	2	485	1770	2255	516	1649	2165	452	1508	1960
£55	Dr. Park	3	389	622	1011	432	687	1119	379	567	946
£70	Dr. Smellie	4	792	676	1468	827	667	1494	862	648	1510
£55	Dr. Black	5	443	804	1247	394	643	1037	275	693	968
£55	Dr. Dewar	6	418	1121	1539	334	1199	1533	181	1027	1208
£55	Dr. Wilson	7	375	278	653	503	299	802	487	407	894
£55	Dr. Orr	8	698	584	1282	676	627	1303	625	652	1277

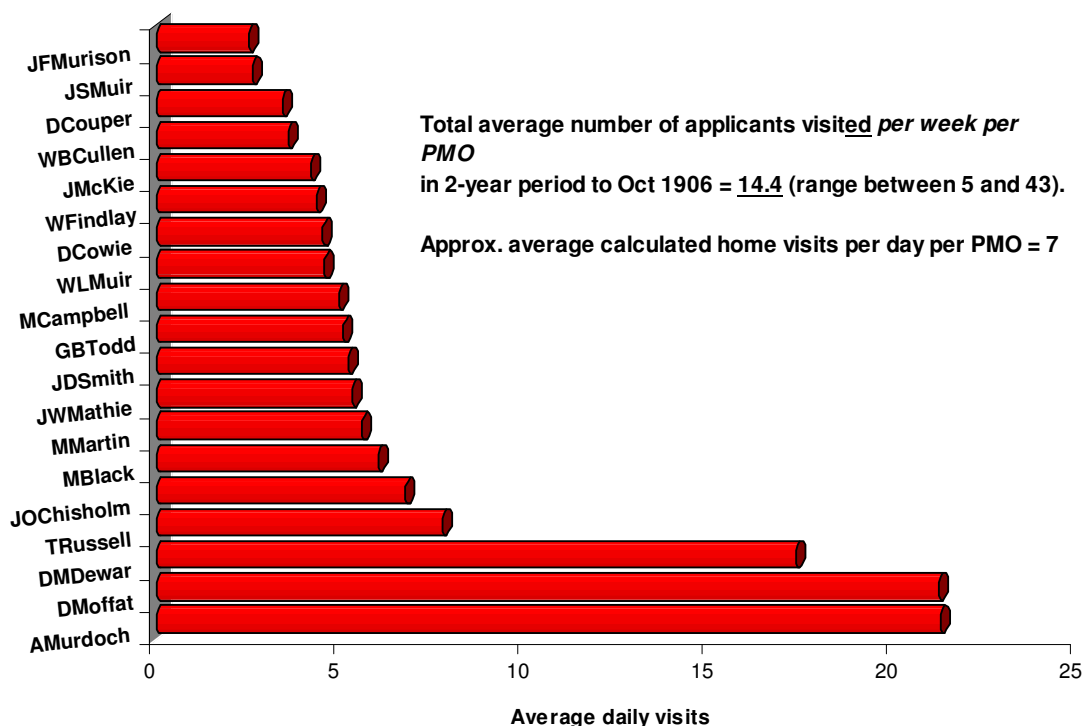
Source: Copy of table from City Parochial Board Medical Committee Reports, GCA ref: D-HEW 1/5/4 (17th February 1887).

From Table 2.6 it can be seen that James Smellie had in the previous year treated around 72 cases and issued 54 certificates, on average, each month. For this Smellie was paid a salary of £70 per annum. John Gibson Leith, the highest earner with an annual salary of £80, handled less than half the cases of Smellie, but was also responsible for examining many more pauper applicants for relief. Daniel McKellar Dewar, again in contrast to Smellie, had in the same year treated just fifteen cases per average each month (less than one-quarter as many as Smellie), yet was also called upon to issue 85 medical certificates monthly (more than half again compared to Smellie). That an officer's workload was dependent on the unique demands of his particular district is demonstrated further when, in July 1892 Robert Orr, in a separate pay claim, advised the parish that his workload had been 'considerably increased' by the opening of 'a second lodging house'. By the 1900s, as many as one in seven of all applications for poor relief in Glasgow and Govan were made from common lodging houses.¹²⁹ Alternatively, in May 1893, PMO Robert Park was called by the MSC of the parochial board to address the issue of his declining workload. He attributed the

¹²⁹ On dwelling homes of applicants for relief in Glasgow and Govan see RC Poor Laws and Relief of Distress (Cd.4978), Appendix CLXIV (C) No. 4.

relatively low number of new cases in his district to the recent depopulation caused by the impact of City Improvement.¹³⁰

Figure 2.8: Average daily home visits to pauper applicants per Glasgow Parish PMO over two-year period to Oct. 1906 (based on a 6-day week and a mean average of 3 visits per applicant visited).



Source: From Medical Officer Returns Data published in bi-annual Parish of Glasgow Statistical Report[s] by the Inspector of Poor, April 1905 to October 1906, GCA ref: GCA T-PAR 1.5

One of the difficulties of calculating the amount of daily home visitation work conducted by individual PMOs is that numbers of cases do not necessarily easily equate to total cases that required visiting or the total visits undertaken (although an average of three visits per case was often used in reports). A second problem is that numbers of visits made was often conflated with numbers of patients visited (depending on which element was to be stressed in the particular context). In the two years detailed in Figure 2.8, applications into Glasgow Parish Council were 24,474 to 15 October 1905, and 22,825 to 15 October 1906; in these years, 23,205 and 21,866 were treated by one or other PMO, and 14,753 and 13,623 of these patients required

¹³⁰ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (21st July 1892 and 19th May 1893).

visiting. With an average over these two years therefore of 14,000+ cases to attend, the nineteen PMOs in the mid-1900s made a mean average of *seven to eight medical home visits each per day* (based on three visits to each case). The average number of new patient cases visited per week ranged from five for John Falconer Murison, to 43 for Alexander Murdoch. Murdoch was the one full-time PMO, occupying a position originally created in 1877. He was PMO for Calton-Bridgeton. David Moffat, who was employed part-time, and who was responsible for Anderston district, also visited 43 new cases each week. Given that several repeat visits were often necessary to each patient, Murison and Moffat therefore likely conducted more than 20 visits each day on behalf of the parish.¹³¹ These Glasgow figures are comparable with evidence for Govan. In 1907 Govan PMO, Robert Davie Taylor, claimed that: ‘My average visits and consultations in parochial cases number 300 per month.’ Fellow Govan PMO, John Veitch Wallace, made a similar claim that: ‘about 4,000 parochial patients pass through my hands on average a year.’¹³²

In 1907 John Veitch Wallace was aged 62. He had been a Govan PMO for 22 years. He was also MOH for Govanhill. In giving evidence in 1907 to the Royal Commission, he pointed out the seeming paradox that state involvement meant that ‘many paupers... are better off for medical attendance than the working classes’. He was clear as to the reasons: ‘The income of many working-people,’ he argued, ‘is not sufficient to meet the expense of sickness.’ Asked to comment on conditions of work in the parish, Wallace argued that he enjoyed ‘a free hand’ in medical decisions, stating: ‘The medicine is of the best quality, and there is no restriction in prescribing as to quality or quantity’. Decisions regarding foodstuffs were also his: ‘Suppose I am prescribing meat, then I write out an order and the patient takes it to the butcher. *He does not go to the inspector of poor.*’ Whilst complaining that parish patients were apt to abuse prescriptions – with ‘much of the medicine the paupers receive [being] sold

¹³¹ On visitations per PMO see, for example, Poor Law Medical Relief (Scotland) 1904 (Cd. 2022), vol. 2, appendix VIII: ‘Medical Officers’ Returns for the six months ended 15th April 1902 [and the six months ended 15th April 1901]’, a paper handed in by James R. Motion; Medical Officer Returns Data published in bi-annual Parish of Glasgow Statistical Report[s] by the Inspector of Poor, April 1905 to October 1906, GCA T-PAR 1.5; and City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (23rd April, 1896).

¹³² John Veitch Wallace and Robert D. Taylor, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 60312/1, and Appendix CXLI.

or destroyed, or used for other purposes' - Wallace was clear regarding the symbolic importance the bottle of medicine he dispensed:

...a great many of them [the pauper-patients] have the idea that unless they are getting medicine now and then they will lose their connection with the parish. They come for a bottle of medicine and keep it up as long as (possible)... they will insist upon having a bottle of medicine (whether or not it will help them).¹³³

Wallace was more complimentary of the fortitude and gratitude of the poor, noting how rarely they complained:

Some of [the paupers] grumble and are dissatisfied if [the medical officer] does not cure them, or refuses to supply them, and will even threaten to complain to the inspector or a member of the parish council. But, on the whole, the pauper bears his miseries very patiently, even cheerfully, and is grateful for small mercies.¹³⁴

Comparisons regarding the exact visitation workload of Edinburgh PMOs are hard to draw, although the six PMOs employed by St Cuthberts reported averages of over 100 patients each month visited over the early 1870s: this was less therefore than in Glasgow and Govan.¹³⁵ A comparison with London poor law medical officers can also be made. A report in 1904 based on comparative data of salaries and workloads of the medical officers of the 129 districts of the 30 Poor Law Unions in metropolitan London for the year ending 25th December 1901 recorded an average of six new cases per week for each poor law medical officer in London; and for this they were paid an average of £125 per annum.¹³⁶

It is to be expected that visitation workload in Edinburgh and in Leith would be less than in Glasgow, mainly because the number of charitable dispensaries providing visitation services amongst the poor in Edinburgh and Leith were significantly higher. Indeed, some Edinburgh PMOs were required to visit surprisingly few cases per year. Thus when in 1891 Henry Hay and Allen Thomson Sloan got together to request a rise in salary, the request was refused on the basis that with an average return of 4s 9d

¹³³ John Veitch Wallace, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 60359.

¹³⁴ John Veitch Wallace, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 60312/12.

¹³⁵ St Cuthbert and Canongate Combination Parochial Board Annual Reports, ECA SL/10/16/6.

¹³⁶ From evidence handed in by Dr A. Downes, Senior Poor Law Medical Inspector under the Local Government Board for England to Poor Law Medical Relief (Scotland) Report, 1904 (Cd. 2022), vol. II, appendix XXIX.

per case visited, both men were considered by the MSC of the parish already suitably well recompensed for their work.¹³⁷

Given the average visitation workload, especially in Glasgow, and that PMOs across Scotland were on permanent call, time management, flexibility, and negotiation skills were obviously at a premium in managing any medical practice that incorporated public appointment. This can be seen in testimony regarding practice routine from December 1876 from Glasgow PMO George R. Mather. Mather – who shared, at the time, a surgery for pauper-patients with William Macewen – made clear the importance of these skills in daily practice:

I conduct the regular work of the 9th district, through the centre of which (by the way) I pass twice daily in connection with my duties at the Royal Infirmary. On leaving the Royal at 3 o'clock [where Mather worked as a surgeon in the outpatients department] I go to 46 George Street [a place of call used by Macewen also] and first attend to the paupers waiting generally in goodly number, secondly visit those who are unable to come to see me, then return to George Street to see if any others have turned up and to fill cordial lines for any requiring such. In addition, I had a distinct understanding with the person in charge that if any urgent case came after I left the party or parties were to be sent to my consulting rooms 104 Bellgrove Street where they could wait by a comfortable fire till I came in to attend to them. When owing to urgent professional work [sic!] I could not be present at George Street, if possible, I sent intimation to [fellow PMO] Dr Lothian who did my work and in his absence I did the same for him.¹³⁸

The issue of workload and working conditions was never far removed from the issue of payment, and no issue of parochial medical work was as contentious as pay. When taking the unusual step of collectively petitioning City MSC in November 1894, Glasgow PMOs raised the professional bugaboo of the 'sixpenny' doctor to emphasise their claim.¹³⁹

Attempts were made early within parishes to standardise amounts but salaries could vary. Salary differentials between PMOs in Glasgow and Edinburgh depended on existing local payment patterns, experience, additional responsibilities such as vaccination and lunacy certification, the level of dispensary support that was available locally to a medical officer (and therefore whether the PMO was required to find his

¹³⁷ *The Scotsman* (19 May, 1891), p. 7.

¹³⁸ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/3 (4th December 1876).

¹³⁹ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (22nd November 1894).

own medicines), as well as projected workload. Seven of the nine Glasgow City PMOs in 1875 were being paid £55 per annum for their work. This was a sum of pay originally fixed in 1854. Simson Buchanan and Alexander Fraser Mackay were paid higher amounts of £70 and £80. This was to compensate each for taking responsibility for conjoined districts. After the PMOs joined forces to put a joint petition before the MSC in November 1894, early in 1895 an additional ten pounds was added to each salary. Standard salaries for the majority of PMOs in Barony had been increased much earlier, rising in the depression year of 1878 to £75 per annum (perhaps as an acknowledgement of increased workloads?). In Govan, though otherwise similarly paid to Barony staff, PMOs received an additional premium of £10 ‘in lieu of lunacy certificates’; and some of the Govan PMOs also managed to increase their total ‘public service’ income by doubling as the local MOH in the districts they served. Changes to the administrative structure of the poor law in Scotland after 1898 brought further financial benefits, and by the time of the Poor Law Royal Commission in 1907, all but two PMOs in Glasgow were being paid £80 or more. With the exception of the one full-time outdoor PMO - in a post created by Barony in April 1877, who by 1905 was being paid £380 -, the average salary of the Glasgow-based PMO increased roughly 54% between 1877 and 1905. Although the profession generally complained that the costs of practice were rising at this time, this effective increase in public pay took place during a period of falling prices and very little inflation (Figure 2.2).

Salaries in Edinburgh were pitched at a very similar level to Glasgow, although overall workloads were seemingly less. In October 1880, Alexander Moir was appointed PMO for the south-west district of Edinburgh City parish at a salary of £60. In September 1884, following the resignation of two of the parishes five PMOs at around the same time, the parochial board took the opportunity to redraw the districts. The two PMOs were not replaced, and the remaining three were given salary increases of £15 each to share out duties, saving the parish £90 to £100: this raised PMO salaries in the parish to £70 or £75.¹⁴⁰ In 1909 all Edinburgh Parish Council’s outdoor PMOs were still drawing the same salaries, except the one with the additional responsibility of certifying lunatics, who drew a salary of £100.

¹⁴⁰ *The Scotsman* (16 Sept, 1884), p. 3.

Whilst much complained about, how did the monies paid to PMOs in Glasgow and Edinburgh compare to colleague across Scotland and to other forms of salaried, outdoor medical work? Evidence on parish pay from the first decade of the 1900s had it that ‘out of 410 cases (being about one half the total number of Medical Officers in Scotland), 306 had salaries below £50 per annum, while only 21 had over £100 per annum’: this meant that Glasgow and Edinburgh PMOs were better remunerated than many colleagues.¹⁴¹ With the exception of one full-time member of staff in Glasgow, all PMOs had part-time responsibilities. Roughly speaking, salaries paid to the PMOs were proportionally equivalent to what a medical practitioner might expect to be paid taking full-time visitation-based employment in other ‘private’ charity areas, such as at a dispensary or colliery practice at one of England’s northern towns, or as a full-time assistant at an established practice in these cities (although assistants often had board and lodging provided). *The Scotsman* newspaper carried regular advertisements for medical positions, a snapshot of which demonstrates the competitiveness of the part-time public salaries paid to PMOs. £120 per year was offered for the ‘whole-time’ post at the Homoeopathic Dispensary in Manchester in 1871; £120 for whole time house surgeon position at the North Shields and Tynemouth Dispensary in 1875; £120 again was offered for the visitation-based work of full-time post of outdoor-medical assistant at the Gateshead Dispensary in 1876; £150 was offered by the Newcastle-on Tyne Dispensary for an Assistant Surgeon; and £100 plus board for the whole-time position at Leeds Public Dispensary.¹⁴² In other equivalent but full-time work, the annually re-advertised ‘Visiting Medical Assistant’ position at the Newcastle-on-Tyne Dispensary paid the position £120-£180 between 1880 and 1910.¹⁴³ Elsewhere, in 1906, Leith Hospital advertised for a surgeon for its outdoor and dispensary department – a position that required a prodigious amount of visitation - for a twelve-month appointment at a salary of £80 per annum.¹⁴⁴ Also in 1906, one unnamed Glasgow medical practitioner advertised for a ‘medical assistant (qualified), for private practice near Glasgow, very easy work; rooms, coal and gas free.’ The

¹⁴¹ Webb, *The State and the Doctor*, p. 23, quoting from evidence by representatives of the SPLMOA.

¹⁴² *The Scotsman* (11th April, 1871), p. 1; (15th Oct 1875), p. 1; (21st July 1876), p. 1; (31st Oct, 1901), p. 9; and (10th July, 1908), p. 9.

¹⁴³ *The Scotsman* (31st May 1880), p. 2, and (11th July, 1908), p. 12.

¹⁴⁴ *The Scotsman* (17th Mar, 1906), p. 11.

salary for this full-time position – likely requiring much visitation work - was £150 per annum.¹⁴⁵ If salaries were low, parishes were not unique in their parsimony.

The one full-time outdoor position in Barony and later under Glasgow Parish Council - manning the heavily Irish-populated working-class district of Calton-Bridgeton in the east-end of Glasgow – paid between £300 and £400. Giving a lie to the notion that any moves towards a ‘whole time’ parochial medical service would automatically meet with opposition from the rank and file of medical profession, this level of salary was sufficient incentive to see 33 applicants come forward to be considered for the post in 1877, 42 applicants when the first incumbent decamped to Govan Poorhouse six years later, and fourteen further applicants when the post next became available in 1910. This level of annual income was right at the middle band of salary that Nenadic stated in her ‘indices of wealth’ was typically indicative of earnings of the Victorian Glasgow middle classes. It was also in line with an estimate from July 1878 of medical practitioner salaries regarding the norm for a successful practitioner of five to ten years standing.¹⁴⁶

Surviving accounts books relating to the private practice of father and son John Mathie and John Wilson Mathie, who served as PMOs in Glasgow, in 1867-77 and 1904-25 respectively – demonstrate just how important this level of guaranteed salary could be, given that so much private practice was conducted on account, especially in established practices with a regular customer base.¹⁴⁷ Overall, the problem of adequate salary, much complained of, was as much a reflection of a changing medical marketplace and intra-professional competition, and of maintaining social standing, as of changing parochial workloads, bringing to general practitioners a growing dependency on monies earned from regular salaried income sources. Govan PMO,

¹⁴⁵ *The Scotsman* (8th Dec, 1906), p. 12.

¹⁴⁶ Stana Nenadic ‘The Victorian Middle Classes’ in W. Hamish Fraser & Irene Maver (ed.), *Glasgow, Volume II: 1830-1912* (Manchester University Press, 1996), ch.5. Per GMJ (Dec. 1878), pp. 555-8: An Army Medical Service report suggested that: ‘Taken one with another, a medical man obtains in civil life a net income of £300 a year within five years of commencing practice. After ten years he is unlucky if he does not net £500 a year, and his income gradually [in later years] rises to £800 or £1000.’ The GMJ was sceptical about these figures, pointing out how much of medical work in early years was ‘unremunerative’ and pointing out too the high cost of purchasing a medical practice.

¹⁴⁷ ‘Yearly Abstracts book of John Mathie and J. W. Mathie’ (provenance unknown) (Glasgow: RCPSG College Library Collection), ref 1/20/3/7. Accounts run from 1864 to 1936. Analysis of the account books show that at the Mathie practice typically around 50% of all income each year was income on account. This money was normally collected once or twice a year, and some had to be written off as bad debt.

John Veitch Wallace, spoke in 1907 of a number of pressures squeezing the purse of medical practitioners during the period detailed here, including the over supply of practitioners, the rising costs of medicine and costs of making a medical living, that consultancy fees had remained stable for a number of decades into the 1900s, and that practitioners faced increasing competition from an expanding range of free dispensary services.¹⁴⁸

The problem of finding a locum during leaves of absence was both perennial and universal for PMOs in Scotland. Leaving patients in the hands of a suitable replacement was difficult for all medical practitioners. In the absence of central guidelines most of Scotland's parishes settled on an arrangement whereby the PMOs themselves were responsible for finding and funding qualified cover during absences, although the parish they worked for continued to reserve their right to ratify nominees.¹⁴⁹ Scottish PMOs generally found few willing to take on a task that involved much public responsibility but with little recompense and little chance of immediate personal gain.

Though in some senses the division of medical work into demarcated districts of individual responsibility militated against collaboration, shared grievances such as the locum issue helped ensure that some spirit of camaraderie developed amongst the PMOs Glasgow and Edinburgh. One obvious expression of this was the SPLMOA, an organization heavily dominated by officers from Glasgow.¹⁵⁰ In June 1892 the PMOs of Glasgow City Parish demonstrated organisation by acting in unison to present a jointly signed petition to the MSC of the parish requesting that each be granted annual holiday pay to fund replacements. The petition stated that not only was temporary cover individually costly, but it was extremely difficult to arrange. Some PMOs – in

¹⁴⁸ John Veitch Wallace, Govan PMO, Parish Councillor and later PMO, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 60312f.

¹⁴⁹ Glasgow City Parish Medical Committee Minutes, GCA D-HEW 1/5/1 (3rd November 1851). After this time a list of delegated replacements was kept by the Committee and updated from time to time. For example, see GCA D-HEW 1/5/2 (1st October 1866). All new appointees in Glasgow were charged with finding a substitute and informing the committee about who it was in advance that: 'would be prepared to act for him when necessary'. See also GCA D-HEW 1/5/2 (31st May 1869).

¹⁵⁰ For example, the main spokesman for the Scottish Poor Law Medical Officers Association during the different inquiries of the 1900s was its secretary, William Limont Muir. At the turn of the century its chairman was Gilbert Campbell, PMO of Partick district of Govan from 1884 to 1915. Its treasurer was Matthew Martin, PMO of Barony then Glasgow Parish Council from 1890 to 1913. *The Lancet* (1900), vol. 1, p. 204.

more isolated, rural parishes - found that to secure cover they needed to offer more than they received themselves, with as much as a month's salary for each week not unusual as an inducement.¹⁵¹ Parochial work was, they stated, arduous, time-consuming, and reaped small dividend. Unless a locum had one eye to a future application for a PMO post, acting as a locum for a PMO was an unattractive proposition for any fellow practitioner. The locum accrued none of the strategic benefits connected to permanent post-holding.¹⁵²

In Glasgow PMOs tended to operate an arrangement where they agreed to cover each other during absences. Some nominated practice partners or juniors as their holiday or sickness cover, and some their sons where the practice had become a family business. In Govan parish, for example, the son of Gilbert Campbell, PMO of Partick district, 1884-1915, James Hamilton Campbell, regularly served as his father's locum after graduating - eventually succeeding him in the practice and as the PMO for Partick in 1916. The son of James Barras, Govan PMO for 50 years, 1863-1913, William George Barras, also covered for his father during periods of absence. For some without immediate medical heirs, partnerships provided a solution. Practice partnerships carried useful marketplace advantages, with pooled resources, shared labour and opportunity for shared expertise. Though not entirely common in the period, there is evidence from the Glasgow City Parochial Board's records regarding locum arrangements that a number of PMOs had a variety of formal or informal, loose or long-term partnership arrangements, often involving a junior and senior doctor. Thus in July 1888, when illness forced William Wilson to take a six week holiday, his assistant 'Dr. Kydd, who is duly qualified and registered Medical Practitioner, and who lives in the house with Dr. Wilson, and who has been assisting him for a little time' took over his parochial duties. Similarly, when in October 1888 James Smellie was off duty with 'severe illness', his locum was Dr. James Dunlop, of whom the committee noted: 'it was understood he had also assumed as a partner'.¹⁵³

¹⁵¹ *The Lancet* (1900), vol. 2, p. 636: this edition carried a by-line reporting on an Irish PMO that had failed to secure holiday locum cover for his post despite offering £6 per week to anyone who would take on the task.

¹⁵² Glasgow City Parish Medical Committee Minutes, GCA D-HEW 1/5/4 (23rd June 1892).

¹⁵³ Glasgow City Parish Medical Committee Minutes, GCA D-HEW 1/5/4 (19th July and 18th October 1888).

2.6 Medical cases, medical treatment, and Applications for Relief

The limitation of voluntary charity to meet all the needs of the poor was widely, if sometimes grudgingly, acknowledged.¹⁵⁴ Whilst parts three and four of this thesis detail how philanthropic and charitable medical relief organisations proliferated in Scotland, particularly after the 1870s, parochial medicine treatment remained central to Scottish services for large numbers of the poor. By 1905 there were regularly in excess of 40,000 new applications for parochial relief yearly to the four parish councils of Glasgow, Govan, Edinburgh and Leith collectively. All these applicants - and sometimes, additional family members - were routinely examined by a PMO during the process of application. In different parishes, parochial boards differed in their views as to whether their PMOs should begin treatment at the initial examination consultation, before the case had been formally decided and relief officially granted. Giving evidence to the Royal Commission in 1907, Inspector of Poor, John Mitchell, was asked by Commissioner Dr. Downes, of practices in Govan: 'Is the first application to the doctor rather the purpose for examination... and not for the purpose of treatment?' To this Mitchell replied: 'If need be. First of all we have got to satisfy ourselves that the person is not able-bodied; and if the doctor finds that he is not able-bodied *he puts him on treatment at once*' [my emphasis].¹⁵⁵ Robert C. Buist, Dundee PMO, stated that in his experience Scottish PMOs were in the habit of providing medical advice to other members of an applicant's family during the medical certification and examination process. The extent to which examinations would have shaded into advice and then into treatment would have varied from case to case, and practitioner to practitioner.¹⁵⁶

Medical work began with examination, of which the 1905 Large Towns Report was critical. The facilities in council offices were generally held to be insufficient for purpose. The commissioners noted that the rooms used at Edinburgh and in Govan

¹⁵⁴ Nicol, *Vital Social and Economic Statistics*, p.23. Dr James Macaulay, re-quoted from the publication *Leisure Hour* in *The Scotsman* (23rd May, 1893), p.8, noted that: 'Even Thomas Carlyle said that the attempt to carry out the voluntary system [alone] was only 'a hope against hope''. See also Poor Law Medical Relief (Scotland) Report 1904 (2008), Vol. II, Evidence of John McC. Johnston; and Dr. James Erskine, member of Glasgow Parish Council, RC Poor Laws and Relief of Distress (Cd.4978), Appendix LII.

¹⁵⁵ John Mitchell, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 59435-59439

¹⁵⁶ Robert C. Buist, Dundee PMO, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 65108.

had neither a washbasin nor a couch in 1905; and that at Leith the room had a washbasin but no couch. Glasgow's room was said to be 'well equipped'. More pertinently, the purpose, method and findings of medical examinations were strongly condemned. The report claimed that over-worked, the PMOs tended to make cursory examinations of little real diagnostic value. The 'nature of an applicant's sickness or infirmity,' was, in many cases, found diagnostically erroneous (or, at least, contrary to later findings). Many diagnoses were overturned by subsequent examination in the regulated environment of the poorhouse hospital shortly after a pauper was admitted.¹⁵⁷ The Report listed a whole series of such cases of misdiagnoses, such as: a woman of 28 admitted to the poorhouse certified as suffering from rheumatism but subsequently found to be suffering from cardiac disease; and a man admitted with a black eye and then found to have an ulcer on his leg. The commissioners noted numerous cases admitted as suffering from phthisis but then diagnosed with unrelated conditions, like piles or alcoholism. The 1905 Report concluded: 'the preliminary examinations are frequently of little value':

The medical examination is not exhaustive, and this could hardly be expected looking to the number of cases that have to be seen... I should say that the examining medical officer was guided chiefly by the general impression made upon him by the applicant's appearance and bearing...¹⁵⁸

The fundamental problem, as the commissioners tacitly acknowledged in their recommendations for change, was that examinations under the poor law concentrated on the process of determining ability to work rather than the overall health of the applicant.¹⁵⁹ Criticisms regarding the diagnostic inaccuracy of the initial examinations thus misrepresented both the purpose under law of the medical certification process and the way in which the initial 'medical' examination of applicants had come to be used as a safety valve allowing a level of localised, contextualised flexibility in the interpretation and application of poor law in Scotland. The PMO in assessing each applicant was operating as the poor law system's facilitator, its gatekeeper. Key amongst the list of questions that the PMO was asked to provide responses to on each certificate he was asked to issue was the second question: 'Is the Pauper able to

¹⁵⁷ LGBS Large Towns Report, 1905 (Glasgow: PP Cd. 2524, 1905), p. xii: in comparing examination approaches the commissioners noted of the poorhouse examination that it was 'usually made when the pauper is in bed and after he has been bathed and cleaned, and probably also observed for some time by the poor house officials.'

¹⁵⁸ LGBS Large Towns Report, 1905 (Cd. 2524), p. x and p. xii.

¹⁵⁹ LGBS Large Towns Report, 1905 (Cd. 2524): Recommendations, pp. xiii-xvii and pp. xxix-xxxi.

do any work?’ rather than the first: ‘Is the Pauper in good health?’¹⁶⁰ Whether a cursory glance at an applicant was enough for a medical examiner to judge whether the person before him was really fit to work might well be questioned, but what the PMO was actually being asked to consider when he issued a certificate was, in reality, is this person before me a suitable candidate for parochial relief? This, of course, is a social as much as a medical assessment.¹⁶¹

The problematic distinction between medical relief and poor relief was further blurred because most successful pauper applicants in Scotland ultimately received some form of medical relief, whether or not ill health was the main cause of their initial application.¹⁶² Although not all applications were successful there were still 25,000 to 35,000 registered paupers in Glasgow, Govan, Edinburgh and Leith each year. Every person admitted onto the pauper roll was automatically entitled to access services of an outdoor PMO as required - a facility that many used. Robert Peel Lamond, legal adviser to Glasgow Parish Council, recorded 22,000-23,000 relief applications to Glasgow per year by 1907; William J. Richard, Medical Officer for Govan Poorhouse, noted that in the year 1905-6, in Govan, 8,174 applications for poor relief were made, of which 6,246 (76.4%) were granted medical relief.¹⁶³ Application for relief to Edinburgh Parish Council between 1896 and 1912 varied between 6,969 applications in 1911, and a top-end of 8,695 applications in 1904; and St Cuthberts Combination Parish alone also had over 4,000 applications a year by the early 1880s. In 1894 and 1904, in Edinburgh, there were 5,580 and 6,634 registered paupers; in Leith, 1,490 and 1,952 respectively; in Glasgow, 10,056 and 14,041 respectively; and in Govan, in 1904, there were 8,072 ordinary paupers registered.¹⁶⁴ In 1886, Glasgow practitioner James Erskine stated that a total of 14,403 individuals were provided medical treatment outdoors by the three Glasgow parochial boards during 1885, and

¹⁶⁰ For copy of standard medical certificate as issued in Govan in 1886 see Appendix VII.

¹⁶¹ Anne Digby, *The evolution of British general practice 1850-1948* (Oxford: Oxford University Press, 1999), p. 319.

¹⁶² John Mitchell, Govan Inspector of Poor, and James R. Motion, Glasgow Inspector of Poor, RC Poor Law and Relief of Distress (Cd.4978), Evidence 59457-9 and 58087/105. Richard Rodger The Labour Force, p.164, refers to: ‘the Victorian umbilical cord connecting poverty to personality’. William Cochran, Chairman of Glasgow Parish Council, RC Poor Law and Relief of Distress (Cd.4978), Evidence 58814/8: ‘As to the causes of pauperism...drink is at the bottom of it, and that it accounts for 90% of it...’

¹⁶³ Robert Peel Lamond and William J. Richard, RC Poor Laws and Relief of Distress (Cd.4978), Appendix LXXXI and Appendix CXVI.

¹⁶⁴ ‘Glasgow, Barony and Govan Parish Abstracts of Accounts 1877-1925’, GCA D-HEW 6/1. This contains Edinburgh and Leith data too.

that 9,476 applicants (65.8%) were visited at their own homes.¹⁶⁵ In 1909, a sample carried out in conjunction with the Royal Commission suggested as many as 2,793 (or 58%) out of the registered poor of Edinburgh as at May 1906 were not only sick and being treated at home by PMOs, but also were receiving additional medical help at one of Edinburgh's public medical charities.¹⁶⁶

PMOs submitted six-monthly medical returns, which were collated by Inspectors of Poor for submission to the LGBS as part of the claim on the Medical Relief Grant. In Glasgow alone, for the two years to 15th October 1906, an annual average of 23,650 applications for poor relief passing through medical hands each of these years. Of these, while it was claimed that only 49% of the applications were directly attributable to ill-health, fully 95% received some form of medical treatment by one of Glasgow's 21 PMOs: and in these years, 14,753 and 13,623 applicants were treated at their homes.¹⁶⁷ Many of these were visited on several occasions during treatment, and at different times of the year on reapplication. In addition to official numbers, one investigation held in Glasgow revealed that by the mid-1870s many who were technically not paupers were also routinely being granted some form of medical relief.

The PMO employed under the poor law needed to be a true general practitioner. As one remarked of poor law cases: 'such medical attention may be of any sort, is given at any hour of the day or night, either at the house of the poor person or at the medical officer's own home...'¹⁶⁸ The kind of cases a PMO might be called upon to treat was often contingent on available supplementary medical services and charitable alternatives: not many parishes in Scotland had the range of specialist medical services enjoyed by Glasgow or Edinburgh. The delivery of babies, the setting of fractures, the performance of a host of minor surgical operations (sometimes under anaesthetic) and the treatment of fever victims were commonplace services performed by PMOs throughout Scotland, though (with the exception of midwifery duties) these were featuring less in the work in the larger Scottish cities in

¹⁶⁵ James Erskine, 'The abuse of our medical charities,' in GMJ (1886), pp. 334-352

¹⁶⁶ A. C. Kay and H. V. Toynbee, Report to the *Royal Commission on the Poor Laws and Relief of Distress on Endowed and Voluntary Charities in certain places, and the Administrative Relations of Charity and the Poor Law*, 1909 (P.P. Cd.4593) Appendix, Vol. XV, p. 243.

¹⁶⁷ Medical Relief Returns to the Local Government Board published in Glasgow Parish Council Statistical Reports by the Inspector of Poor, GCA T-PAR 1/5.

¹⁶⁸ Dr W. L. Martin, RC Poor Laws and Relief of Distress (Cd.4978), Appendix CIII.

the period.¹⁶⁹ However, much pauper sickness in Scotland was poverty related and tied, particularly, to chronic and degenerative conditions. It was explained that: ‘the great majority of cases on the roll are permanent cases. It is easier to become a pauper than to cease to be one’.¹⁷⁰ In 1904 the Glasgow poorhouse medical officer, John McCubbin Johnston, confirmed that poor law medicine in the large urban parishes of Scotland did indeed largely consist of many chronic complaints, such as: ‘advanced or recurring cancers, chronic ulcers, multiple tubercular bones and joints, chronic bronchitics, permanent paralytics, and the crowds...who suffer from phthisis.’ Accounting for the morbidity of the poor is extremely difficult for the nineteenth century, because systematic local records are lacking. Scottish poor law records, whilst problematic, provide some clues.¹⁷¹ In 1902 Glasgow’s Inspector of Poor, Andrew Motion, conducted a full analysis of one year of first-time applications for relief in Glasgow. He listed 5,656 first-time applicant medical cases, including several infectious diseases that were first diagnosed and treated by poor law doctors before being passed to the sanitary services. Motion demonstrated a broad spread of cases: respiratory problems, including bronchitis, phthisis and influenza (29%); digestive system problems, including many diarrhoea issues (10.6%); skin diseases, such as scabies, eczema, and boils (7.2%); nervous system complaints (6.3%); cardiac cases (4%), urinary complaints (2.5%); and amongst the remainder, rheumatism, insanity cases, venereal diseases, midwifery and gynaecological cases, and hundreds of cases of general debility and ‘senile decay’.¹⁷² A sample of 957 Applications for Relief by first time applicants in Glasgow and Govan between 1876 and 1898 shows continuity with findings for 1902, that the most common pauper complaints dealt with by PMOs over the period included bronchial cases; rheumatic cases; tuberculosis; insanity; venereal cases; limb injuries; ulcers and skin

¹⁶⁹ In cases requiring a second person to administer anaesthetic, typically, a PMO called upon a fellow PMO as a colleague to assist. Although the colleague effectively went unpaid, this was a kind of *quid pro quo* arrangement that echoed that in place for locum arrangements.

¹⁷⁰ Thomas Jones’ Interim Report, p. 261.

¹⁷¹ The lack of systematic record at local level was realised contemporarily. Thus in September 1891, Glasgow PMO, William McKnight Wilson, suggested that the MSC start keeping duplicate copies of prescriptions ‘for future guidance’. Whether or not this advice was followed neither the originals nor these duplicates survive in the archives. See City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (17th September 1891).

¹⁷² James R. Motion, *Analysis of applications for Relief made for the first time, for Year ending 15th May 1902*, handed in to the Poor Law Medical Relief (Scotland) 1904 (Cd. 2022), vol. 2, appendix VII.

complaints; catarrh; child illnesses; and maternity and gynaecological complaints.¹⁷³ Pneumonia was another common malady.¹⁷⁴

Scottish poor law records for individual relief applications are often fuller and better preserved than their English counterparts, and for the parishes of Glasgow and Govan are very well preserved for this period. Accurate record keeping was one of the main responsibilities of the Inspector of the Poor of a Scottish parish. Scots parishes also early adopted the casebook method of record keeping, as advocated by Thomas Chalmers, and the fortunes of individual applicants are far easier to trace than in England. The paperwork of applications formed the administrative 'backbone' of the system.¹⁷⁵

In Scotland particular emphasis was put on the value of the case record. Social, medical and economic assessment always vied with moral judgement in determining provision of poor relief in Scotland.¹⁷⁶ From an administrative point of view the application process had three linked but separate aspects: determination of the circumstances of the applicant (which included determination of disability); his habits; and the issue of settlement responsibility. The richness and detail of surviving Scottish poor relief applications is a direct reflection of these separate processes of inquiry. Settlement issues required detailed paperwork, since all parishes needed to know where financial obligations lay for support of a given applicant, and this, in turn, depended on a complex and shifting set of regulations concerning birthplace, maturity, marriage and former residences. This plus the migratory nature of persons moving between parishes coupled with the parochial nature of the Scottish poor law guaranteed the survival of documents throughout the lifetime of the system.¹⁷⁷

England may have had similar problems, but being divided into larger poor law

¹⁷³ Sutton, *Grateful For Small Mercies*, pp. 102-3. It is the nature of Application For Relief records that it is far easier to determine cause of illness amongst first-time applicants than amongst repeat applicants: this is because each first-time application carries most detail.

¹⁷⁴ Thomas Barr, M.D., 'Notes on Pneumonia: based on sixty-four cases of the disease observed in private practice,' in *GMJ*, v. 7 (1875), p. 347: Barr notes that in the year to March 1875 one in twenty patients who came before him had pneumonia.

¹⁷⁵ Poor Law (Scotland) Act, 1845, section 55, details the responsibilities of the Inspector. Applications for Relief for Glasgow as part of the GCA series ref: 15/; for Govan (1876-1930), series ref: 17/; for Glasgow (1851-1948), series ref: 10/.

¹⁷⁶ *Royal Commission on the Poor Laws and Relief of Distress Report for Scotland, 1909* (Cd. 4922), part III, chapter 9, 219: 'Generally speaking, the purpose of the visit [by an assistant inspector] does not extend beyond an investigation of the economic condition of the poor person.'

¹⁷⁷ Peter Beattie, *Barony Parish Parochial Law* (Glasgow: 1881), vol. 1, p. 5.

unions, was less affected by financial issues caused by migration between neighbouring parishes.

Determining where financial responsibility lay meant that much time was taken up in recording who applicants were and where they had formally resided: testimony was cross-checked with an array of witnesses. These records of residence sometimes necessarily ran for many years. Thus surviving parochial records are an important (if underused) testament to the migratory tendencies of the poor of urban-industrial Britain. Parochial records show how many urban settlers across the nineteenth century were constantly moving home (even if often only within the perimeter of particular neighbourhood or network of familiar streets). Necessity to flit as money ran out for rent plus the ready availability to the poor of a series of different grade of rooms to rent on a weekly or even daily basis with few questions asked, added to the migratory tendency. People quickly relocated as fortunes changed. Such frequent relocation can be taken as evidence of the survivalist strategies of the poor in action. Home – and attachment to it – would therefore have meant entirely different things to a person under these circumstances, and this naturally would have affected attitudes to strangers calling, or practitioners visiting at the door.

From the point of view of a medical historian interested in domiciliary care issues parochial ‘Applications for Relief’ are a mixed bag. They provide substantial, quantifiable details about applicants, their domestic circumstances, and their families (i.e. the poor patients). Many records also identify the individual medical practitioners called to attend each case. The application pro-forma also routinely records the illness or disability certified by the PMOs. Unfortunately, however, the applications provide almost no detail about the actual treatments conducted in the home. The very absence of detail in the parochial records reflected the free hand practitioners were given.

Any evidence for the type of medical treatment provided by PMOs in given situations is found only rarely in parish records and is often incidental and vague. For example, for one applicant to City chambers, in 1898, it is recorded only that they *‘called and got 2’’ worth of plaster and refused to given any information’*: for another *‘bottle got’*

is all that is recorded in the ledger.¹⁷⁸ Even this level of detail is uncommon. In a rare example, Govan PMO, Robert Davie Taylor, records on the medical certificate he issued in 1887 for applicant John McGraw that he had examined the applicant in his home using what he referred to as ‘water-casting techniques’. It reads: ‘*Says he has Brights [illeg.] of Kidney – found his urine normal on examination. Test him in hospital*’. Few applications in the archives are as forthcoming.¹⁷⁹

The generic or stock bottle of medicine remained a standard weapon in the medical officer’s arsenal throughout the period, partly because of its symbolic importance. It came to represent a totemic link between the pauper, the practitioner and the parish. In the practitioner’s absence the bottle he left behind served as a visible reminder of official concern. In an age that was largely characterized by therapeutic impotence for many diseases and conditions, and given the attendant stresses of poverty, the value of the presence of a doctor at the bedside of a sick pauper should not be under-estimated. The attentions of a competent and considerate practitioner would have been important to the poor.¹⁸⁰ The relationship between practitioner and patient was all-important. Success could depend upon the trust engendered, and the ability of the practitioner concerned to manage the expectations of a patient, family and friends, as much as upon successful diagnosis and the ability to relieve suffering. Misunderstanding of the use of stock medicines by medical practitioners in an age before effective curative treatments has fed into long-standing criticisms of the parochial system. By the 1900s a new generation of medical graduates thought of the mixing of stock medicines as a component of old ways of doctoring. The new generation were raised into a fast-changing social and medical environment where trained and registered dispensers of pharmacy had absolved regular medical practitioners of much of this responsibility and need for this kind of knowledge. Patented proprietary medicines were much more widespread by the 1900s. By then, the tabloid had come into vogue. This too reduced the need for practical pharmacy skills once a critical part of medical training. These traditional skills were quickly undervalued in the rush to find space on the medical

¹⁷⁸ Glasgow City Parish Applications For Relief, 1898, GCA D-HEW 10/196, app. No. 10, and D-HEW 10/197, app no. 100.

¹⁷⁹ Govan Parish Applications For Relief, 1887, GCA D-HEW 17/304, app no. 85401.

¹⁸⁰ On this notion see Georges Canguilhem, translated by Arthur Goldhammer, *Ideology and Rationality in the History of the Life Sciences* (Cambridge, Massachusetts and London: MIT Press, 1988), p. 53.

curriculum for science and new specialties.¹⁸¹ 1875 saw important change in Britain in terms of the licensing of the vending of proprietary medicines, augmenting considerable change in the medical marketplace.¹⁸²

PMOs in Glasgow and Edinburgh were said to have acted in their parochial work in the same way as in general practice. One guidebook used in Glasgow and published in 1907 makes the important point that: ‘the work undertaken by a doctor in general practice is not decided by what he is capable of doing but what he is willing to undertake’.¹⁸³ The idea that it was *willingness* rather than capacity that defined the limits of treatment in different circumstances, feeds back into explanations of frustrations with, and changes to, domiciliary medical services that were beginning to be aired and take effect from around the turn of the twentieth century. The venting of frustrations by Glasgow PMOs, particularly when asked directly by the MSC members of the parish to reflect upon their work and experience amidst the Glasgow poor in the 1890s, became a factor, for example, in both the development of outdoor domiciliary nursing arrangements and the subsequent decision of the local parochial authorities in Glasgow to loosen their dependence on an outdoor medical relief system. Thus notions that the homes of the Scottish urban poor were substandard - and therefore ill-equipped to cope with modern medical treatments and techniques - is a key findings of the Royal Commission on the Housing of the Industrial Population of Scotland Report (1917); their descriptions of Glasgow housing echoed sentiments already being expressed by practitioners in Scotland, sometimes decades earlier.

Domiciliary nursing support for PMOs was available. Nursing had developed unevenly between the institutional and the domiciliary wings of the poor law in Scotland, particularly after 1885 when the Medical Relief Grant was used to promote trained nursing staff but only for poorhouses. Some PMOs had however, from as early as the mid-1870s, flagged the desirability of parallel outdoor trained nursing

¹⁸¹ *The Scotsman* (7 May, 1904), p. 9: ‘If the Parish Councils [supply drug depots], then I fear the supply will be scanty indeed... Unless cases of Burroughs, Wellcome, & Co.’s tabloids, and these are expensive, are provided at their depots, the *old system* of bottles, corks, labels, measures, and innumerable stock bottles will be an unmitigated nuisance to the medical officer.’ On the decline of pharmaceutical skills amongst medical practitioners see *The Scotsman* (22nd April 1882).

¹⁸² S. W. F. Holloway, *Royal Pharmaceutical Society of Great Britain 1841-1991: A Political and Social History* (London: The Pharmaceutical Press, 1991), p. 245.

¹⁸³ Edred M. Corner and H. Irvine Pinches, *The Operations of General Practice* (London, Oxford University Press, 1907), p.3 and p. 271.

assistance. Ad hoc ventures were tried though attitudes were mixed.¹⁸⁴ The desirability of district nursing assistance for chronic outdoor cases was a theme taken up again by City PMO William Findlay when questioned by the MSC of the parochial board in March 1892. When asked to reflect upon the work of his district Findlay took the occasion to state that: ‘cases...occurred sometimes where it was difficult to treat a patient properly, as they were evidently in a dying condition and their surroundings unsatisfactory.’ He therefore suggested that perhaps: ‘a nurse might be provided in certain cases.’¹⁸⁵

Several district visiting nursing organisations operating out-with the poor law were active in Glasgow around the turn of the twentieth century: such organisations were echoed in other Scottish cities. In January 1896 the secretaries of both the *St. Elizabeth's Home for District and Private Nursing* and the *Glasgow and Sick Poor Private Association* contacted the City parochial board to remind them of the charitable nature of the work they were each doing in the parish. Both requested of the board they therefore provide ‘some pecuniary recognition’ of their respective nursing support work. Indeed, the second-named association claimed they were already receiving subscription-support from Barony and Govan parishes.¹⁸⁶

In considering its response to these requests for financial support City MSC decided to consult with its serving PMOs, declaring its findings in March 1896.¹⁸⁷ All eight practitioners offered extensive responses, but each also widened the agenda into a more far-reaching comparison of the respective medical value of domiciliary medical treatment versus that of alternative supervised hospital treatment.

It can be hypothesised that the origins of the policy shift that saw substantial investment in municipal hospital provision in Glasgow after the turn of the century can be found in the attitudes of the parochial board’s MSC and its PMOs, attitudes expressed when pondering the question of the extension of outdoor nursing provision in 1896. A clear shift towards the primacy of the hospital as the ideal locus of future

¹⁸⁴ For example, *Poor Law Magazine*, Vol.VI (Edinburgh: 1878), pp. 73-6.

¹⁸⁵ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (17th March 1892).

¹⁸⁶ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (23rd January 1896).

¹⁸⁷ City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (19th March 1896).

public treatment can be detected. The concluding paragraphs of the MSC report on nursing provision read:

On the whole, the Sub-Committee deduce from the testimony of the Out-door Medical Staff that, as contrasted with the treatment of the sick in the Poorhouse Hospital, treatment in the homes of the sick poor outside is not satisfactory.

Looking to the want of accommodation in the houses of the poor who seek relief from the Parish, want of ventilation and cleanliness, absence of proper clothing or food, the risk of stimulants ordered by the Doctors being abused, and general surroundings, the Committee are of the opinion that in lieu of Grants being made to private associations outside, the fullest advantage should be taken of the Poorhouse Hospital, which is now fully equipped with Trained Nurses and every appliance which Medical skill can suggest.¹⁸⁸

In a number of their responses to the MSC, the PMOs described the unsatisfactory nature of the 'straitened accommodation and most insanitary surroundings' of the poor. Living conditions were undermining the effectiveness of their medical skills.

PMO Andrew Mitchell's testimony encapsulated the issue:

In the homes of our sick poor...surgical cleanliness – the importance of which cannot be over-estimated – is not only seldom seen but rarely understood; personal cleanliness is equally rarely seen; indeed, many of our poor are so unclean that cutaneous symptoms of zymotic diseases are quite invisible beneath the superficial covering which no soap dare disturb, and thus the bodies, as well as the homes, of our sick poor become veritable hot-beds for the development of pathogenic micro-organisms. Again, the insanitary condition of the homes of our sick poor is a powerful ally of the consuming diseases...and an equally potent antagonist of the curative influences which are brought to their aid....moreover, the individual peculiarities of the 'tableaux vivants' themselves are quite beyond the control of district nurses and physicians whose diurnal visitations reveal the fact that the patients have been indulging between visits in treatment unquestionably agreeable to themselves, but undoubtedly opposed to that which has been prescribed for them by the attendant physician.¹⁸⁹

Any shift away from the predominance of parochial treatment in the home was not to come immediately. As the sub-committee report of 1896 realised, without compulsion the poor could not be made to enter hospital facilities, and the ongoing preference of

¹⁸⁸ Conclusion of Medical Committee Sub-Committee Report into District Nursing, City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (19th March 1896).

¹⁸⁹ A.R. Mitchell, Medical Committee Sub-Committee Report into District Nursing, City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (19th March 1896). William Cullen also made reference to the especial difficulty of treating women within a domiciliary environment: 'these patients...to fulfil their self-elected task of retaining their humble homes have to be on their feet most of the time for the purpose of cooking and attending to the wants of themselves, and frequently others'.

the pauper at this time remained for ‘treatment outside and a money allowance’.¹⁹⁰

Despite misgivings, therefore, as to the good it might ultimately accomplish, Glasgow parish councillors elected to subscribe to both nursing associations.¹⁹¹

Table 2.7: Cases visited by nurses of the St Elizabeth’s Home, Glasgow, in 1897

complaint	Cases	
	no.	(%) of total
consumption	118	7.4%
pneumonia	99	6.2%
bronchitis	115	7.2%
influenza	74	4.6%
obstetric	85	5.3%
monthly nursing	31	1.9%
heart disease/dropsy	57	3.6%
skin and bone disease	98	6.2%
cancer	32	2.0%
abscesses/ulcers	163	10.2%
accidents	94	5.9%
burns	82	5.1%
rheumatism	82	5.1%
paralysis	44	2.8%
peritonitis	34	2.1%
pleurisy	56	3.5%
British cholera	29	1.8%
miscellaneous	300	18.8%
total	1,593	

Source: St Elizabeth’s Home, for District and Private Nursing Annual Report (Glasgow: 1897)

One of the two nursing associations - trained ‘to see the orders of the doctors [were] carefully carried out’ - utilised by the poor law services in Glasgow was St Elizabeth’s Home for District and Private Nursing. Under the patronage of the Bute family, this was a Catholic organisation, found in 1893. It was part of an inter-connected web of Catholic welfare organisations, and purposely rivalled the Glasgow Sick Poor and Private Nursing Association found in 1875 by Mrs Higginbotham. It worked not only with the poor law but also with other private charities as well as all the prominent Catholic institutions of the city. The records of the home give a good (if indirect) indication of the type of medical domiciliary medical case that was typically the focus of the work of both the poor law and private charities. In one year taken at random, 1897, St Elizabeth’s had eight nursing staff. They made 21,956 visits (53

¹⁹⁰ Medical Committee Sub-Committee Report into District Nursing, City Parochial Board Medical Committee Reports, GCA D-HEW 1/5/4 (19th March 1896).

¹⁹¹ George Dott, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 58782-58789.

visits per nurse per week), serving over 18,226 hours on duty (approximately 44 hours per nurse per week). They dealt with 1,593 cases (averaging therefore 13 to 14 visits per case). These were made up of types of complaint shown in Table 2.7.

One way in which application records can prove useful reflects their original purpose. Occasional ephemera appended to ledgers means that some applications can be used to throw a light on more obscure or disputed aspects of poor law medical service.¹⁹² For example, it is clear from documents appended to some ledgers that PMOs did not operate in isolation from other public authority services and, in fact, often worked in unison with them. When, for example, in September 1886 the estranged wife of a Hugh Barrie made application to Govan Combination Parish to secure his immediate removal to the poorhouse, concern over her account to the inspector of the condition of Barrie's home resulted in an emergency visit by the PMO accompanied by several other public officials. That the PMO James Barras did not attend alone is obvious only from the hastily scribbled note that he sent to Govan's Inspector of Poor. The note demonstrates the parlous conditions that could face officials on home visits, plus the poor law officials' lack of legal authority to force any persons who were not directly certifiable as being either insane or suffering from a recognised and notifiable disease – no matter how wretched their circumstances out of home and into a poorhouse for treatment.¹⁹³ Faced with someone that simply refused to enter the poorhouse, PMOs often had little choice, but to continue to offer treatment outside.¹⁹⁴

¹⁹² Survival rates vary, and in Glasgow each parochial board had its own procedures, but in some cases the original application form survives supplemented by an array of additional documents, including: clipped newspaper reports of articles relating to identified applicants; police reports (particularly where an applicant had been either sent to or from the police offices); hand written notes serving as letters of reference and referral from a host of different agencies that would have been carried by applicants into the parochial offices at the moment of application, including from neighbours, other family members, missionary organisation representatives, churches, and from superintendents of one of Glasgow's many model-home accommodations; correspondence between different parish administrations regarding particular applicants; testimonials relating to settlement, work and character issues from neighbours or employers or local worthies; ad hoc casual observations deemed pertinent enough by different attending PMOs to warrant separate correspondence to the inspector regarding particular cases (most often in the form of scribbled notes on issues prescription pads); provision requisition slips; referrals and communications from voluntary institutions and the sanitary local health authorities (most particularly regarding infectious disease or vaccination cases); lunacy certificates; settlement claim documents raised on other parishes; and occasional correspondence on headed notepaper or doctor prescription pads which also take the form of quasi-referrals to the parish and filled by private practitioners who claim to have previously attended the said applicant.

¹⁹³ Notifiable Infectious Diseases in Scotland, circa 1900, under public health and sanitary legislation included: smallpox, measles, diphtheria, scarlet fever, typhus, typhoid, enteric fever, bubonic plague and whooping cough. Tuberculosis and phthisis, at his time, were not notifiable.

¹⁹⁴ Govan Parish Application For Relief, GCA D-HEW 17/298, app. No. 83413.

2.7 Conclusion

It has been shown that parochial medical care was a central component of domiciliary medical services for designated sections of the poor of Glasgow and Edinburgh before 1911; and that the parochial medical officers (PMOs) were, in turn, central to the process of poor law provision. Appointed PMOs had a range of duties encompassing social, medical and nutritional aspects (Chapter 2.1). Despite the development of a central administration, poor law provision in Glasgow and Edinburgh was tied to local parish arrangements. As demonstrated, poor law medicine in Scotland was separately arranged, organised and funded than elsewhere in Britain. This meant Scotland was less affected than England by the anti-outdoor relief movement that swept Britain from the end of the 1860s (Chapter 2.2). Given the continuing importance of the parish in Scotland, local management was fundamental in determining the nature of outdoor relief. Medical sub-committees developed in Scotland's larger parishes to manage the system of domiciliary medical care. Made up of elected officials, different medical practitioners like Thomas Drysdale Buchanan and Thomas Lapraik who sought election came to play an important if, to now, unidentified role in shaping services (Chapter 2.3).

Historians have tended to dismiss the parochial medical officers (PMOs) who manned the poor law service across Britain, en masse, as a set of low-status, insecure, inefficient, backward-looking practitioners, hog-tied by an over-bearing, overly parsimonious, and cost- and deterrence-obsessed band of local inspectorates and parochial boards. The standard picture of the PMO is challenged (Chapter 2.4). A new picture of parochial work emerges (Chapters 2.5, 2.6). The accepted definition of a pauper under the poor law in Scotland meant that the medical practitioner appointed became a central figure in the practical exercise of the Scottish poor law (Chapter 2.1). The medical examination and certification process was pivotal in determining relief outcomes; and whilst criticised and held as evidence of the substandard nature of medical care by the LGBS Large Towns Report, 1905, certification was a process of facilitation, and therefore a social as much as a medical assessment (Chapter 2.6). Appointments were competitive, and study of appointment process shows that 'right' age – by which was normally meant a man into his thirties - solid experience, proven

medical ability, and above all, proof of having been long-established in general practice locally, were the key factors in successful appointment. Prosopographic study of Glasgow and Edinburgh medical practitioners employed as PMOs undermines the standard picture further (Chapter 2.4). A tradition of service to the poor can be identified, particularly amongst the Glasgow doctors studied. And whilst some undoubtedly did use parochial work as a stepping stone to career advancement, most served for many years; and whilst it might have been the case that some felt insecure in their work - without the much bemoaned security of tenure enjoyed by inspectors of poor - the evidence here suggests that the chances of being removed from their post on a whim were actually very remote. The PMOs were valued, and consulted by local parish representatives. Pay might not have been substantial – or be it that it was, with one exception, for part-time work – but it did rise (Chapter 2.5). The average salary of the Glasgow-based PMO increased roughly 54% between 1877 and 1905; this in a period when of falling prices nationally, and very little inflation (Figure 2.2). The one full-time post created came with a very competitive salary of £300-£400.

In her work on Glasgow, Blackden has questioned both the efficacy and the adequacy of outdoor parochial medical aid.¹⁹⁵ These are both relative terms, of course, and the reader is left unsure of the yardstick against which she wishes to measure the service. The term ‘efficiency’ directly echoes national concerns during the 1900s; and if efficiency means ‘much for little,’ then this was undoubtedly achieved by Scottish poor law medicine (Tables 2.3 and 2.4). The notion that before 1911, in Scotland’s largest towns at least, domiciliary poor law treatment was less adequate than treatment more generally available to the working majority of the community is one that was challenged widely by those engaged in the system. Those involved in both Glasgow and Edinburgh often stressed that parochial medicine was the equal or even better than that offered to the working classes and the general poor out-with the poor law. Thus when pushed for his opinion by poor law commissioners in 1907, in an arena where criticism was welcomed, George Donald, Leith PMO, claimed that: ‘So

¹⁹⁵ Stephanie Blackden, ‘The Poor Law and Health: A Survey of Parochial Medical Aid in Glasgow, 1845-1900’ in T. C. Smout, *The Search For Wealth and Stability* (Macmillan, 1979), p. 262: ‘On outdoor medical relief the parishes never succeeded in meeting demand, since surgeons working only part-time and for low pay could never provide an efficient service’. Stephanie Blackden, ‘The Board of Supervision and the Scottish Parochial Medical Service, 1845-95’ in *Medical History No.30* (Wellcome Institute, 1986), p. 17: ‘Glasgow’s... parochial domiciliary medical service did not give adequate care’.

far as the legal poor of Leith are concerned they want for nothing in the shape of medical assistance, and are very much better provided with medical requisites than thousands of others who are paying rates...'; Glasgow medical practitioner and parish councillor, James Erskine, claimed that: 'Since I became a member of Council I have made it a point to bring myself into touch with the medical officers in the districts of the city, and have found them all attending to the poor people with even more care and assiduity than their own private patients...'; and John Veitch Wallace, Govan PMO, that: 'Many of the paupers... are better off for medical attendance etc. than the working classes, who are liable to run up a doctor's bill'. William Limont Muir, Representative of the SPLMOA – and one of the biggest critics of standards of service –, three years earlier had also claimed that: '[We] believe that in the cities and large towns, medical relief now in force is adequate in all respects, and that you could not very well extend it without the danger of pauperising the working-class population.'¹⁹⁶

W. Leslie Mackenzie, the first full-time medical member of the LGBS, suggest that in judging the standard of poor law medical work that five criteria could be applied: contemporary medical understanding; the equipment and drugs provided by parish to PMOs; the nature of disease of applicants; the skill and dedication of PMOs; and the aims of poor law policy.¹⁹⁷ By these measures, only the aims of poor law policy might be said to have been wanting in the service looked at here. Glasgow and Edinburgh PMOs were capable men, with some dedicating long years to service. Others, like William Macewen, were amongst those at the cutting edge of medical understanding (with new surgical frontiers being established in Scotland). They were generally well resourced and said to want for nothing that was provided in general practice to the labouring classes, albeit within a service resistant to the use of new proprietary medicines. The poor law services in Scotland were limited merely by fact that most cases were chronic cases. This begs the question: what could have been done with chronic illness, so pervasive in Scottish homes, had the parish not provided this service?

¹⁹⁶ George Donald, RC Poor Laws and Relief of Distress (Cd.4978), Appendix XLIII: James Erskine, RC Poor Laws and Relief of Distress (Cd.4978), Appendix LII, para. 13:'; John Veitch Wallace, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 60312/11; William Limont Muir, Poor Law Medical Relief (Scotland) 1904 (Cd.2022), vol. 2, Evidence 992-1187.

¹⁹⁷ W. Leslie Mackenzie, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 56605/20.

CHAPTER 3

PRIVATE PROVISION – MEDICAL CHARITY

3.1 Medical charity and home visitation of the poor in Glasgow and Edinburgh – a prospectus

The agencies of voluntary effort for medically assisting the poor in Edinburgh are very numerous.

Edinburgh medical practitioner and PMO William Lewis Martin (1907)¹

There are various charitable institutions in the city of Glasgow. Indeed they are so numerous that one could not enumerate them without referring to the Glasgow Post Office Directory.

Hugh Barrie, Free Gardeners Friendly Society, Glasgow (1907)²

The extent of outdoor medical charity was widely commented upon. Most agreed that the range of agencies providing medical services to the poor in Scotland's two leading towns at the turn of the twentieth century were unrivalled by previous generations.

Hospital services had seen significant expansion by 1911, but it was non-hospitalising, outpatient, dispensary and domiciliary services that continued to lead the way. Outdoor services dominated in terms of volumes of patients treated in Glasgow and Edinburgh, and were the most accessible for the poor not catered for by the poor law. They saw substantial (and what in some quarters was understood as quite worrying levels of) growth: as too did treatment type, ambition and scope.

A number of factors account for a growth of outdoor charity medical services from the mid-1870s. Motive coincided with opportunity, and supply grew to meet growing demand. Firstly, dispensary and domiciliary-based services were comparatively low

¹ Evidence of W.L. Martin, (Royal Commission) Poor Law and Relief of Distress, Appendix Vol.VI.: Minutes of Evidence, 95th to 110th Days, and 139th and 149th Days, with Appendix [RC Poor Laws and Relief of Distress] (PP Cd.4978, 1910), Appendix CIII, para. 5. See also . C. Kay and H. V. Toynbee, Report to the Royal Commission on the Poor Laws and Relief of Distress on Endowed and Voluntary Charities in certain places, and the Administrative Relations of Charity and the Poor Law, 1909 (P.P. Cd.4593) Appendix, Vol. XV, Sections on Edinburgh.

² Hugh Barrie, RC Poor Laws and Relief of Distress (Cd.4978), Appendix XVII. The number of medical charities in Glasgow and Edinburgh was such that in 1909 the trustees of the estate of a Mr James Dick found 'no fewer than 160 institutions' to distribute his estate to: *The Scotsman* (12th February, 1909), p. 9. See also James Nicol, Vital Social and Economic Statistics of the City of Glasgow, 1881-1885 (Glasgow: 1885), p. 26.

cost start-up affairs. Although the average cost of charity-bed provision in Glasgow and Edinburgh was said to be significantly less than equivalent costs in London or other provincial locations, outdoor services in Scotland were still far cheaper in terms of fixed capital outlay than equivalent bed-based services. They were easier to organise. The support needed for a dispensary to be established was much less.³ In difficult economic or epidemiologic years, surges in numbers requiring treatment could also be more readily accommodated by dispensary charities than in wards.

Dispensaries and domiciliary services proved demonstrably adept and adaptable arenas for the implementation of a range of new forms of specialist treatment. For example, Edinburgh New Town Dispensary, the city's second oldest general dispensary offering home visitation services from 1815; from the 1850s offered dedicated midwifery and vaccination services; in 1872 instituted 'a special clinique for the treatment of diseases of the throat, wind pipe and ear'; from 1875 employed a medical officer with specialty interest in mental disease; from the 1880s employed separate specialists with interest in diseases of the eye, diseases of women, and children's diseases; and in 1895 opened a dedicated dental department (with teeth extracts listed under operations performed from the 1869).⁴ By the summer of 1890, the range of specialist postgraduate classes running at the different medical dispensary charities in Edinburgh included courses on: 'practical bacteriology'; 'ophthalmoscopic diseases'; 'chest and allied throat diseases'; diseases of children; ear and throat diseases; 'electricity, medical and surgical'; 'massage and medical gymnastics'; diseases of the nervous system; and 'refractive abnormalities'.⁵ In Glasgow, the Public Dispensary by the late 1880s also offered a range of special clinics, for diseases of the throat and chest, diseases of the skin and ear, kidney and urinary organ diseases, and diseases of women and children. Anderson's College Dispensary in 1888 had two skin disease physicians, one surgeon for diseases of the eye, one surgeon for diseases of the ear, two surgeons for diseases of the throat, and

³ *The Scotsman* (23 Dec, 1904), p. 7: enquiries in 1904 on the cost of London hospital medical provision found that, on average, the per-bed price of eleven London hospitals ranged from £115 10s at St Mary's, to £156 at St George's. In Glasgow, it was estimated that the average cost per bed at the Western Infirmary was just £70; and it was estimated that the average cost per bed at the Edinburgh Royal Infirmary was £64, 15s. The average expenditure per bed at Leeds General Infirmary was given as £79, 15s.

⁴ Per Edinburgh New Town Dispensary Annual Reports (various 1862-1918).

⁵ *The Scotsman* (6th August 1890), p. 9.

one physician for diseases of women and children; and Glasgow Central Dispensary, established after the closure of Anderson's in 1889, re-opened with a women's department, a children's department, an eye department, ear department, skin department, nose and throat department, and (from 1891) a urinary department.⁶ Often these services predated equivalent departments established at the main infirmaries.⁷

Dispensaries were also, commonly, more locally amenable to the poor. They were often the likely first port of call for many sick poor because on their doorstep. In most cases new charity dispensaries deliberately set down close at hand to the poor, an important factor in manufacturing demand. Overall, outdoor services proliferated where they met genuine need otherwise not catered for.

Growth in outdoor medical charity had both demand and supply-side impetus. Growing population fuelled demand. As the number of people in Glasgow and Edinburgh grew, numbers in poverty expanded. Contemporary references to the underclass of very poor in Scotland referred constantly to a 'submerged tenth' although industrial poverty was not, of course, a fixed proportional problem.⁸ The population of both Glasgow and Edinburgh in the decades from the 1870s in fact swelled at great rate. Census returns record near-equivalent population growth for Glasgow and Edinburgh of 62.9% and 58.8% respectively over the three decades before 1901, and by the 1900s the burgh population of Edinburgh had reached nearly 400,000 and that of Glasgow over 900,000 (Table 2.1). Expansion and overcrowding

⁶ James Christie, *The Medical Institutions of Glasgow* (Glasgow: James Maclehose & Sons, 1888), pp. 139-40 and Glasgow Central Dispensary records, Greater Glasgow Health Board Archives, ref: GGHB48.

⁷ For example, the Ear, Nose and Throat Department of Edinburgh Royal Infirmary was only established in 1883, eleven years after ENTND established such a service. On establishment of specialist departments within different infirmaries see, for example, A. Logan Turner, *Story of a great hospital : the Royal Infirmary of Edinburgh, 1729-1929* (Edinburgh: Mercat Press, 1979); John Patrick, *A short history of Glasgow Royal Infirmary* (Glasgow: Glasgow Royal Infirmary, 1940); Jacqueline Jenkinson, Michael Moss & Iain Russell, *The Royal: the history of the Glasgow Royal Infirmary, 1794-1994* (Glasgow: Bicentenary Committee on behalf of Glasgow Royal Infirmary, 1994); Loudon MacQueen and Archibald B. Kerr, *The Western Infirmary, 1874-1974* (Glasgow and London: John Horn, 1974); S.D. Slater and D.A. Dow, *The Victoria Infirmary of Glasgow 1890-1990* (Glasgow: Victoria Infirmary Centenary Committee, 1990).

⁸ The term 'submerged tenth' had wide currency. For example, *The Scotsman* (8 Dec, 1906), p. 8, and *Glasgow Herald* (8th December 1906), p. 9: 'Lord Overton... [said] it [the work of the Glasgow Medical Missionary Society] reached a class of people who, he fancied, belonged to the submerged tenth, and for the most part had no definite church connection.' 'That human residuum known as "the submerged"' referred to also in *Organised Help*, Vol. 30 (Glasgow: Charity Organisation Society, 15/2/1901).

in both places was especially marked in un-regenerated poorer districts, and in over-spill, suburban and outlying areas. The continued trend of immigrants pouring into both centres from the hinterlands, the Highlands, Ireland or elsewhere, plus the increasing incidence and intensity of periods of industrial economic difficulty, meant, periodically, a swelling in the ranks of the unemployed, underemployed, casual and chronic poor in both cities. Reduced earnings opportunities during periods of particular difficulty within different sectors of the economy reduced to the ranks of the poor some ordinarily, independently able to pay or make provision for their own medical care in better times. Contemporary evidence here - Chalmers, Kay et al, Table 3.2 - shows that not only did people migrate into Glasgow or Edinburgh, but came in also as patients, swelling further the demand for medical charity.

By the late nineteenth century town infirmaries in places like Glasgow and Edinburgh were less readily associated with the poor than with workingmen. Ward surgeons targeted industrial injuries, and, quid pro quo, those regularly in work found they were expected to make contribution towards the upkeep of services that they might benefit from via collection plate. New obligations or expectations that workers should routinely contribute in advance for what they might one day call upon created changed attitudes regarding entitlement. Sir John Struthers, manager of the Edinburgh Royal Public Dispensary, noted that the effect of change by 1898 was the creation of an informal demarcation between indoor and outdoor charity services, arguing: 'there were many who took advantage of the city hospital who were in a position to pay their doctors, and who ought to do so, but those treated by the Royal Dispensary were *really* poor and deserving people'.⁹ Changing patient rosters had direct consequences on funding, creating an identity crisis within the charity sector. Debating the abuse of charity and the prospective usurpation from it of the very poorest, one correspondent wrote to the *Glasgow Herald* in December 1906 that:

While on the whole there is no doubt that it is really necessitous cases which are reached and dealt with, it is also too true that there are a goodly proportion of cases who should never be there at all. The directors of these [medical charity] institutions know this perfectly, but they are afraid to put down their foot, because they fear that the subscriptions from the big yards would cease. The kind of working man who comes to these dispensaries looks on his

⁹ *The Scotsman* (31 Jan, 1898), p. 6.

subscription as a sort of insurance affair, and tries to get as much for his money as he can.¹⁰

A second correspondent, signing as ‘Slum Haunter,’ was even more categorical about the consequence for the poor:

The medical profession have a “real grievance,” but... the poor also have a grievance. A poor working man or woman has often to wait at those hospital dispensaries for two or three or even four or five hours, and then is seen and either not examined at all or examined in a perfunctory manner, because the doctor is tired and wants to get away. A stock mixture is prescribed, which may or may not hit the mark. The doctor is not to blame, because he has too many patients to see in the time, and those who could pay occupy the time that should be taken up only by those who cannot pay.¹¹

Glasgow and Edinburgh grew unevenly. Improvement projects in both places had not solved problems of poverty so much as move the problems around. This relocation shifted the demand for different charities in different districts of each city at different times. Areas like Havannah, Govan, Anderston and (later) St George’s in Glasgow, or the Cowgate and Canongate in Edinburgh, became synonymous with poverty in different decades, and thus magnets for charitable endeavour at those moments. For ambitious and enterprising professionals, graduating into an overcrowded profession, justification and opportunity aligned. Each new medical charity venture embarked upon typically began in like fashion, with a show of support and demonstration of the sheer extent of previous unmet demand, in that place, and for that service. Each identified what they declared to be virgin territories for their services.

Medical charity and medical education were closely bound. Charity workloads echoed both the climatic seasons and the rhythms of the academic year, being traditionally busiest when school was in, and over winter. Scotland was synonymous with recognition of the importance of providing arenas for the acquirement of practical outdoor experience of as part of the routine curriculum of medical education. In 1875, for example, whilst there were 21 different British courses of study providing a prospective route to qualification and legal registration as a medical practitioner in Britain, only the eight Scottish routes stipulated as mandatory requirement that each student before qualification needed to demonstrate and certify that they had

¹⁰ ‘Observer’ in *Glasgow Herald* (8th December, 1906).

¹¹ ‘Slum Haunter’ in *Glasgow Herald* (18th December, 1906), p. 10.

undertaken six months dispensary or outdoor practice.¹² Scottish medical charities consciously served a dual purpose.¹³ As a consequence, alongside the expansion in the number and range of medical charities at work in Glasgow and Edinburgh – detailed below, Tables 3.2, 3.3, 3.4 – there was growth in the total numbers of medical students at study in the two towns (Table 3.1). The relationship between students at study and provision of outdoor services was clear, if not simple. Strongly encouraged by teaching staff to build self-reliance through utilisation of the opportunity provided to study cases, the willingness to devote time to different medical charities was not a given amongst students where it could be avoided. Student commitment fluctuated, with shifting training options and examination requirement, with changing medical infrastructure, changing specialty interests, preferences and perceptions of best route to career advancement, and shifting (generational) attitudes towards ideas of philanthropy, evangelicalism, and charitable giving.¹⁴ With the proliferation of specialist strands of medicine, medical charity dispensaries found they were able to attract qualified practitioners back into study too, on postgraduate practical medical courses.¹⁵

¹² See EMJ, v. XX, 1 (1875), p. 349. Per *Medical Directory* (1875), pp. 873-9, Edinburgh University cited need for ‘at least six months, by apprenticeship or otherwise, the out-practice of an hospital, or the practice of a dispensary, physician, surgeon, or member of the London or Dublin Society of Apothecaries;’ and Glasgow University cited need for ‘out-door practice, during six months, at an hospital or dispensary’. *Medical Directory* (1900), p.1553: Royal College of Surgeons, Edinburgh, regulation 3, cited need, in addition to courses of lectures and examinations, for: ‘(a) Of having attended not less than six cases of labour under the superintendence of the practitioner who signs the certificate... (b) Of having attended, for three months, instruction in practical pharmacy... (c) Of having attended, for twenty-four months, the medical and surgical practice of a Public General Hospital... (d) Of having attended, for six months (or three months, with three months’ hospital clerkship), the practice of a public dispensary specially recognised by the College, or of having engaged for six months as visiting assistant to a registered practitioner. (e) Of having been instructed in vaccination during a period of not less than six weeks.’ By 1905, requirements for graduation from any Scottish University medical school stated that the final (fifth) year to include nine months engaged in ‘clinical study’ at a recognised hospital or dispensary, and for six months, ‘by apprenticeship, or otherwise,’ attendance at an out-practice of an hospital, or dispensary, or at a doctor’s surgery...’.

¹³ For example, directors of Anderson’s College Dispensary in Glasgow claimed at the first annual meeting in 1879 that the dispensary was both ‘adding to the equipment of the medical school, [and] productive of much benefit to the poorer classes of the community.’ See *The Scotsman* (23 June, 1879), p. 4, and (19 Apr, 1881), p. 4.

¹⁴ Annual meeting of the Edinburgh New Town Dispensary reported in *The Scotsman* (4 Mar, 1882), p. 9: ‘Dr Dunsmure, in moving a vote of thanks to the acting medical officers, said he understood that there were not so many pupils attending the Dispensary as the medical officers would like. It was thought that this was owing partly to the new system of teaching in the Infirmary; but students, he pointed out, had the advantage in the dispensary of having the cases under their own charge, thereby learning self-reliance.’

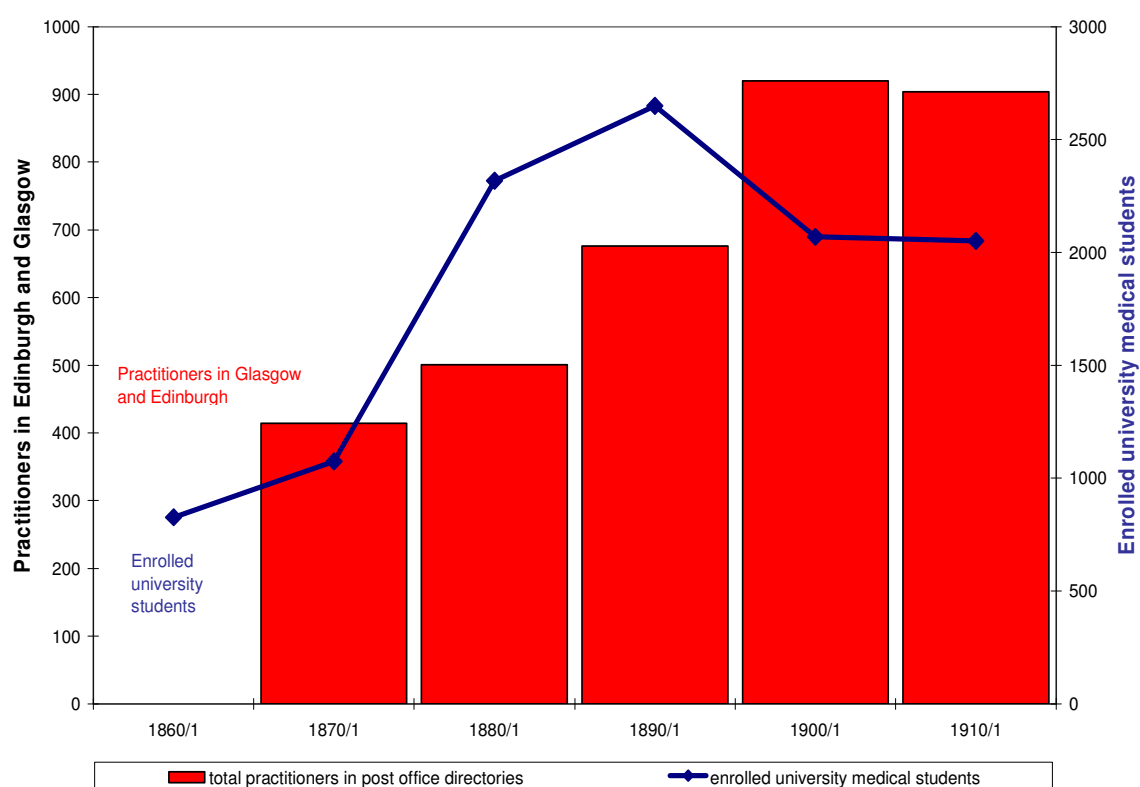
¹⁵ *The Scotsman* (6 Aug, 1890), p. 9, carried notice of a range of short, postgraduate practical medical classes running in Edinburgh before the start of the new academic year.

Table 3.1: University medical enrolments at Scottish universities, 1861-1911.

University Medical Enrolments						
	1861	1871	1881	1891	1901	1911
Aberdeen	160	216	336	472	326	283
Edinburgh	543	725	1669	1852	1396	1326
Glasgow	283	349	649	797	673	725
St Andrews					20	31
Scots total	986	1290	2654	3121	2415	2365

Source: Taken from R. D. Anderson, *Education and Opportunity in Victorian Scotland* (Oxford: Clarendon Press, 1983).

Figure 3.1: Number of medical practitioners in Glasgow and Edinburgh as a reflection of number of medical students enrolled, 1860/61-1910/11



Source: Enrolled students from R. D. Anderson, *Education and Opportunity in Victorian Scotland* (Oxford: Clarendon Press, 1983); number of practitioners as listed in Post Office Directories.

In terms of its broader appeal, Scottish medical education was at its zenith during the period of interest here. Recovering from a slump in reputation, medical enrolments in Scotland more than tripled in thirty years after the Medical Act of 1858, one unforeseen manifestation of the attempt to create an integrated and more centralised

system of medical education in Britain.¹⁶ The Student's Representative Council estimated that overall there were around 2,000 medical students in Edinburgh alone by the mid-1880s. Medical student numbers - represented in Figure 3.1 by the subset of number of enrolled university medical students, and thus excluding for the moment those additionally also at study at extramural schools - expanded rapidly from the 1870s and were, as Anderson has shown, to a peak by around 1890 in Glasgow and Edinburgh. The medical student population at this time were boosted by a number of factors, including: the general expansion of the middle classes; post-1858 Medical Act educational arrangements that ultimately proved supportive of Scottish institutions; the recognised popularity and relative inexpense of acquiring a Scottish medical education; and, latterly, by the acceptance of female students to the study of medicine. Of Scottish medical schools it was formally, if grudgingly, acknowledged from London that students came to 'recognise [both] the cheapness and excellence of their education': the cost of a medical education could be as much as half the equivalent cost in Glasgow or Edinburgh compared to London.¹⁷ With the growth in numbers of medical students there was a correlated rise in the numbers of qualified medical practitioners thereafter found to be settling to practice in the two places (Figure 3.1). The number of medical practitioners at work in and around Edinburgh and Glasgow, and as listed in the local town's directories, rose noticeably throughout the later decades of the nineteenth century on the heels of the student population. This growth in the numbers of students and practitioners expanded the pool of potential medical charity staff. It also created tension. As the decades passed, it fuelled resentment amongst vulnerable sections of the already qualified at the competition that was being engendered in the medical marketplace by charity services.

¹⁶ Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press, 1957), p. 110. On the impact of the Medical Act of 1858 on Scottish university medical education see James Bradley, Anne Crowther, Marguerite Dupree, 'Mobility and Selection in Scottish University Medical Education, 1858-1886' in *Medical History*, 40 (1996), p. 1.

¹⁷ Report of the Royal Commission Appointed to Inquire into the Medical Acts, 1882 (PP C.3259-1), paragraph 44. On preference for a Scottish medical education see, for example, Bradley et al, 'Mobility and Selection', pp. 18-19, quote from Charles Bell Keetley, *The student's guide to the medical profession*, 2nd ed. (London: Ballière, Tindall and Cox 1885), pp. 116-17, to point out that the average cost of a medical education in London (for a student graduating in the shortest possible time) might cost about £600, whilst a medical education in Scotland might have been had for little more than half this (i.e. £300+), though with students from abroad spending considerably more. Wendy Alexander, *First Ladies of Medicine* (Glasgow: University of Glasgow Wellcome Unit, 1989), p. 18, quotes *The Queen: the lady's newspaper* (5th Sept. 1894) that at this time it was estimated that for women the cost of a medical education in Glasgow was approximately £400 plus £200 additional for accommodation.

This expansion of outdoor medical services needs to be mapped if it is to be understood. Accepting that objections can be attached to the veracity of what were self-audited Victorian and Edwardian company and charity reports, the challenge becomes to pinpoint, within the limitations of the sources, the exact magnitude of this market of charitable medical services for the poor, *at least as it was reported*.¹⁸ In Glasgow the biggest culprit of inflated reporting of performance figures was said, contemporarily, to be the most prestigious institution of all, the Glasgow Royal Infirmary (GRI). The GMJ, in 1878, pronounced itself extremely sceptical in reporting returns for the GRI dispensary cases, recording:

...We confess to a certain amount of doubt as to the value of statistics, slumped together from the practice of some half-dozen men. *They doubtless give a fair conception of the work done...* but little else of value.¹⁹

Cross-checking of a range of sources provides one way of eliminating some issues of exaggerated reporting. Different charities, being subject to similar pressures and biases, by the nature of competition, would have had an interest in policing each other's output, thus curbing some of the excesses. Additionally it is also the case that the late-Victorians were generally obsessed with the accurate quantification of social phenomena. Members of the medical profession, in particular, saw themselves at the cutting edge of the statistical science movement. This is a solid reason for the historian to approach patient data optimistically, if cautiously. The importance therefore of trying to maintain accurate quantification in case returns produced was not lost on medical practitioners, keen to map disease trends. Each of these factors would have directly militated against overly excessive acts false reporting. It is known that at least one major charity organisation took direct steps to ensure the validity of its statistical returns, recognising the value of accurate records for future business.²⁰ Lastly, if actual totals remain exaggerated and the historian sceptical despite reassurances, comparative workloads of each charity can still be evaluated and identified as a worthwhile exercise.

¹⁸ On general criticisms of Victorian company accounts see Avner Offer, 'The British Empire 1870-1914: A Waste of Money?' in *Economic History Review*, vol. 46 (1993), pp. 216 & 219. On how in their respective desire to exude success medical charities could be induced to produce unreliable source material, see Hilary Marland, *Medicine and society in Wakefield and Huddersfield 1780-1870* (Cambridge: Cambridge University Press, 1987), p. 94.

¹⁹ GMJ, v. 10 (1878), p. 176.

²⁰ *Report of the Superior Council of the Society of St Vincent de Paul in the Archdiocese of Glasgow* (Glasgow, 1907), p. 3.

Table 3.2: Number of medical charity outpatients in Glasgow and Edinburgh from five contemporary reports, 1874, 1886, 1897 and 1906.

Glasgow (including Govan)	1874	1886	1897	1906	1906*
	(Russell) ^a	(Erskine) ^b	(Horder) ^c	(Chalmers) ^d	(Chalmers adjusted) ^d
Dispensary / Outpatients	29,409	72,217	-	-	-
Domiciliary patients	2,542	5,838	-	-	-
Total Outpatients	31,951	78,055	78,302	163,961	147,565*
Inpatients	6,654	-	20,863	-	-
Popn. of Glasgow & Govan					
(per Medical Directory)	556,070	669,100	756,325	905,931	905,931
Outpatients per pop. est (%)	5.7%	11.7%	10.4%	18.1%	16.3%
Home patients per pop est (%)	0.5%	0.9%	-	-	-
Edinburgh (excluding Leith)					
			1897	1907	1907**
			(Horder) ^c	(Kay et al) ^e	(Kay adjusted) ^e
Dispensary / Outpatients			-	92,289	76,256
Domiciliary patients			-	12,244	12,244
Total Outpatients			109,141	104,533	88,500**
Inpatients			14,763	14,868	
Popn. of Edinburgh (exc. Leith)					
(per Medical Directory)			269,407	316,479	316,479
Outpatients per pop. est (%)			40.5%	33.0%	28.0%
Home patients per pop est (%)	-	-	-	3.9%	

Note: Medical charities in both cities served broader hinterlands. *The second greyed set of data for Glasgow 1906 presents an adjustment in line with A.K. Chalmers observations on the numbers of infirmary outpatients in Glasgow who (he noted) came from outside the city; this was based on findings that around one in eight Glasgow Royal Infirmary and Western Infirmary outpatients and nearly one in two Glasgow Sick Children's Hospital and Samaritan Hospital outpatients were found to have come to the institutions from homes located outside Glasgow.

**The second set of data for Edinburgh 1907 also includes an adjustment to exclude the number of persons treated in Edinburgh outpatients and charities but who were similarly resident *outside* Edinburgh when using the service. In their report Kay and Toynbee reduced their outpatient data by a larger amount than was suggested by Chalmers for Glasgow (by around 22%), and this based on separate findings that between one in six and as many as one in three of Edinburgh Royal Infirmary, Church of Scotland Deaconess Hospital, Royal Victoria Consumption Hospital, Sick Children Hospital and Edinburgh Eye, Ear and Throat Infirmary patients came from *outside* Edinburgh. All remaining data is the unadjusted totals of patients treated as originally presented in the sources below.

Source: Data from: (a) J. B. Russell, 'Report on Uncertified Deaths' (1874) quoted in Thomas Ferguson, *Scottish social welfare, 1864-1914* (Edinburgh, 1958); (b) James Erskine, *The Abuse of Our Medical Charities* (Glasgow, 1886); (c) Dr T. Garrett Horder, Hospital Reform Association report to BMA meeting, in *The Scotsman* (27 July, 1898), p. 9; (d) A.K. Chalmers, paper handed in to RC on the Poor Laws and Relief of Distress Report for Scotland, 1909 (P.P. Cd.4978) App. No. CLXXXVI (c); (e) A. C. Kay and H. V. Toynbee, Report to the Royal Commission on the Poor Laws and Relief of Distress on Endowed and Voluntary Charities in certain places, and the Administrative Relations of Charity and the Poor Law, 1909 (P.P. Cd.4593) Appendix, Vol. XV, Sections on Edinburgh.

Whether to support arguments regarding the oversupply or abuse of medical charity, or what for others were areas of deficiency in services, over the four decades before World War One various medical practitioners, medical officers of health, charity officials and/or government commissioners found cause to survey the numbers of persons receiving charitable medical care in different British cities. Five studies of the numbers of sick-poor treated in Glasgow and Edinburgh have been identified (Table 3.2).²¹ These provide evidence regarding numbers of outdoor cases – infirmary outpatients plus dispensary patients plus domiciliary patients – for Glasgow (including Govan) for 1874, 1886, 1897 and 1906, and for Edinburgh (but excluding Leith) for 1897 and 1907. These surveys, when set side by side, confirm impressions regarding the expansion in medical charity in Glasgow; for Edinburgh, they point to the sustained importance of dispensary charity. Data from Kay et al (1907) also points to the significance of home visitation in that city. Indeed, Kay and Toynbee estimated that the number of domiciliary patients being treated by charity dispensary annually, circa 1907, was almost equal with those receiving hospital care in Edinburgh, with 12,244 domiciliary patients in Edinburgh during 1906, set against 14,868 inpatients.

The starkest measure of growth in outdoor charity in Glasgow between 1875 and 1911 is provided by comparison of the surveys by Medical Officers of Health James Burn Russell and Archibald Kerr Chalmers produced 32 years apart. Russell estimated during 1874 there had been 31,951 outpatients - or outdoor - cases treated in Glasgow. In comparison, Chalmers calculated 163,961 outdoor cases in 1906. This equates to a fivefold rise. In real terms, new estimates presented here suggests that outpatients also more than doubled when allowing for population growth in Glasgow and Govan, with 9.1% of the total population recorded as charity outpatients in the mid-1870s, and 19.3% in the mid-1900s (Table 3.3). In Edinburgh - even excluding the appended and overlapping services of the dockside area of Leith -, surveys by the BMA in 1897 and for the government in 1907 both revealed in excess of 100,000 outdoor cases per annum in the years either side of the turn of the century (Table 3.2). Depending on estimates and adjustments for persons coming into the city from

²¹ For an additional summary of Edinburgh charity see Francis H. Groome (ed.), *A historical perspective, drawn from the Ordnance Gazetteer of Scotland: A Survey of Scottish Topography, Statistical, Biographical and Historical* (Edinburgh: Thomas C. Jack, Grange Publishing Works, 1882-5), available on-line: <<http://www.geo.ed.ac.uk/scotgaz/towns/townhistory337.html>>[accessed July 2008].

outside Edinburgh for treatment, this represents an equivalent of between 28% and 40.5% of the local Edinburgh population accessing outdoor charity each year.²²

Glasgow practitioner James Erskine, in 1886, calculated the number of individual outpatients treated by voluntary medical charity in the city that year was 78,055. Erskine's concern was charity abuse although he was also particularly keen to map the extent of medical visitation of the poor. 5,838 (7.5%) of these individual cases, he claimed, were patients treated in their own homes. Twelve years earlier, as Glasgow's first full-time MOH, Russell had set himself the task of accounting for the problem of uncertified deaths in the city. He surveyed medical charity to support the theory that a relative lack of outpatient services in Glasgow compared to other British cities, at this time, added to a relative lack of emphasis on domiciliary services when compared to Edinburgh, were the most significant factors. By looking just at the four main medical charities of the city, Russell calculated that '38,910 patients were treated in the course of a year' by private voluntary charity. Of these, he said, 31,951 were treated outdoors, either by outpatients or dispensary service. Of this sub-total, 2,542 (8% of all outpatients) had been seen at home. Those seen at home were done so by one of just two private agencies that Russell identified operated such a service at this time. These were the Glasgow Medical Missionary Society and the Glasgow Maternity Hospital. By Russell's calculations, a poor person in Glasgow was - in the mid-1870s - four or five times more likely to be treated as an outpatient case than gain admittance to hospital. Comparing Erskine and Russell's surveys, outdoor private medical charity cases in Glasgow had doubled over the decade from the mid-1870s. This level of growth reflects a decade of particular dynamism in terms of the expansion of medical services in the town.²³

If charity abuse had inspired Erskine, it was the overcrowded medical marketplace that fed into the survey presented by Dr T. Garrett Horder to the B.M.A. Edinburgh conference in 1898 (Table 3.2). Horder was from Cardiff. His interest in Scottish

²² Whilst a high percentage, this is in line with the finding of the Association for Improving the Condition of the Poor 'The Charities of Edinburgh' Report (1890), which found 'more than half the population [of Edinburgh] were in the habit of expecting medical treatment gratis.' See *The Scotsman* (9 Aug, 1890), p. 6 and (11 Aug, 1890), p. 7.

²³ James Burn Russell, 'Report on Uncertified Deaths' (1874), quoted in Thomas Ferguson, *Scottish social welfare, 1864-1914* (Edinburgh, 1958), p. 443-4. See also Charles Cameron, M.P. speech recorded in the GMMS Annual Report (1883), p.7.

medical charity was a consequence of his position as honorary secretary of a lobbying organisation of fellow medical men styled the Hospital Reforms Association (HRA). The HRA had gathered data on Scotland's eight principal towns and cities in advance of the conference.²⁴ Their findings suggested that across urban Scotland, on average, by the mid-1890s, a poor person was nearly six times as likely to be treated outdoors, as an outpatient or dispensary patient, than indoors, in a hospital ward. The ratio varied. For Glasgow (with its expanded infirmary base) it was 3.8:1 outdoor cases to indoor cases. For Edinburgh, with its much greater and more established network of charity dispensaries but single main general infirmary, the ratio was 7.4:1 outpatients to inpatients. For Leith – treated separately - with its tremendous emphasis on infirmary outpatient home visitation, the ratio was 15.9:1 outdoor cases to indoor cases. The HRA survey did not give separate details of domiciliary visits; and its calculation on the number of outpatients in Glasgow, circa 1897, at 78,302, seems light compared to new estimates (Table 3.3). Horder reported the number of outpatients for the home conference city of Edinburgh to be 109,141.²⁵

In advance of the publication of the final reports of the Poor Law Royal Commission in 1909, Kay and Toynbee were appointed as special commissioners to report on the extent of 'endowed and voluntary charities in certain places' across Britain. Scottish enquiries took in Edinburgh (again, excluding Leith), Montrose, and Rural Aberdeenshire.²⁶ They produced separate surveys for hospital outpatients and charity dispensary, and calculated that 14,868 individual inpatient cases and 59,993 outpatients during 1906/7 attended at a general or specialist hospital in Edinburgh; and 45,140 outdoor patients attended at one of nine identified independent charity dispensaries then in operation in the city. Of the 104,533 total combined outpatients and dispensary patients (Table 3.2), 12,244 were cases seen at home: with 826 of these midwifery cases. Identifying that a problem existed in estimating the extent of doubling-up, and making final adjustments to allow for approximated numbers of people they identified as being treated in Edinburgh but who were actually resident *outside* the city when accessing services, Kay et al concluded that approximately

²⁴ *The Scotsman* (27 July, 1898), p. 9.

²⁵ It is highly likely that the HRA Report on Glasgow had completely overlooked the vast amount of medical work conducted by the medical missions: this would most readily account for much of the discrepancy between the HRA estimate and the new estimate presented here in Table 3.3.

²⁶ Kay and Toynbee, (Cd.4593) Report on Endowed and Voluntary Charities, Sections on Edinburgh.

88,500 (or 28.0% of) Edinburgh residents annually accessed outdoor charity services at this time, This was a figure they called ‘remarkable... given that this does not include 18,000 dental cases plus parish cases... [and especially given that] Edinburgh is largely a residential city and the population is such a description that it would not be expected that a considerable percentage would apply for free medical aid.’²⁷

Following the precedent, the numbers of poor that attended at uniquely dental establishments are not included in any of the data tables offered here. This is not a failure to acknowledge that this form of medical treatment was of great importance to the poor: indeed, dentistry and eye care are great continuities in working-class demand for health services. It is instead recognition that from the late 1870s dentistry was legally a unique and separate branch of medicine in terms of qualification. Whilst excluded, an outline of numbers can be given. Glasgow Dental Dispensary was found in November 1879 in conjunction with Anderson’s College Medical Faculty and in the wake of the Dental Act of 1878.²⁸ Whilst it did not pay home visits it treated from several thousand rising to an average of 12,507 cases per year by the period 1903 to 1914. Edinburgh Dental Dispensary (by 1880 restyled as the Edinburgh Dental Hospital and School of Dentistry) treated similar numbers to Glasgow. It also operated on a similar basis, to facilitate training for dental students. Whilst patients attending at specialist dental charities are excluded from composite data tables here, dental cases treated at the general dispensaries are included because not all charities separated dental and other forms of medical case in their final reports. All general charity dispensaries offered dental services.

In addition to identifying a host of hospital and medical dispensary services in Edinburgh, Kay and Toynbee also outlined a range of additional welfare charity that provided charitable medical services in ‘money and kind’. As well as lay visits to the poor some also facilitated organised nursing visits and/or enabled access to doctors who, at different times, held honorary association with the different organisations. This welfare-based charity comprised a range of different shelter schemes, lodging homes, church-based charities, personal and special interest group charities,

²⁷ Kay and Toynbee, (Cd.4593) Report on Endowed and Voluntary Charities, p. 243.

²⁸ Rufus M. Ross, ‘Glasgow Dental Hospital and School: The Early Days,’ in *History of Dentistry Research Group Newsletter* (April 2000). Adapted from R M Ross, ‘The Development of Dentistry: A Scottish Perspective circa 1800-1921,’ unpublished PhD thesis (University of Glasgow, 1995).

almshouses, and other sick-poor oriented pension charities. Far and away the biggest, in Edinburgh, measured by income, was the Edinburgh Society for the Relief of the Destitute Sick. This was followed by the Catholic charity, St Vincent de Paul Society. Four nursing organisations were identified as providers of sick-poor domiciliary services. The biggest was the Queen Victoria's Jubilee Institute for Nurses, important, across Britain, from the 1890s onwards.²⁹

In giving evidence to the Poor Law Royal Commission in March 1908, MOH Chalmers presented his survey identifying 21 charities offering medical treatment in Glasgow. He confessed that his count was probably not exhaustive when he totalled 163,961 outpatients for Glasgow during 1907 (Table 3.2). As with the Kay and Toynbee survey of Edinburgh, Chalmers adjusted this figure down in an attempt to calculate the exact proportion of the total population this meant annually acquired charitable medical care. He based adjustments on observations that around one in eight Royal Infirmary and Western Infirmary outpatients and around one in two Glasgow Sick Children's Hospital and Samaritan Hospital outpatients typically came from outside the immediate Glasgow area. Given the adjusted figure, Chalmers concluded that, in total, approximately one in six of Glasgow's municipal residents annually accessed medical charity outpatient (or outdoor) services. This was a figure, which if behind calculations for Edinburgh, he still called: 'a good deal more than I had anticipated.'³⁰ The sheer extent of medical charity constantly seemed to surprise everyone who looked at it.

Whilst he did not give details of the numbers of home visits, the extent of outdoor medical charity in Glasgow, Chalmers noted, masked a decline in domiciliary care of the poor in the city. This, he said, he regretted. As Glasgow's chief public health official, the spur to his interest in the extent of outdoor medical charity, he said, had been a series of disputes in the city amongst its medical professionals over the

²⁹ Kay and Toynbee, *Report on Endowed and Voluntary Charities*, p. 225 f. and p. 241: the four nursing organisations together paid 127,706 visits in the year 1906/7 to 6,474 poor cases in Edinburgh. The origin of the Queen Victoria's Jubilee Institute for Nurses was in the work of the founders of the Edinburgh School of Cookery, established in 1875. In Glasgow, the Glasgow Sick Poor and Private Nursing Association was also found in 1875, by Mrs Higginbotham.

³⁰ Archibald Kerr Chalmers, *RC Poor Laws and Relief of Distress* (Cd.4978), Evidence 95097-95323 and Appendix CLXXXVI: Chalmers noted that his tables did not include either the Glasgow Maternity Hospital or the Glasgow Dispensary for Skin Disease.

efficacy of public authority support for the policy of founding yet more charity dispensaries. This debate, a heated one, had been sparked a couple of years previous by the proposal for a new institution in what had been identified as a previously under-served part of the city. Whilst not named, Chalmers was referring to the protracted controversy that surrounded the founding of Anderston District Health Association Dispensary.³¹ During cross-examination, Chalmers particularly bemoaned the stagnation of home visitation amongst outdoor charity services in Glasgow:

[RC Poor Laws Chairman, Lord Hamilton:] Do any of the officers of these dispensaries pay domiciliary visits to the poor that attend? – [Chalmers:] Except in connection with the Medical Mission and Anderston Dispensary, I believe they do not, and I think that is a defect in them. I think that is where they fail.³²

As a public health official, Chalmers saw that visit-based medical interventions had a particular cachet in terms of enabling and facilitating the implementation of preventive health measures. It was for this reason he felt it was substantially under-utilized. Responding to particular questions about recently instigated infant and mother services in Glasgow, Chalmers lauded the vital role of home visits in these new areas of medical policy. Under the terms of the Notification of Births Act that came into force in January 1908, a pool of volunteer lady health visitors had been organised in Glasgow. These visitors reported to a newly appointed female medical assistant in the public health department and were assigned the task of visiting all mothers, in Glasgow, with new born. Such home visits were a means to a greater end:

[Chalmers to RC, 1908:] One of the advantages of all this system of visiting is to keep hold of the baby, as it leads you directly into the house, and you very often find conditions there that are capable of alteration... [Chairman, Lord Hamilton:] I suppose you attach very great importance to these domiciliary visits? – [Chalmers:] I think that is where the importance lies. There are cases where there have been quite stark reforms in the whole domestic hygiene: the house is kept clean, and more attention is paid to the food. [My emphasis]³³

The visiting scheme described by Chalmers had been organised in conjunction with the COS and with the British Women's Temperance Association, although it was not

³¹ Archibald Kerr Chalmers, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 95141: 'I was eager to have a children's dispensary... and secondly, I was eager to have a tuberculosis dispensary established. The gentlemen who were interesting themselves somewhat extended the scheme beyond that and it created a good deal of opposition, which led me to enquire more accurately where free medical relief stood'.

³² Archibald Kerr Chalmers, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 95145.

³³ Archibald Kerr Chalmers, RC Poor Laws and Relief of Distress (Cd.4978), Evidence 95131-4.

manned directly by medical practitioners. Thus Chalmers was keen to point out that the visitors offered medical advice rather than medical treatment. A grey area between the two was admitted. In cross-examination, Beatrice Webb asked Chalmers directly: 'Is there a dividing line between advice and treatment?' Chalmers responded by admitting the line drawn between the two activities was in reality quite thin, but that *advice*, he said, consisted of recommendations for behavioural change that would lead by extension to an improvement in health (such as by way of a change of dietary), whilst *treatment* 'comes[s] in if some obvious symptom of disease were present.' This distinction reflected essential elements in the schism that opened from the second half of the nineteenth century, across Britain, between preventative medicine and general medical practice.³⁴ Chalmers was one of a series of Scottish witnesses who left a lasting impression. Beatrice and Sidney Webb subsequently pointed out they simply could not conceive of a health system without this kind of visitation, arguing:

It is, indeed, difficult to take seriously in the twentieth century, as an organisation professing to treat disease, the typical arrangement under which an overworked and harassed house-surgeon gives a few minutes each to a continuous stream of the most varied patients; without knowledge of their diet, habits, or diathesis; without any but the most perfunctory examination... and without any attempt at domiciliary inspection and visitation.³⁵

The investigations brought together here are valuable but represent a series of one-off summaries. Each provides a static picture, being constructed at separate times, by different practitioners, and compiled to differing personal agendas and imperatives. They exhibit in their execution different levels of thoroughness and vigour. Discontinuous and methodologically inconsistent, whilst indicative, the surveys are a problematic set for longitudinal study. Additionally, the numbers of domiciliary patients was not always explicitly stated. Thus, in order to gain a clearer, fuller, more consistent, and more fluid account of the extent of medical charity in Glasgow and Edinburgh across the whole period 1875 to 1911, published returns have been re-aggregated (Tables 3.3 and 3.4). The attempt to recalculate the data is not a claim of greater authority over contemporary observers but rather one of simple utility.³⁶

³⁴ Archibald Kerr Chalmers, *RC Poor Laws and Relief of Distress* (Cd.4978), Evidence 95097-95323.

³⁵ Sidney and Beatrice Webb, *The State and the Doctor* (London: Longmans, Green & Co, 1910), p. 134. See also T. Garrett Horder, 'Hospital Reform' in *BMJ* (30th March 1907) on the need for all public health outpatient services to be informed by domiciliary visitations.

³⁶ David Landes, 'The fable of the dead horse; or, the industrial revolution revisited' in Joel Mokyr (ed.), *The British Industrial Revolution: An Economic Perspective* (Westview Press, 1993), p. 168: Numbers here are not necessarily better or worse, just methodologically more consistent.

Table 3.3: Newly estimated number of outdoor cases in Glasgow (and Govan), recalculated from annual reports etc., mid-1870s to mid-1900s.

Glasgow (and Govan)	c. mid-1870s	c. mid-1880s	c. mid-1890s	c. mid-1900s
Dispensary patients -				
hospital outpatients	28,970	56,487	72,743	128,379
dispensary patients	3,771+	17,050+	15,987+	17,522+
medical missions	15,833	20,450+	25,000+	24,000+
Total dispensary	48,574+	93,987+	113,730+	169,901+
Domiciliary patients -				
hospital outpatients	927	1,560	2,100	2,100
dispensary patients	0+	1,500+	0+	0+
medical missions	1,266	1,886+	2,793+	2,073+
welfare charity medical visits	unk.	unk.	80+	500+
Total domiciliary	2,193+	4,946+	4,973+	4,673+
Annual Total Outpatients	50,767+	98,933+	118,703+	174,574+
Outpatients per pop. est (%)	9.1%	14.8%	15.7%	19.3%
Home patients per pop (%)	0.4%	0.7%	0.7%	0.5%

Table 3.4: Newly estimated number of outdoor cases in Edinburgh (and Leith), recalculated from annual reports etc., mid-1870s to mid-1900s.

Edinburgh (and Leith)	c. mid-1870s	c. mid-1880s	c. mid-1890s	c. mid-1900s
Dispensary patients -				
hospital outpatients	23,962	40,742	51,530	73,081
dispensary patients	21,175	26,276	27,532+	28,807+
medical missions	12,914+	10,169+	10,360+	11,798+
total dispensary	58,051+	77,187+	89,422+	113,686+
Domiciliary patients -				
hospital outpatients	2,699	4,561	5,067	7,861
dispensary patients	5,907	9,116+	9,002+	8,844+
medical missions	3,272+	3,201+	3,512+	3,211+
welfare charity medical visits	unk.	unk.	unk.	unk.
total domiciliary	11,878+	16,878+	17,581+	19,916+
Annual Total Outpatients	69,929+	94,065+	107,003+	133,602+
Outpatients per pop. est (%)	28.3%	31.6%	31.6%	34.0%
Home patients per pop. (%)	4.8%	5.7%	5.2%	5.1%

Note: Numbers in both Table 3.3 and 3.4 represent *a minimal estimate picture*, with data for various smaller medical charities either unknown or unidentified (indicated by a + sign next to numbers). For each identified charity either a decade average has been used, otherwise a figure for the middle year in each decade (where this has been found); alternatively the number of patients is calculated from known ratios of indoor to outdoor patients, or has been estimated from nearest known years in order to give an approximate figure.

Source: Various, including extant charity reports, centenaries, historical texts, medical directories, newspaper and journal reports.

Both the contemporary accounts of medical charity (Table 3.2) and the reconstituted accounts (Tables 3.3 and 3.4) confirm that from the mid-1870s through to 1911, in Edinburgh and Glasgow, there was a significant growth in numbers of patients using charitable institutions offering outdoor medical assistance, and therefore enabling patients to stay in their homes during treatment. What newly aggregated estimates also confirm, in regards to medical charities, missions, and other welfare agencies offering home visits particularly, there was also a net overall increase in domiciliary care. Although total numbers of cases visited increased, there is clear divergence between Glasgow and Edinburgh in terms domiciliary provision.

Feeding into totals in Table 3.3 and 3.4, for Glasgow and Govan nine hospital institutions and infirmaries (excluding dental services), sixteen charity dispensaries, nine medical missions, and six welfare organisations have been identified providing outdoor medical charity services; and for Edinburgh and Leith, seven hospital and infirmary outpatients, thirteen charity dispensaries, seven medical missions, and five welfare societies have been identified. In Glasgow, new estimates suggest that from c.1875 to c.1905, the number of patients treated outdoors by infirmary outpatient department, medical charity or medical mission dispensary - excluding those treated at home - rose 250%, from 48,574+ cases to 169,901+ cases. Over these decades the number of hospitals and infirmaries offering outpatient service had doubled; and the number of medical dispensaries had expanded from five to nine. Infirmary outpatients had risen fastest, from a reported total of 28,970 cases c.1875, to 128,379 cases by the mid-1900s (a 343% increase). Two major general infirmaries plus a major children's infirmary had been found in the period. The patients recorded accessing independent dispensary services in the city had also quadrupled, to 17,522+ by the mid-1900s. The founding of Anderson's College Dispensary (ACD), in May 1878, had initiated much of this growth in dispensary charity. At a peak, seven per thousand (0.7%) Glasgow and Govan residents annually accessed treatment by one or other private charity in their homes. Particularly striking is this lack of charity dispensary domiciliary cases.³⁷

³⁷ I have recorded the numbers being visited in the mid-1870s, mid-1890s and mid-1900s as 0+. The plus records the fact that some *may* have been given home visits by institutions whose data is unaccounted for. For example, the relatively minor Glasgow Ear Institution (GEI) (founded 1887); the Glasgow Public Dispensary (GPD) (founded 1876, and which treated in total around 1,200 to 1,600 patients each year); or by medical students active in one of the several Glasgow student settlement

Overall, the number of patient cases treated at charity dispensaries in Edinburgh and Leith rose less dramatically than in Glasgow, but from a significantly higher base (Table 3.4). Numbers treated outdoors – excluding domiciliary cases – increased decade upon decade: from 58,051+ in the mid-1870s; to 77,187+ by the mid-1880s (a 33.0% rise); to 89,422+ by the mid-1890s (a 15.9% decade rise); and then to 113,686+ each year by the mid-1900s (a 27.1% decade rise). Although the main medical services also served a broader hinterland, there was a prodigious amount of outdoor medical charity work amongst residents of Edinburgh. Thus around 5% of the total population of Edinburgh (including Leith) were each year treated for medical complaints via home visits from one or other medical charity organisation. Home visits were only conducted within a set radius of the dispensaries so are a solid indication of take-up amongst local residents. Excluding those also receiving ad hoc medical visits from one of numerous different charity societies (accurate assessment of which remain unrecoverable from studied surviving records), new estimates of individual cases visited at home each year show 11,878+ cases in the mid-1870s, and 19,916+ cases in the mid-1900s (a 67.7% rise). The sustained importance of dispensary domiciliary services, added to the great expansion of the home visitation wing of the Leith Hospital and Dispensary, account for these impressive numbers.

Not all charities that provided home visitation services declared in their literature exactly how many patients they visited each year (hence the use of + signs in Tables 3.3 and 3.4).³⁸ As with parochial visitation figures given, case numbers recorded also tended to ignore those additional family members who also benefited from medical advice or treatment as an offshoot of a particular visit. By best estimates therefore, for two and a half decades from the mid-1880s, 20,000-25,000 sick-poor each year across

associations (found in the 1880s and 1890s). Numbers of home visits on the university settlements go unrecorded in records consulted. Such visits, if conducted by students independently of university staff and out-with a hierarchical supervisory education structure, would have been extremely risky for the medical students involved. They would have falling foul of the rules of qualified practice as laid out by the GMC in 1888 (discussed in this part of the thesis). *The Scotsman* (4 Mar, 1903), p. 11, records details of the Annual Meeting for 1903 of Glasgow University Student's Settlement Society Dispensary and notes that by the previous year, 'the Medical Faculty was the predominant partner,' and that 'a report by Dr Mary Graham was read on the dispensary for women and children'. Ferguson, *Scottish social welfare*, p. 444, does not mention home visits but claims that the GUSSS Dispensary was treating around 1,000 cases per year in the early 1900s.

³⁸ As Tables 3.3 and 3.4 for Glasgow and Edinburgh make clear, presented data is still a minimal estimate.

the two cities combined were treated by private charity in their homes. If one adds the total of parochial medical cases already calculated in this thesis – and accepting that some may have doubled-up on services -, a combined estimated total approaches 45,000 domiciliary poor cases annually. Given that multiple visits to each case were typical, this would have meant the number of total medical home visits to the poor of Glasgow and Edinburgh conducted each week could also be measured in thousands.

A host of different justifications vied to explain why domiciliary medical visits of the poor might or might not be undertaken, at different times, by the different charity agencies identified. In 1891, for example, renowned controversialist and Liverpool based medical practitioner, Robert Reid Rentoul, M.D., published a study on the theme of medical services for the British poor in which he bemoaned, particularly, the lack of use of home visitation hitherto, especially in England. He highlighted some of the main advantages to be accrued by an immediate, nation-wide adoption of a formalised public program of domiciliary medical care. Seeking to establish the efficacy of an interventionist government, he forcibly put the case for a greater health and welfare role for what he foresaw as (necessarily and desirably) a more autocratic future for the British state. Charity abuse was a contemporarily vexed subject. The only sure way to eliminate it, Rentoul suggested, was via the complete usurpation of all private forms of voluntary medical relief for the poor. Given the amount of private medical charity activity that he identified – and that has been calculated here for Edinburgh and Glasgow -, this was obviously a radical proposal at this time. Rentoul put the case for replacement of all private charity dispensaries with a single system of national public dispensary services. These, he argued, should be provided by, funded from, and operated at all times in the interests of central government. Using ideas that a decade later were recast to provide a framework for his personal interests in racial eugenicist theory, Rentoul proposed a grander, more interventionist medico-moral and civil service role for British medicine. Medical practitioners in Britain, he suggested, should each become full-time agents of the state (something anathema to many in the profession at this time).³⁹

³⁹ Robert Reid Rentoul, *The Reform of our Voluntary Medical Charities* (London: 1891).

As an interim fix on the road to the full abandonment of the existing patchwork of voluntary agencies, Rentoul made 21 recommendations by which, he said, all existing medical charity in Britain would immediately benefit. Centrally and most fundamentally, Rentoul argued, there needed to be greater resort to domiciliary medical services for the treatment of the poor. Acknowledging the special difficulties and strains incumbent upon medical practitioners asked to give time and resources in engagement in such visits, Rentoul also proposed that a dedicated, suitably salaried and also full-time 'Home Patient Medical Staff should [immediately] be appointed by all the general medical charities across Britain,' arguing that

...such a system would reduce the great overcrowding of, [and] prolonged waiting in, the out patient rooms. More important still, it would bring practitioners into direct contact with the *homes* of patients. It would also tend to diminish the spread of infectious disease, as at present a considerable number of cases are spread by their collecting in the *out* patient rooms. If such home patient treatment were successful then the out patients might be gradually done away with. Such *home* patient departments would be a good means for training senior students. [Italics in original]⁴⁰

Though maverick in many of his views, in choosing to point out the advantages to be accrued by the systematic use of home visitation, Rentoul here was simply reapplying lessons learnt whilst a student in Edinburgh in the mid 1870s. Student medical visitation of the poor, in Edinburgh, had had a long tradition of support, and had been an established part of the dispensary system in the city for fully one hundred years by the beginning of the last quarter of the nineteenth century. The Edinburgh Royal Public Dispensary was established in 1776, one hundred years before Rentoul graduated with the double qualification of the Royal Colleges of Edinburgh in 1877.

Fundamentally, as Rentoul's argument reflected, Edinburgh-trained medical students had long had it drilled into them that home visits were efficacious both for their training and for meeting broader social and medical objectives. They brought the practitioner directly into the patient's world. Through access to the home and through the contact involved - Rentoul would have been encouraged to learn as a student - the medical practitioner came to enjoy a clearer and an earlier understanding of the

⁴⁰ Rentoul, *Reform of Medical Charities*, p. 136. He graduated LRCPSE in 1877, acquiring his M.D. from his native Ireland in 1880, before settling into general practice in Liverpool. Per both his obituary notice and correspondence relating to evidence given before a Select Committee Inquiry in 1892, he cut a notorious figure in Liverpool and in the profession. See *BMJ*, vol. 2 (1925), p. 630, and *Report from the Select Committee on Midwives' Registration* (BPP Session no.289i, 1892), Appendix 5.

context of disease, and the environment in which sickness bred. By learning of a patient's true circumstances, he (the practitioner) would then know better both *how* and *what* as well - as importantly, in terms of curbing the abuse of charity and providing the optimum course of relief - *whether* and *whom* to treat. By gaining access into the home, the practitioner put himself in a position from which to exert greatest personal influence, and (ultimately, hopefully) gain the trust and authority necessary to instigate desired modifications in both patient and family behaviour necessary to lead to improvements in health.⁴¹ Home visits thus also served an aspect of what has elsewhere and subsequently been termed by another Edinburgh-trained practitioner of the period 'community', 'conservative' or 'constructive' medicine.⁴² At a time when bacteriology was in infancy, home treatment of the poor too played an important preventive, or containing, public health role. As Rentoul therefore also pointed out (be it idiosyncratic manner), systematic visitation amongst neighbourhoods of the sick-poor aided broader society in the stricter utilitarian sense, facilitating earliest detection of illness, and in turn enabling the implementation of more effective policies to minimise cross-contamination to curtail the further spread of infectious disease. Visiting the poor, as Rentoul argued, additionally supported broader professional and social objectives by providing an ideal testing ground for the training of medical students.⁴³ Domiciliary services were thus multi-functional.

Whilst patient returns (Tables 3.3 and 3.4) point to the particularly close connection of Edinburgh to home visits, around the mid-1880s particularly, there was a groundswell of professional opinion regarding the efficacy of using medical students to undertake home visits of the sick-poor in Glasgow too.

Glasgow practitioner James Erskine – Table 3.2 - was a near contemporary to Rentoul when, in 1886, he surveyed the extent of medical charity in Glasgow. Both Erskine and Rentoul had toyed with the problems of the abuse of medical charity at this time,

⁴¹ There is obviously here a paternalist and social control argument that might be made about who determines what constitutes desirable, healthy behaviour: for Rentoul, the answer would have been simple.

⁴² Sir George Newman, *The Rise of Preventive Medicine* (London: Oxford University Press, 1932), p.3.

⁴³ Rentoul, *Reform of Medical Charities*, pp.75-6: 'Medical charities treat symptoms only, and not the cause of disease... The chief end of a medical charity *is to prevent disease*, and to stamp out disease-producing conditions. It is the duty of all true practitioners to drive home these facts, and show that they can act as a moral, as well as a medical force.'

and both related the issue to the need for training medical students. Like Rentoul, Erskine also pointed out the attendant value both to the profession and to broader society of organised systems of home visits to patients. He presented his findings on the matter to fellow professionals of the Glasgow Southern Medical Society (GSMS). His paper was evidently well received for it led to the establishment of a dedicated GSMS committee to consider all issues of medical philanthropy in Glasgow.⁴⁴ Just four years qualified from Glasgow University at this time, Erskine was a man who like many of his fellows at this time straddled the demands of private general practice, honorary appointment, and an interest in specialty medicine. He had experience of medical philanthropy, being at the time of his paper an aural surgeon at Anderson's College Dispensary (ACD). Significant in terms of his views on abuse and visitation, Erskine was also one of a small band of Glasgow medical practitioners serving as a council member for the Glasgow COS. Erskine was to cement his interest in issues of public welfare policy in Glasgow through election onto both the town and parish councils.⁴⁵ His analysis of the problem of charity abuse in Glasgow was borne out of the particular experiences of his adopted home city. Between 1885 and 1887 - the years surrounding his paper -, the Glasgow economy was severely depressed. The surest indication of this, the Town Council had opened emergency relief works in Glasgow. This was only the second time the authorities had deemed industrial unemployment sufficiently dire to undertake such a public show of response: the first had been during the first two winters in the wake of the Bank of Glasgow collapse in 1878. Periods of economic depression always resulted in growth of demand for medical charity services just when subscription monies were hardest to come by. Thus stretched services always heightened sensitivity towards their usage.

Erskine demanded a reapplication of first principles, reminding exactly whom it was he said were meant to be the true and worthy recipients of medical charity. Charity, he

⁴⁴ James Erskine, *The Abuse of Our Medical Charities* (Glasgow, 1886).

⁴⁵ Throughout his career Erskine straddled general practice and specialty medicine, medicine and politics. He served to 1899 as the aural surgeon at Glasgow Central Dispensary. He also served at the Glasgow Ear Institution, and as a lecturer on aural surgery at Anderson's College. He developed alongside this a general practice that included, from 1910 to his death in 1922, service as a Glasgow PMO. In order to take up this role, the then fifty-five year old of necessity had resigned from his elected position as parish councillor. This he had held for five years. After resigning as a parish councillor, Erskine went on to serve on the more prestigious Glasgow Town Council. He was also active in the B.M.A., and, in the years before his death, served as chairman of the District Hospitals Committee in Glasgow.

stated, was for that 'class between pauperism and an ability to pay fees that needs and deserves it.'⁴⁶ In order to restrict medical charity to the correct class, those that were the truly *the poor* by accepted professional definition, Erskine therefore proposed all medical charities in Glasgow should immediately adopt as a key principle the policy of greater initial interrogation in order to determine the true deserts of all its applicants. Greater discrimination in sifting applications necessarily begun, he said, with more thorough inquiries into circumstances. This, in turn, automatically necessitated first-hand knowledge of the home-life of applicants. This line of reasoning was essentially a reiteration of COS views, built on the Scottish principle of informed, targeted welfare provision. Indeed, as Erskine suggested: 'there is no better means of administering public charity than through such a medium as the Charity Organisation Society.'⁴⁷ In fact, different medical charities in Edinburgh and Glasgow were already alive to this line of argument, with some using their attendant medical officers as de facto investigators-in-chief. The regulations of the Edinburgh Royal Public Dispensary, for example, had it laid out by Royal Warrant in 1834: 'that in the event of the patient being visited at his or her dwelling-house, the medical practitioner is to satisfy himself of the situation of the patient as to poverty, &c. before he issues a prescription to the apothecary.'⁴⁸ The medical secretary of the much shorter lived and lesser known Northern Free Dispensary in Edinburgh, in 1882, noted that it made similar demands on its medical officer, and that: '...in no case was medicine given gratis unless the medical officer was satisfied that the patients were not in circumstances to procure it for themselves.'⁴⁹

The ideal model for any medical charity dispensary, Erskine argued, was that of a dual purpose institution: 'exist[ing both] for the good of the deserving poor, and the advancement of medical knowledge'.⁵⁰ Such medical knowledge (contextualised clinical knowledge), he reasoned, was built on an understanding of the environment in which the medical condition had first become manifest. ACD, where Erskine gave gratuitous service, was the required type of institution he said - as, indeed, were many of Edinburgh's medical dispensaries, upon which the visitation system at the

⁴⁶ Erskine, *Abuse of our medical charities*, p. 335.

⁴⁷ Erskine, *Abuse of our medical charities*, p. 344.

⁴⁸ *Royal Warrant and Regulations of the Royal Public Dispensary, 1834* (Edinburgh City Archives), ref. SL73/1/1: Miscellaneous Papers relating to Edinburgh New Town Dispensary.

⁴⁹ *The Scotsman* (25th March 1882), p. 8.

⁵⁰ Erskine, *Abuse of our medical charities*, p. 349.

dispensary in Glasgow was modelled. What these centres of medical service, medical education and medical knowledge production shared in this period was a commitment to the provision of home visitation services.

While Erskine did not explicitly list all the advantages, he acknowledged throughout his paper the essential and central roll of medical home visitation. Home visits were crucial to determining the true deserts of applicants. Additionally, medical visits brought medical agencies 'at the very doors of the poor,' enabling a doctor better management during the course of treatment. 'By visiting the patient, when required,' Erskine argued, 'the real necessities of each case can be discovered, and therefore properly attended to'. Home visitation was not only a valuable part of training medical students for the demands of future general practice, earliest medical intervention was made possible (something that Rentoul too was to argue). Home visitation services also meant that care could be offered for those identified as suffering from chronic conditions, and who by dint of their complaint fell outside the orbit of institutions more interested in acute cases. Thus Erskine argued:

Medical charities, which not only visits the poor and help them... can give them proper attention when their cases come first under their cognisance, and often prevent the malady becoming chronic; they can [also] undertake chronic cases, such as phthisis, and lighten the great burden they impose...⁵¹

⁵¹ Erskine, *Abuse of our medical charities*, pp. 350-351.

3.2 Edinburgh's outdoor medical charity services

The sustained importance of outpatient, dispensary and domiciliary charitable medicine in Edinburgh has been shown (Tables 3.2 and 3.4). A breakdown of the new calculations for annual numbers of cases visited and treated at home in Edinburgh, by charity, identifies the range and diversity of domiciliary service providers (Table 3.5).

Table 3.5: Breakdown of annual number of domiciliary cases, by charity, in Edinburgh (and Leith), mid-1870s to mid-1900s.

	Circa...	mid-1870s	mid-1880s	mid-1890s	mid-1900s
outpatient services:	Inst.				
Leith Hospital Dispensary	1815	1,820	3,972	4,470	7,161
Edinburgh Royal Maternity	1843	338	589	597	700
Edin. Royal Hosp. Sick Children	1859	541	-	-	-
Outpatient sub total		2,699	4,561	5,067	7,861
charity dispensary:					
Royal Public Dispensary	1776	1,973	1,963	2,200	2,620
New Town Dispensary	1815	3,384	2,493	2,225	1,644
Western Disp./Chalmers Inst	1870	550	[1,300]	[1,400]	740
Edinburgh Provident Dispensary	1878	-	2,960	2,727	2,290
Edin. Disp. Women and Children	1878	-	unknown	[50]	[50]
Northern Free Dispensary	c.1880	-	[400]	-	-
Victoria Disp. For Consumption	1887	-	-	[400]	[400]
Women's Disp. (Canongate)	1887	-	-	unknown	unknown
St Anne's R.C. Dispensary	1887	-	-	unknown	1,000
Dispensary sub total		5,907	9,116+	9,002+	8,844+
medical mission dispensary:					
EMMS	1853	3,272	3,201	3,427	3,211
Carrubber's Close Med Mission	1858	unknown	unknown	unknown	unknown
Burns Thomson's Med Mission	1874	unknown	-	-	-
Causewayside Medical Mission	1874	unknown	-	-	-
Canongate Christian Institute	1882	-	unknown	-	-
Jewish Medical Mission Society	1889	-	-	unknown	unknown
Edinburgh Jewish Dispensary	1895	-	-	[85]	-
Medical Mission sub-total		3,272+	3,201+	3,512+	3,211+
other:					
Destitute Sick Society	1785	-	-	-	-
Assoc Improving Cond. Poor	1868	-	unknown	unknown	unknown
Edin. Assoc Relief of Incurables	1874	unknown	unknown	unknown	unknown
Jewish Lying-In Society	1875	unknown	-	-	-
Jewish Board of Guardians	1899	-	-	-	unknown
Welfarist sub total		0+	0+	0+	0+

Note: Numbers here are averages calculated and summarised in Table 3.4. Numbers in brackets represent best estimates from available sources. 'Unknown' indicates that charity was (or was probably) carrying out home visits but exact numbers have not been found (hence + used in final figures). These numbers represent persons visited and not the total number of visits actually made.

Loosely speaking, by the dates the institutions were found, the general pattern of development of medical services in Edinburgh was the provision of infirmary

services, followed by general charity dispensaries, followed by medical missions, followed by specialist services, although all forms expanding from the mid-1870s.

In terms of total numbers of patients treated, hospital outpatients grew fastest, tripling over the period from the mid-1870s to the mid-1900s. The outpatients of Edinburgh Royal Infirmary (ERI), of Leith Hospital, of what became after 1883, the Eye, Ear, Throat Dispensary (EETD), and of the Edinburgh Royal Hospital for Sick Children (ERHSC), each reported substantial increases in patients in the decades before 1911.⁵² In addition in Edinburgh (including Leith), from c.1875 to c.1905, total infirmary outpatient domiciliary medical cases visited also tripled, from 2,699 to 7,861 per annum (Table 3.5). Three outpatient services provided home visits over this time. Leith Hospital outpatients department was the most substantial domiciliary service. Until abandoned in 1879, visitation had also been a part of the dispensary work of ERHSC. It was also a substantial part of the work of the Edinburgh Royal Maternity Hospital (ERMH).

Although total patient numbers grew at a much slower rate than for infirmary outpatient services, independent general charity dispensaries also treated tens of thousands of sick-poor each year in Edinburgh between 1875 and 1911 (Table 3.4). These dispensaries, combined, were the most active in terms of domiciliary care. 5,907 individual cases were visited at home by one of three dispensaries operative in the city in 1875 (Table 3.5). With the addition of Edinburgh Provident Dispensary in 1878, total annual cases visited across Edinburgh by charity dispensary rose to 9,116+ cases each year by the mid-1880s: and numbers of visitation cases each year remained at around 9,000 cases until 1911. In total, nine separate charity dispensaries have been identified providing home visits. Seven medical missionary organisations also provided medical home visits; and at least five other charities organisations facilitated home visits by practitioners on an ad hoc basis (Table 3.5). By total reported patient numbers, the four main (non-medical mission) charity dispensary visitation services

⁵² A. Logan Turner, *Story of a Great Hospital: the Royal Infirmary of Edinburgh 1729-1929* (Edinburgh, 1937), p. 293: ERI outpatients more than doubled from 15,000 in 1879-80 (first year of relocation) to 33,412 in 1903-04, and doubled again by the late 1920s. Per new estimates, Leith Hospital Dispensary outpatients rose from 4,719 circa 1875 to around 12,000 per annum by the mid-1900s. Between 1879 and 1894, the number of reported outpatients treated at the dispensary of ERHSC rose by two-thirds, from 4,961 to 8,218; and by 1907 to over 27,000.

in different parts of Edinburgh were the Royal Public Dispensary (ERPD), New Town Dispensary (ENTD), Western Dispensary, and the Provident Dispensary.

The Dispensary method of the provision of medical care for the sick poor had been begun in Edinburgh in the second half of the eighteenth century.

John Wilkinson, EMMS (1991)⁵³

The oldest of the charity dispensaries in Edinburgh before 1911, by several decades, and the first to provide gratuitous outdoor services for the sick poor, was the Public Dispensary (ERPD). It was established in 1776 upon European models. It was found by Professor Andrew Duncan, referred to as ‘the father, if not the founder, of all our modern dispensaries in Scotland’. Duncan lectured on medical policing and had formed the habit of giving instruction to students using live cases from the local poor early in his teaching career. He was influenced in founding the dispensary by German principles of public health. Along with the Aldersgate Street Dispensary (1771) and the Westminster Dispensary (1776) – both in London –, the ERPD was one of a handful of dispensaries found in medical towns in Britain in the 1770s with a view to providing opportunity for the practical clinical training of medical students.⁵⁴

In being granted its Royal Warrant in 1834, the role of home visitation was made central to the work of the dispensary. Regulations made clear that anyone ‘whose illness does not confine them to the house’ was expected to attend at the dispensary. However, those requiring treatment at home were duly visited. First visits to a new case was normally arranged for the same day initial contact was made, in line with poor law visitation standards; this was providing addresses and details were supplied early enough in the day to the dispensary apothecary. To qualify for treatment at ERPD, for much of the nineteenth century, a letter of commendation was needed from subscriber or ‘minister or elder of the Parish in which he or she resides’ confirming that ‘the individual is unable to pay for medicine, and a proper object to receive

⁵³ John Wilkinson, *The Coogate Doctors* (Edinburgh: Edinburgh Medical Missionary Society, 1991), p. 22.

⁵⁴ Sir Zachary Cope, ‘The influence of the free dispensaries upon medical education’, in *Medical History*, 13.1 (1969), pp. 29-30; On the ERPD see also W.S. Craig, *History of the Royal College of Physicians of Edinburgh* (Oxford: Blackwell Scientific, 1976), p. 499; Richard Scott, ‘Edinburgh and general practice,’ in Gordon McLachlan (ed.), *Medical Education and Medical Care, a Scottish-American Symposium* (London: O.U.P., 1977); David Hamilton, *The Healers: A History of Medicine in Scotland* (1981) (republished Edinburgh: Canongate, 2003), p. 107; and Sir John Brotherston and Dr John Brims, ‘Introduction’ in Gordon McLachlan (ed.), *Improving the Common Weal: Aspects of Scottish Health Services 1900-1984* (Edinburgh University Press, 1987), p. 9. Duncan also found Leith Dispensary in 1816.

medicine... gratis.' Subscriber lines appeased charity sponsors and were a method of ensuring a balance between social and medical interests. The two 'managers ex officio' of ERPD were the presidents of the Royal College of Physicians and of the Royal College of Surgeons in Edinburgh. The tie to the colleges was strong. All medical officers appointed were expected to be fellows of one or either body. All appointments were honorary, and time was given gratuitously. Unlike the managers, practitioners employed by the ERPD were not allowed to hold appointments at other dispensaries during tenure. With its close ties to the town hall and to the royal colleges - and therefore to the elite of the medical establishment of the town - ERPD remained at the centre of the network of free dispensaries in the city.⁵⁵ In 1898, the chairman claimed 'he knew of no class which contributed so greatly to the charity of the city as the doctors, and that [the] dispensary had in its service the very best surgeons and physicians that the Edinburgh Medical School had produced. These gentlemen gave their services gratuitously and ungrudgingly...'.⁵⁶ Thus the medical staff of the ERPD belie any notion that all charity dispensary staff was second rate.

Despite its establishment ties, ERPD was one of the first medical institutions in Edinburgh to open its doors to female medical students.⁵⁷ It was also amongst only two charity dispensaries in Edinburgh before 1911 not to introduce charges on the poor. Gradually, penny fees for medicines became the norm at the dispensaries, with the exception of ERPD and the Edinburgh Medical Missionary Society Dispensary. Charging remained limited as it had both practical and pragmatic restrictions. There was an obvious limit to the expectation that poor people could pay. Also, if they wish avoid payment of assessed rates levied on businesses in the city, Edinburgh's dispensaries also needed to make sure they continued to comply with the conditions imposed for exemption as a charity: that is, that they provided relief for persons of all religious faiths, and that they *mostly* provided relief gratuitously.⁵⁸

⁵⁵ ERPD Royal Warrant, ECA ref: SL73/1/1: the Lord Provost of Edinburgh was automatically made a manager of both ERPD and ENT. Per *The Scotsman* (29 Jan, 1906), p. 6: 'it was not generally known that the medical officers of the Dispensary must, according to the charter, be men of the highest professional standing.'

⁵⁶ *The Scotsman* (31 Jan, 1898), p. 6.

⁵⁷ *The Scotsman* (24 May, 1870), p. 2.

⁵⁸ *The Scotsman* (17 Feb, 1906), p.8: to claim exemption, a charity had to show that they provided relief gratuitously, or that they mostly provided relief gratuitously. Institutions that either used their premises to make profit or trade, or that charged patients at rates beyond the cost of "keep" were not exempt from payment of rates. Neither were charities that were 'restricted to members of a particular

The patients attending at ERPD for non-vaccination purposes each year, per reports, varied in total number from between 5,000 and 8,000 between 1875 and 1911. The number of patients visited at home rose over the period, and rose too as a percentage of total workload, from an average per annum of 1,973 cases (or 22.8% of all dispensary cases excluding vaccination cases) in the 1870s, to an average of 2,620 cases per year (or 49.4% of all dispensary cases) in the 1900s. Midwifery cases attended to at home between 1870 and 1910 ranged from 100 to 300 per year (or 10% of total domiciliary cases) (Table 3.6).

Table 3.6: ERPD annual average patient cases, 1870s to 1900s.

ERPD Av. For:	General visited	Midwifery Visited	Av. total visited	Dispensary patients	vaccinations	Av. Total patients
1870s	1720	250	1973	6646	approx. 2000	10954
1880s	1802	170	1963	6438	approx. 500	8653
1890s	2216	165	2200	5794	approx. 500	9233
1900s	2509	110	2620	5300	-	7937

Source: Annual Report data as published in *The Scotsman*.

The sustained importance of home visitation of the poor is clear. For the directors and managers of the ERPD, home visitation of the sick-poor served two main medical functions. Visits were a way in which to provide an outreach service, enabling the institution to get at and treat those poor whose condition prevented them for attending at the dispensary. Visits also served as an infectious disease detection and prevention service. Thus the busiest year in terms of home visits at ERPD was 1891. This coincided with an influenza epidemic in the city, a direct consequence of which: ‘[the] number of cases visited at their own homes exceeded by about a thousand that of any previous year’.⁵⁹

Although the number of repeat visits paid to each patient is not stated and would have varied by case, in 1887, Secretary, Mr R.C. Gray, S.S.C., claimed: ‘patients may attend for weeks at the dispensary, or may have a dozen or more visits paid to them at their homes’.⁶⁰ This level of prospective repeat visitation was reiterated at annual

sect’: for this reason, medical charity institutions were often keen to stress their ecumenicalism. Only one Edinburgh charity that applied for exemption from payment of rates failed the test of sectarianism in 1906. That charity was the St. Teresa Catholic Orphanage for Girls.

⁵⁹ ERPD Annual Report detailed in *The Scotsman* (1st Feb., 1892), p. 6.

⁶⁰ *The Scotsman* (31st Jan., 1887), p. 6.

meetings held in both 1897 and 1903.⁶¹ Such statements at face value suggest that in excess of 10,000 actual visits were paid by staff and students of the ERPD each year. In 1889, the medical officer's report - presented at the annual meeting that year by Dr Melville Dunlop - reinforced the impression that the dispensary staff and students were active re-visitors of cases. Dunlop claimed that the sick poor visited were, in each case, always 'attended to until convalescence had been established'.⁶²

Located across the bridge from the old town and deliberately set at a distance from the main hub of medical institutions, the New Town Dispensary (ENTD) was instituted in 1815. This was to an important year for the expansion of medical services into the peripheries of the expanding city, with the establishment in Leith, also in 1815, of the Humane Society Dispensary (later renamed Leith Hospital). ENTD, its directors claimed, was found to meet growing demand from the poor spilling out into districts around the expanding *new town area* of Edinburgh, and more particularly in 'the closes of the northside of the of the High Street and Canongate, St James Square and Street, Greenside, Canonmills, Waters of Leith, and Stockbridge'.⁶³ The new town area of Edinburgh had undergone prime suburban residential development from the late eighteenth century, as the city began to outgrow its old walled limits.

Patient numbers at ENTD rose quickly after 1815, and home visitation was from the beginning held at the foremost service offered by the medical staff. Drs Blair Cunynghame and Thomas Graham Weir, secretary in 1873 and 1877 respectively, thus claimed 'it is from carrying out this system of home visitation, by which the most destitute can at all times procure skilful medical advice, that the managers mainly attribute the high place which the dispensary has [among Edinburgh charities];' and that home visiting was 'the most important organisation of the institution'.⁶⁴

From the 1850s to the 1870s, cases visited at home were around one in three of all individual cases treated by the dispensary. This proportion fell but slightly, to around one case in four thereafter into the 1900s. From 1875 until the end of the 1890s total

⁶¹ *The Scotsman* (1st Feb., 1897), p. 6, and (2nd Feb., 1903), p. 6.

⁶² *The Scotsman* (28th Jan., 1889), p. 6.

⁶³ James Crauford Dunlop, M.D., evidence to RC Poor Laws and Relief of Distress (PP Cd.4978, 1910), appendix XLVII.

⁶⁴ ENTD Annual Report (1873), p. 2, and (1877), p. 2.

patients treated by the ENT D ranged between 8,000 and 11,000 per annum. Total domiciliary cases ranged between 1,800 and 2,800. The number of midwifery cases typically (as at the ERPD) accounted for around one-tenth of the home visitation cases. Facing economic hardships, after 1897 the number of cases treated each year was allowed to fall away. During the 1900s, therefore, the ENT D was overtaken by the ERPD in terms of annual domiciliary cases: on average at the ENT D there were just 1,463 general domiciliary cases, 182 midwifery cases, and 5,238 dispensary cases during this decade. Average cases per decade are summarised below (Table 3.7)

Table 3.7: ENT D annual average patient cases, 1870s to 1900s.

ENT D Av. For:	General visited	Midwifery visited	Av. total visited	Dispensary patients	Av. Total Patients	Ratio disp. To home cases
1870s	3112	272	3384	7795	10879	2.3 : 1
1880s	2130	289	2493	7175	9509	2.9 : 1
1890s	2010	204	2225	6934	9147	3.1 : 1
1900s	1463	182	1644	5238	6882	3.2 : 1

Source: Annual Reports.

Although its services remained aimed at the non-pauper poor or those considered unable to pay for medical treatment, from 1880, ‘in accordance,’ it stated, ‘with the example of similar institutions,’ and faced with mounting economic difficulties, the managers of ENT D opted to levy a charge of ‘the small sum of one penny for each subscription... [on] all who are willing to give it.’⁶⁵ In the first full year that the levy was introduced £55, 5s, was raised. This was 17.1% of total income.⁶⁶ After 1880 and through to 1911, around £70 to £75 was collected each year from the patients in various ways. This was a small but significant sum, for the dispensary operated on ordinary annual receipts of £300-£500 during this time. For example, in 1892 ENT D reported total subscriptions of £415 5s 4½d which included £40 14s 10½d from boxes placed amongst patients in the dispensary, £35 0s 4d from the prescription box, and £5 16s from a street collection box. Not all patients were equally thankful to the institution or were equally willing to give. Accumulated pennies in boxes on premises created security risks. In 1885, the medical secretary, Dr Dunsmure, noted wryly in his address to the gathered directors and subscribers that a collection box containing three months’ worth of collections was stolen from the dispensary, ‘carried off by a

⁶⁵ ENT D Annual Report (1880), p. 3. Per ENT D Annual Report (1868), p. 1, focus was on those who could not otherwise have secured ‘the comforts of medical attendance and personal advice’.

⁶⁶ *The Scotsman* (4 Mar, 1882), p. 9.

patient in the agony of a toothache.⁶⁷ Unusually, for many years during the nineteenth century, the collection of subscriptions by the ENT D was carried out by a dedicated collector working to a commission rather than by female volunteers: collection of charity subscriptions was a frontier in shifting attitudes from amateurism and towards professionalism affecting all aspects of late-Victorian social life.

The ERPD and ENT D were prestigious medical dispensaries and amongst the better-supported institutions in the town. Despite the fact that legacies, donations and bequests substantially boosted the balance sheet in good years, margins and monies for medicines were always tight at both of Edinburgh's main two charity dispensaries. It was in terms of the quality of medicines dispensed rather than the medical advice offered that managers of these charities therefore might have admitted that what was provided the sick-poor fell below what might be hoped for. In 1870, the medical officers employed at ENT D were openly advised by their managers to 'economize in the expenditure of drugs to the utmost'. Medical officers of the ERPD were likewise warned that: 'the prescriptions of pupils must be signed with the name of the pupil and made with strict regard to economy'. Edinburgh's students were thus trained to economise.⁶⁸ The poor law public services were evidently not uniquely bound by the limitations of finance in terms of the quality of service they were able to offer.

The Edinburgh Provident Dispensary on Marshall Street opened in May 1878. Thereafter, the balance sheet dictated the type of service provided. Finding virtue in necessity, its directors sought to overcome potential financing difficulties involved in establishing a new charity venture during a period of recession by opting to charge all patients, from the first, penny fees for medicines. Ever creative, additional revenues were generated by opting to charge students for the opportunity to study cases. Directors also took maximum advantage of the bounty scheme offered by the city for reporting infectious disease cases. By levying nominal contributions towards cost of medicine, the dispensary was not therefore a strictly provident institution of a kind that might encourage prospective patients to make provision for prospective sickness *in advance*. The label 'provident' was instead used to signify a commitment to the efficacy of promoting self-sufficiency amongst the labouring classes. The dispensary

⁶⁷ *The Scotsman* (8 Mar, 1886), p. 4.

⁶⁸ ENT D Annual Report (1871), p. 2; ERPD Royal Warrant, ECA ref: SL73/1/1.

directors' were able to claim that it catered for a class of poor persons a cut above the 'merely charitable aid' seekers, re-categorising the poor into three sets: paupers, who required public charity; the dependent poor, who required private charity; and the staunchly independent poor, who preferred [sic!] provident assistance.⁶⁹

Attached to the dispensary, and closely associated with it, was a School of Medicine and Pharmacy. This was opened at the end of 1881. It offered medical students throughout Edinburgh added opportunities to catch-up or make headway in studies. It carved a niche by providing summer sessions of classes. By May 1883 it advertised classes and practical experience in midwifery; practical and sanitary chemistry; materia medica and pharmacy; botany; preliminary medical and pharmaceutical examinations; plus outdoor practice; practical midwifery; practical materia medica; and physical and surgical diagnosis. Operating within the Edinburgh medical school system, the directors pointed out that 'these classes qualify for Universities and all Licensing Boards'.⁷⁰ By the late 1880s, the School of Medicine and Pharmacy also offered a full medical training course, with in-house diploma award, for would-be nursing staff. Nursing the Edinburgh poor was sold to prospective career nurses as a stepping-stone to better position. Thus, in January 1887, the small advertisements in *the Scotsman* carried notice that the dispensary was currently offering a full one-year training course for 'lady-nurses for [future] home and London service'. The fees for the one-year course were given as £16, 16s, with board at 15s per week.⁷¹

The Edinburgh Provident Dispensary recorded the second highest number of visits most years before 1911 amongst all Edinburgh general medical dispensaries. A multi-purpose establishment, it declared that its objective was not only to provide medical assistance to the poor but at the same time to provide the city with a needed medical training institution; to provide a unique providential service to encouraged the poor in the ethos of self-help; to provide a public health surveillance service; and to provide a

⁶⁹ R. Urquhart, Edinburgh Provident Dispensary Secretary, quoted in *The Scotsman* (28 Dec, 1883), p. 4: "There is a yearly increase of patients who seek advice at this institution, of a class who would not *under any circumstances* [sic!] seek merely charitable aid or be classified as paupers. We believe we are thus reaching a class which probably might be otherwise neglected.' See also Rev. Robert Henderson, *The Scotsman* (28 Dec, 1888), p. 4. In *The Scotsman* (20 Nov, 1897), p. 8., Edinburgh Provident Dispensary director, Rev. Hugh Black, held that this 'providential' spirit chimed with what he called 'the spirit of Scottish independence which was so dear to their people'

⁷⁰ *The Scotsman* (31 Mar, 1881), p. 4, and (2 May, 1883), p. 1.

⁷¹ *The Scotsman* (3 Feb, 1886), p. 1, and (1 Jan, 1887), p. 1.

highly localised medical service. The dispensary was deliberately targeted on what it identified to be the formerly un-served and 'crowded' Newington area, to the south of the main city centre, and therefore (again) at a suitable distance from previously established institutions. As a self-declared provident institution, the charity dispensary came to benefit from much on-going support from the local clerical community. It was therefore seen, and sold itself, very much as a Christian organisation.

Perhaps due in part to the fact it lacked in terms of basic facilities and medical amenities like a proper waiting room - which was only installed after the rebuilding of the dispensary buildings between 1897 and 1900 - home visits immediately became a significant part of the medical service offered. Responsibility for these visits rested with a dedicated outpatient medical officer, who supported by nursing staff, and by students. One-third or more of all cases that passed through the books of the dispensary were treated at home, and typically 2,000-2,500 domiciliary cases were handled each year. As at the ERPD and ENTID midwifery cases in most years accounted for 5% to 10% of total domiciliary cases treated, numbering 150 to 350 cases per year before 1911. In the first full year of operation, during 1880, when domiciliary cases accounted for over 60% of all cases, midwifery cases reached a high of 555 (equating to 13% of all cases treated).⁷² Reported data suggests that each domiciliary case saw the patient visited, on average, three to four times. In comparison each dispensary case was said to have resulted in two to three consultations each. In recognition of the especial hard work involved in conducting home visits incentives were devised. Annually, from 1883, the student who singularly visited the most patients at home during each year was presented a silver medal.

Like the Edinburgh Provident Dispensary, the Edinburgh Provident Dispensary for Women and Children was also established in 1878. The two institutions were independent. The Woman and Children's Dispensary was founded by Sophia Jex-Blake. It was designed to serve as an outlet for women to practice medicine and be provided with an opportunity to train. Unlike the Edinburgh Provident Dispensary, the Jex-Blake dispensary was more legitimately a provident enterprise. Tickets enabling treatment had to be purchased before hand; and levels of access to treatment when and

⁷² *The Scotsman* (18 Dec, 1880), p. 6.

where subsequently needed depended on the price that had been paid. It also provided home visits along the standard Edinburgh model (of a student-led service). Unlike other dispensaries, however, this was never meant as an exclusive service for the poor. With initial costs set at ‘three pence for medicines required at each visit,’ charges would have been prohibitive. By 1902, the restyled Hospital and Dispensary for Women and Children had a breakdown of 18 (12.5%) private patients, 82 (56.9%) provident patients, and just 44 (or 30.6%) treated entirely gratuitously that year.

Last amongst the identified network of four main general charity dispensaries providing visitation services to the poor in Edinburgh was one established in the Fountainbridge area and that was originally found in 1870. Reflecting its geographic location, it became known as Edinburgh’s Western Dispensary (and Chalmer’s Institute) in 1875. By 1890, now based at Ponton Street Hall, it had become a major training site for medical students, particularly those engaged in fulfilling qualification criteria of six month’s dispensary practice. As at other dispensaries mentioned, it also provided training for nurses. The Edinburgh Training Institution for Sick Nurses provided the dispensary with a steady stream of trainees, who were advised in the early 1870s that after four years’ training a salary of £30 per annum could be expected. Interestingly, the Western Dispensary training facilities were also made available to any other private individual willing to meet the cost of a guinea per week.

Patients visited at home by staff and students of the Western Dispensary rose over the decades at the end of the nineteenth century, from around 600 in 1875, to 1,200-1,500 annually in the 1880s and 1890s. Altogether, from one-third to one-quarter of all patients treated were visited at home. Per the annual report in 1884, ‘5,000 patients had received treatment, over 1,200 had been visited at their own homes, 505 children had been vaccinated, and a considerable number of patients had been treated in a special department of the throat and ear, diseases of women, &c.’ Medical staff at this time included Dr Diarmid Noel Paton as assistant physician. Paton was later to succeed to the Chair of Physiology at Glasgow University in 1906. Lending support to the controversial Anderston dispensary project on arrival in Glasgow, Paton helped link the culture of charity services in the two cities.⁷³ As with the Provident

⁷³ *The Scotsman* (29 Nov, 1884), p. 6.

Dispensary, the managers of the Western made much of what they claimed were attempts to restrict the service the genuinely poor, advising that ‘*special care* had been taken to avoid abuse of the charity by those not fairly entitled to its benefits.’⁷⁴

Though in a measure overshadowed by the Royal Infirmary, the Leith hospital has done a large amount of valuable work among the sick poor of the port, not the least part of which is included in the line of operations not undertaken by the Edinburgh institution – the visiting and prescribing for the sick at their own homes by one of the medical staff and a trained nurse.⁷⁵

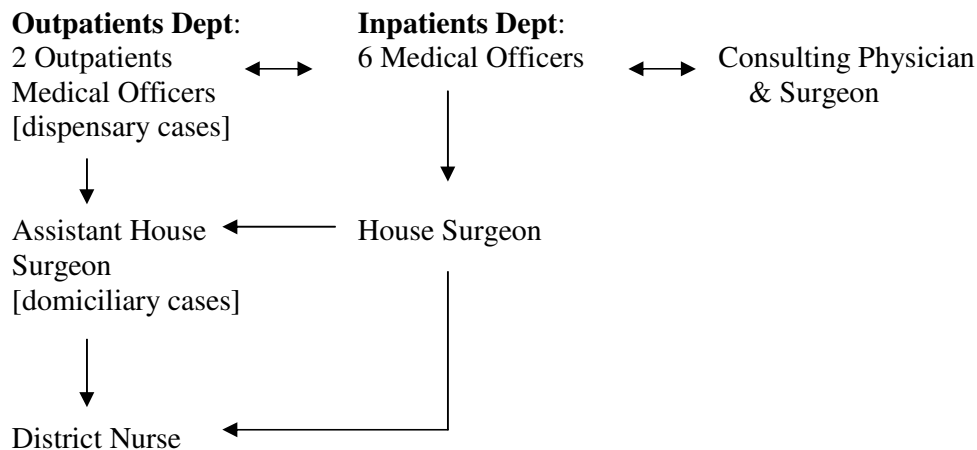
The origins of Leith Hospital – or Edinburgh and Leith Humane Society, Dispensary, & Casualty Hospital – lay with the Edinburgh and Leith branches of the London Humane Society which united to found a Dispensary in 1815. The dispensary reopened as a Casualty Hospital in 1837. The Hospital premises were then re-equipped and modernised in 1887, and the venture eventually became a joint-stock company known as Leith Hospital (Incorporated) in 1907. Although not unique in a Scottish context, the directors of Leith Hospital saw home visitation to be the thing that fundamentally set it apart as a hospital institution in Edinburgh. Per guidelines published in 1891: ‘Patients whose cases admit of their leaving home receive advice and medicines at the Hospital every day (Sunday excepted) at twelve o’clock; and all who cannot attend are visited by the Assistant Surgeon, and in cases of urgency by one of the members of the Medical Committee.’⁷⁶ As the quote (above) highlights, it was in the deployment of a salaried assistant house surgeon dedicated to the task of visiting that the service most differed; the assistant house surgeon was employed on a single year contract as junior staff member. That amongst medical staff only the house surgeon, the assistant house surgeon engaged to visit patients, the superintendent of the institution, and the district nurse were salaried, is testimony to the arduous nature of visitation. The organisation of domiciliary work within the staffing structure of Leith Hospital is shown below (Figure 3.2).

⁷⁴ *The Scotsman* (20 Feb, 1890), p. 4.

⁷⁵ *The Scotsman* (3rd May, 1887), p. 3.

⁷⁶ Leith Hospital Annual Report (1891). Leith Hospital Annual Reports, 1890-1903, and *The Story of Leith Hospital* (Leith: 1896) are bound as one volume in the Lothian Health Services Archives (LHSA), ref: LHB6/2/79.

Figure 3.2: Leith Hospital staffing structure circa 1886:



Average daily visitation workloads varied over time but were generally relentless. Leith Hospital witnessed and accommodated a high turnover for the position of assistant house surgeon as a result. In the 1880s and 1890s, typically, the surgeon in situ was expected to make ten to twenty home visits each day. Thus in September 1886, during the quietest month of his employment, Robert Beveridge was called upon to make 270 domiciliary visits: three months earlier, during June, he had made 452 visits. During the winter months of 1891, recent graduate, James McCall Morrison, made an average of 17 domiciliary visits every day. The role got harder. By the mid-1900s the workload had doubled from what it was twenty years earlier. In the difficult economic years of 1904 and 1905, the assistant house surgeon was called upon to make a prodigious round of 51 and 42 visits per day respectively. This was equivalent at a standard rate of twenty minutes per visit over a six day week of between thirteen and seventeen work hours everyday. In total, to March 1905, 9,541 new cases visited were reported for the previous year.⁷⁷ As with the decision by some of Edinburgh's medical charities to charge patients, the decision to make home visitation responsibilities a form of paid professional employment instead of a student-led or honorary appointment service was necessity made virtue. In the 1880s the directors had discussed the idea of expanding the institution to become a fully-fledged teaching hospital. Spotting a gap in the educational market, it opened a female medical school in 1887, taking students from the newly established Jex-Blake

⁷⁷ George Donald, M.D., *RC Poor Laws and Relief of Distress* (Cd.4978), Appendix XLIII. Number of cases also reported in *The Scotsman* (4 Mar, 1905), p. 8.

Edinburgh School of Medicine for Women. This decision was influenced by the idea that it would be easier to attract better female medical students – with fewer alternatives open to them – to what was otherwise a geographic outpost of the Edinburgh medical educational establishment.⁷⁸

Average annual cases treated by Leith Hospital are given (Table 3.8). The population of Leith between the late 1870s and 1911 was between 50,000 and 80,000. Although the number of cases visited by the hospital's district nurse was fewer than visited by the assistant house surgeon, these were cases that required multiple visits during treatment and convalescence. From 1866, when appointed as the first district nurse to the hospital, until replacement due to ill health in 1887, Mrs Jane Brown recorded 8,000-13,000 nursing visits per year. Some patients were visited daily over many months: in 1876, for example, one patient was visited a recorded 309 times.⁷⁹

Table 3.8: Leith Hospital annual average patient cases, 1870s to 1900s.

Leith cases:	Admitted	Dispensary	Domiciliary	Nursing home cases	total cases
Mid-1870s	371	4719	1820	201	7111
Mid-1880s	660	7340	3972	382	12354
Av. For 1894-6	896	9998	4470	348	15712
Est. Mid-1900s	1200	12000	7161	350?	20711

Source: Annual Reports.

Leith Hospital was supported by a mix of public and private initiative. Although run as a voluntary charity, it worked closely with the sanitary and policing services of the port town. The Town Council in Leith contributed funds, and in return medical staff was expected to treat both 'police cases' and 'fever cases'. Co-ordination with the police was further strengthened due to the fact that most medical visitations amongst the sick-poor were carried on in what was most commonly regarded as the most criminal parts of the town.⁸⁰ For the assistant house surgeon, visits to the homes of Leith's poor provided both familiar and unique elements. In 1869 it was noted by the

⁷⁸ Per *The Scotsman* (21 Feb, 1885), p. 6.

⁷⁹ Leith Hospital Annual Report (1876), LHAS ref: LHB6/2/8.

⁸⁰ Leith Hospital Annual Report (1869), LHAS ref: LHB6/2/1: Provost Watt, presiding over the annual meeting, commented on having visited the homes of the poor in the company of Leith Hospital Medical Officer, Dr J. Struthers. These were homes that had been otherwise condemned as uninhabitable by the sanitary authorities. Watt commented (p. 5): 'he was quite horrified to see some of these dwellings, which were not fit for the habitation of lower animals... the districts he referred to did not only furnish the largest number of fever patients to the hospital, but they were also a great nursery for crime.'

medical officer in charge, in a common refrain, that ‘these poor people had often only one room, they had no other place to go’. More uniquely, the vice president of the hospital, Professor James Harper, noted that the peculiar character of Leith, as a seafaring town, meant many foreign inhabitants taken ill in the town also sought treatment. The government contributed funds towards medical care for naval patients.⁸¹ It was claimed that the large amount of domiciliary cases was contingent on the peculiar working life of Leith. As a ‘large and populous’ port community, both accidents and infectious disease outbreaks were more than ordinarily common.⁸² Visitation provided the town a vital method for restricting the spread of infectious diseases and was hailed as ‘the essence of a successful fever and general hospital.’⁸³

‘The fact that Leith Hospital has always on its staff a Resident Doctor, whose sole duty it is to visit out-door cases, greatly facilitates the working of the whole Dispensary Department. It is thus possible for the medical staff to follow up the further course of cases seen at the Dispensary consultations, which require treatment at home. As his work lies chiefly among those who are unable to pay for a regular medical attendant, and who live in conditions under which infectious diseases are most apt to arise, it is often in his power by the early isolation of such cases to prevent the occurrence or reduce the virulence of epidemics in the community at large.’⁸⁴

As well as receiving visits by medical staff, all patients of Leith Hospital were also routinely visited by local clergy, to make sure that all cases were ‘thoroughly entitled to receive the medicine gratis.’⁸⁵ Flexibility was necessary in the difficult work:

I know that objection is taken to this part of the work... But I do not forget, and we must not forget, that there is a very great difficulty encountered in work of this kind; and we cannot lay down hard and fast lines on which to conduct it, but be prepared to either give or take...⁸⁶

The particular difficulty encountered in establishing the poverty credentials of patients – alluded to above - was held as the justification for the abandon home visitation by the Edinburgh Royal Hospital for Sick Children (ERHSC). ERHSC, found in 1859, had seen 15.9% of cases in the patient’s home in 1875. With more and more coming

⁸¹ Leith Hospital Annual Report (1869), LHASA ref: LHB6/2/1.

⁸² Rev. Mr David Thorburn, South Leith Free Church, in Leith Hospital Annual Report (1877), LHASA ref: LHB6/2/9: ‘Leith Hospital was one of our most valuable local institutions; that it had rendered important services to the community in the way of curing diseases and preventing their spread, in cases of submersion and those numerous accidents to which in a seaport and manufacturing town they were peculiarly liable...’

⁸³ Leith Hospital Annual Report (1878), LHASA ref: LHB6/2/10.

⁸⁴ The Story of Leith Hospital, p. 27.

⁸⁵ Leith Hospital Annual Report (1878), LHASA ref: LHB6/2/10.

⁸⁶ Rev. James Stevenson, Leith Hospital Annual Report (1884), LHASA ref: LHB6/2/16.

into Edinburgh from outside to access the charity, this proportion dropped to 6% in the next three years. At the annual meeting of directors in January 1879, the impact on revenue of the collapse of the City of Glasgow Bank was the key topic of conversation. As with other medical charities a 'dark cloud of adversity' hung over proceedings, caused both by a reduction in subscriptions and a sizeable increase in demand. Home visits, already gradually being reduced in order to concentrate resources on the faster throughput services of the dispensary, became a direct casualty of the depressed economy. Whereas at the annual meeting in 1870, it had been argued of providing treatment at home that 'it was only by going to their dwellings and seeing how they were lodged that one could form a correct idea of their condition,'⁸⁷ nine years later directors operating in a different economic climate claimed instead:

The system of visiting patients at their own homes was not working satisfactorily, as many took advantage of it who were not in need of gratuitous advice.⁸⁸

Before the decision was taken to abandon the domiciliary service, there was also indication that the directors of ERHSC had come to believe that the homes of the poor provided neither a safe nor healthy environment for a sick child to convalesce. Thus in 1878 they had struck a deal with 'a family in Corstorphine' to receive and care for convalescing patients. Here, a local medical practitioner visited the children instead.⁸⁹

Types of diseases treated:

Generally scant record survives about individual cases treated in the home by different charity dispensaries. Few accounts go beyond generic statements about treatments offered. Most simply indicate that different organisations normally deployed practitioners to act in a manner consistent to how they would in regular private practice. Like the poor law medical officers, charity doctors were expected to treat an array of complaints. A breakdown of domiciliary cases undertaken by Leith Hospital is available for 1869. Of 1,756 cases visited that year, 384 were fever cases (including 174 measles cases); 91 cases of rheumatism; 66 for diseases of the nervous system; 377 for diseases of the digestive system (with 94 for diarrhoea and 82 for dyspepsia); 391 were respiratory cases; 102 for genitourinary problems (including 48

⁸⁷ *The Scotsman* (22 Jan, 1870), p. 7.

⁸⁸ *The Scotsman* (31 Jan, 1879), p. 4.

⁸⁹ See *The Scotsman* (31 Jan, 1879), p. 4.

for ‘uterus and passages’); 105 for skin conditions, burns, ulcers and abscesses; and 79 for wounds, bruises and sprains.⁹⁰ This can be compared to the workload of John Tod as assistant house surgeon, in 1884, fifteen years later (Table 3.9).

Table 3.9: Breakdown of domiciliary cases attended by John Tod, assistant house surgeon of Leith Hospital, during 1884.

	cases visited
Alimentary system	1073
Respiratory	925
Circulatory	58
Nervous	123
Genito-Urinary	97
Integumentary	138
Constitutional States	414
Zymotic Diseases	503
Surgical Affections	446
Miscellaneous	65
Total cases	3842

Source: Leith Hospital Annual Report (1884).

Most common were alimentary afflictions - dyspepsia, diarrhoea, stomach and gastric complaints - and respiratory problems - including catarrh, bronchial, and phthisical conditions, and pneumonia. Tod carried out 446 surgical procedures in the homes of the poor during 1884 (equivalent to more than one a day). Like a succession of men appointed to the task during the 1880s and 1890s, Tod had been appointed by Leith hospital within months of graduation from Edinburgh University. Whilst Leith Hospital differed from charity dispensaries in not actually employing students for visits, by employing newly licensed graduates, it was utilising men who were, in actuality, little more experienced than the senior medical students deployed elsewhere in Edinburgh’s dispensaries. In actuality, as yet unlicensed senior students were little removed from freshly graduated cohorts. The surgeons were therefore significantly less experienced than those appointed to carry out similar work under the poor law. In the appointment of graduates to undertake its visitation duties Leith Hospital was not unique: ERMH likewise employed graduates as visiting surgeons.⁹¹ Enthusiasm was essential for this line of medical work, and to some extent energy counteracted the drawback of a lack of experience. The visitation experiences gained served Tod well; for his next appointment was at Glasgow Maternity Hospital.

⁹⁰ Leith Hospital Annual Report (1869), LHS ref: LHB6/2/1.

⁹¹ Edinburgh Royal Maternity Hospital records, LHS ref: LHB3/18.

Table 3.10: Cases attended to by medical officers of ENT D, 1877-1902 (dispensary and domiciliary cases).

Type of case:	1877	1882	1887	1892	1897	1902
Consumption, & Diseases of the Respiratory Organs	2370	1506	1338	676	797	727
Diseases of...						
Digestive System	2555	1079	1356	631	836	794
Heart & Blood Vessels	427	346	133	328	327	254
Nervous System	209	580	277	126	259	243
Genito-Urinary System	635	680	436	127	436	297
Cutaneous System	903	666	485	362	327	201
Bones, Joints, Glands, Wounds	474	776	563	491	385	189
Rheumatic Afflictions	560	256	267	211	429	449
Fevers, etc	69	-	-	-	-	-
General (not categorised)	935	1659	1875	1447	1576	1245
Vaccinations	1204	1193	1030	979	563	329
Midwifery	308	389	242	231	255	170
Ear and Throat Cases	356	332	258	416	259	631
Eye Cases	43	168	173	245	420	336
Diseases of Women	-	-	416	194	205	140
Diseases of Children	-	-	-	1020	827	423
Surgical Dept.	-	-	-	-	308	293
Teeth Extractions	389	456	578	725	1032	134
TOTAL	11437	10086	9427	8209	9241	6855
% Visited at home	17.7%	23.3%	23.4%	23.4%	21.8%	18.6%

Source: Annual Reports.

Whilst dispensary and domiciliary cases are mixed together, ENT D reports also give an indication of the range of work undertaken in the homes of Edinburgh's poor by Edinburgh's dispensary charities (Table 3.10). Consumption and respiratory diseases, as well as diseases of the digestive system, figure highly. ENT D annual reports show that caseloads and case types treated by medical staff altered over time. Most significant were changes as a consequence of new specialist departments are introduced. Through the changes, teeth extractions and vaccination work remain important. Only for 1874 does the ENT D give separate details of cases treated specifically at home as distinct from at the dispensary. In this year it was forms of chest disease that were most prominent amongst domiciliary cases. The majority of what are collectively categorised as 'zymotic' diseases or 'abdomen diseases' were also seen at home rather than at the dispensary. During 1874, 59 unspecified surgical procedures (equivalent to 11.0% of all surgical cases) were also carried out in the homes of the poor rather than at the dispensary.

3.3 Glasgow's outdoor medical charity services

In Glasgow, the network of outdoor charity and medical provision was vast, with hundreds of different charity institutions at work in the city by the end of the nineteenth century.⁹² The pattern of development of domiciliary medical services was, however, very different to that in Edinburgh. This is clearly shown by a comparison of patient numbers previously presented (Tables 3.3, 3.4). The difference between Edinburgh and Glasgow in this matter was clear to contemporaries. In a speech in December 1883, for example, qualified medical man and Glasgow M.P., Charles Cameron, drew the comparison:

On inquiry... into the matter he [Cameron] ascertained that in Edinburgh a system of dispensaries had long prevailed, in connection with which there was a staff of physicians and students, who visited the sick poor, when requested, in their own homes.

...Now he had often advocated the adoption of a similar system in Glasgow... without any success.⁹³

Whilst dispensary and outpatient services were extensive (Table 3.11), as MOH James Burn Russell's study of uncertified deaths had detailed, for most of the period from the 1870s to 1911 very few, non-midwifery, poor patient cases were visited at home in Glasgow, unless by poor law doctors, or by medical missions. A few hundred a year did receive some sort of medical-complaint related home visit, but not from the dedicated medical charities. These visits came instead as an offshoot of the work of broader poverty charities like the COS, or the St. Vincent de Paul Society.⁹⁴

⁹² On the range of medical charitable work in Glasgow see the still in-exhaustive handbooks of Glasgow charity produced by the COS: *Handbook of the Glasgow Charities* (Glasgow: Charity Organisation Association, 1876); *Handbook of the Glasgow Charities* (Glasgow: Charity Organisation, 1881); *Handbook of the Glasgow Charitable and Beneficent Institutions* (Third Edition) (Glasgow: Charity Organisation Society, 1888); and *Handbook of the Glasgow Charitable and Beneficent Institutions* (Fourth Edition) (Glasgow: Charity Organisation Society, Glasgow 1897). In 1876 the handbook detailed that 180 organisations worked amongst the sick-poor; in 1888, the number had risen to 274! By index, these included outpatients and dispensary services; benevolent societies and convalescent support agencies; mortifications; missions and medical missions; nursing and ambulatory services; medical facilitation and social improvement organisations; friendly societies and trade benevolent societies; and municipal and state agencies.

⁹³ Glasgow Medical Missionary Society Annual Report (1883), p.7.

⁹⁴ Miss Marion Rutherford, RC Poor Laws and Relief of Distress (Cd.4978), Appendix CXXI: Giving evidence, Miss Marion Rutherford, a district secretary of the COS, confirmed that the organisation were occasionally requested to supply a doctor to attend either the wife or child of an 'able-bodied man' denied parochial assistance on that basis. In the year previous to her giving evidence, Rutherford confirmed that 22 such cases had been passed to her district of the society in Glasgow, resulting in 157 visits by a COS medical officer.

Table 3.11: Breakdown of annual number of cases treated at dispensary or outpatients, by charity, in Glasgow (and Govan), mid-1870s to mid-1900s.

	circa...	mid-1870s	mid-1880s	mid-1890s	mid-1900s
outpatient services:					
	Inst.				
Glasgow Royal Infirmary	1794	15,800	22,000	22,500	45,000
Glasgow Lock Hospital	1805	-	-	-	50
Glasgow Eye Infirmary	1824	4,200	13,500	17,000	23,573
Glasgow Ophthalmic Institution	1868	3,054	3,300	3,300	8,231
Western Infirmary	1874	5,916	17,500	13,727	24,577
Samaritan Hospital for Women	1886	-	187	633	1,519
Sick Children's Hospital Disp.	1888	-	-	6,747	11,429
Victoria Inf. & Bellahouston Disp	1890	-	-	8,836	14,000
Outpatient sub total		28,970	56,487	72,743	128,379
charity dispensary:					
Glasgow Uni. Lying-In Hospital	1840(?)	unk.	-	-	-
Skin Disease Dispensary	1861	1,250	1,500	1,500	1,750
Disp. Disease Chest and Throat	1861	[1,000]	[1,000]	-	-
Hosp & Disp Diseases of Ear	1872	321	750	1,237	2,150
Glasgow Public Dispensary	1876	[1,200]	[1,200]	[1,400]	1000
Diseases Peculiar to Women	1877	-	[600]	[500]	unk.
ACD/ Glasgow Central Disp	1878	-	10,000	7,000	9,722
Glasgow Polyklinik	1885	-	2,000	[2,000]	-
Disp. for Diseases of the Spine	c. 1885	-	unk.	-	-
Glasgow Ear Institution	1887	-	-	1,150	-
Glasgow Cancer & Skin Inst	1887	-	-	[1,200]	[1,200]
Glasgow Cancer Hospital Disp	1895	-	-	unk.	unk.
Quarrier Sanatoria Dispensary	1901	-	-	-	700
G.U.S.S.S. Dispensary	1900s	-	-	-	[1,000]
ADHAD	1907	-	-	-	-
Dispensary sub total		3,771+	17,050+	15,987+	17,522+

Note: Numbers here are averages summarised in Table 3.3. Numbers in brackets represent best estimates from available sources. 'unknown' is given where data has not been found. Missing from this list are Glasgow Maternity (or Lying-In) Hospital (1834), which did not have an outpatients, only a dispensary and wards service; Glasgow Dental Hospital Dispensary (1879); Glasgow Public Homoeopathic Dispensary (operative from 1885 to c.mid-1890s) and the Homeopathic Dispensary for Glasgow (1909); neither of these homeopathic institutions was strictly charitable and for the poor.

Amongst the range of specialist charities dispensaries and infirmary outpatients (listed in Table 3.11) Glasgow's two main general charity dispensaries of the Edinburgh-type were the Glasgow Public Dispensary and Anderson's College Dispensary: both were established in the late 1870s. Anderson's closed in 1888, with Glasgow Central Dispensary found in its place in 1889. Glasgow Polyklinik, established in 1885 to provide clinical material for training purposes for the Glasgow Western Medical School, provided an additional general dispensary service, although it was short-lived. Treating a reported 2,000 cases per annum at the end of the 1880s, the Polyklinik offered free advice to patients but not free medicines. In levying a nominal charge for

medicine the Polyklinik mirrored charities like the Provident Dispensary in Edinburgh and the Public Dispensary in Glasgow that similarly ascribed to contribution evidence of social and moral veracity, measured by what they claimed was the spirit of independence amongst the poor they treated. The Polyklinik had six specialty departments, but leaves no evidence to suggest it ever conducted home visits.⁹⁵

Glasgow Public Dispensary (GPD) was Glasgow's longest-standing independent general charity dispensary. It was established in 1876 with the stated objective being the provision of free advice 'to persons in necessitous circumstances, not receiving parochial relief'.⁹⁶ It operated on the small income of around £200-£350 annually. For this, on average, each year, 2,000-3,000 consultations were conducted, and around 1,200 patients treated.⁹⁷ The dispensary had a loosely 'providential' ethos. No fixed charging system was levied but its patients, where they were deemed to be able, were expected to contribute what they could towards the cost of any medicines supplied. This proved not an insignificant source of revenue, as patient contributions were most years more substantial than subscriptions. Taking one year, during 1900, GPD received £341 18s 6d in income, and of this £232 17s 2d was 'received for medicines' by patients. In that year its medical officers treated '1663 new cases...making on average four or five attendances'.⁹⁸ Described as the 'deserving poor' in GPD literature, patients by 1909 were on average contributing a shilling a head towards the cost of treatment.⁹⁹

Surveying scant records of its work it appears that GPD planned, but do not appear to have ever offered, a medical practitioner home visitation service. In 1883, the directors of the dispensary said they had yet to establish home visits by medical staff, although they hoped to do so, if and when 'a more generous public support being

⁹⁵ Mentions of the work of Glasgow Polyklinik found in James Christie, *The medical institutions of Glasgow: a handbook, prepared for the annual meeting of the British Medical Association held in Glasgow, August 1888* (Glasgow: Maclehose, 1888), and in *the Medical Directory*.

⁹⁶ Christie, *The Medical Institutions*, pp. 139-40. See also Matthew Gemmell, *The Societies of Glasgow* (Glasgow: The Citizen Press, 1943).

⁹⁷ Per eighteen reports found between 1881-1909, GPD reported an average of av. 2,904 consultations.

⁹⁸ *The Scotsman* (30 Nov, 1900), p. 5.

⁹⁹ *The Scotsman* (15 Dec, 1909), p. 8: '1032 cases had been dealt with throughout the year, entailing 2057 consultations. The revenue from the sale of medicines was £56, 6s, 2d – an average of almost a shilling per head – and from subscriptions £47, 13s, 6d, or less than 11d per head.'

forthcoming'.¹⁰⁰ An independent claim was made in a publication in 1888 that Glasgow students were 'invited to visit patients unable to come to the [Public] Dispensary, under the supervision of one or more of the medical officers'.¹⁰¹ Despite this suggestion, made in what will be shown to be a pivotal year for home visitation services, no corroborative evidence has been found to show this scheme was ever implemented.

The establishment of Anderson's Medical College Dispensary (ACD), in May 1878, was seen as a significant moment for medical services in the city, and was given strong coverage in the press. *Glasgow Medical Journal* hailed it as 'an event of importance, both in the Medical Schools and in the medical charities of Glasgow'. The GMJ noted of ACD that in purpose, intent and organisation, it had been consciously modelled upon 'out-door dispensary practice which has for fully a century been a much-valued and attractive feature of medical education in Edinburgh'. The GMJ remarked further that the dispensary provided a service that had 'hitherto been denied to the pupils of Glasgow.' Pointing out that it was 'home work' that was its unique founding feature, the GMJ also commented that medical institutions in Scotland owed to the church extension movement that had altered the face of worship in urban areas the example of the benefits to be accrued by setting services down on the doorstep of the poor. Bringing the service direct to the poor was what the founders of the ACD said they aimed to do. Giving its guarded support for the venture, the GMJ demonstrated tact and local sensitivity by warning against the taking of trade from private practitioners in the area. The GMJ editorial stated it wished to see 'judicious oversight and careful precautions against imposition': this checking of patients became a further justification for supporting the home visits.¹⁰²

Accounting for all the recorded number of cases of non-pauper poor visited at home in Glasgow and Govan by one or other charity dispensary (Table 3.3), ACD provided visits within a tightly defined radius of the centre of the city. As with dispensaries in Edinburgh, its domiciliary work was purposely constructed to offer senior students in their final year of study the opportunity to enhance their medical training and bridge

¹⁰⁰ *The Scotsman* (6 Feb, 1883), p. 5.

¹⁰¹ Christie, *The Medical Institutions*, pp. 139-40.

¹⁰² GMJ, v. 10 (1878), pp. 270-2.

their path into subsequent medical practice. ACD student visits were supervised by a member of staff purposely appointed to serve as superintendent of the outdoor visiting department. Reflecting again the arduous nature of this line of work, this was made a paid rather than honorary position.

As an example of ad hoc interconnections between different private charitable organisations where and when mutual interests were served, directors of the ACD agreed to provide visits and medical treatment to persons 'unemployed' who were recommended to them as worthy recipients of relief by Glasgow's COS.¹⁰³

Anderson's College medical students also made home visits by agreement to pensioners on the books of the Association for the Relief of Incurables Glasgow. Glasgow practitioner James Christie described in detail, in his publication of Glasgow medical charity, the territoriality and student-led focus of ACD visitation work as it had evolved by its last year of operation, in 1888.¹⁰⁴

With the opening of Western Infirmary in 1874, and the Victoria Infirmary after 1889, Glasgow by the 1890s had a more substantial spread of charity hospital services than Edinburgh. In contrast, the only infirmary outpatient medical visitation service in Glasgow was for midwifery cases. At one of the cities oldest medical institutions, the Glasgow Eye Infirmary, home visits had once been made. Whatever its utility to the institution or to the poor, visits had ceased long before 1875.¹⁰⁵ For managers of the Glasgow Hospital and Dispensary for Diseases of the Ear, its services were just not possible in the homes of the poor:

The in-door patients consist of patients who suffer either from the more serious consequences of purulent disease of the ear, or from the more simple forms of deafness, when, owing to the destitute condition of the patients, there is no chance of the treatment being carried out satisfactorily at home.¹⁰⁶

¹⁰³ *The Scotsman* (2 Sept, 1887), p. 4.

¹⁰⁴ Christie, *The Medical Institutions*, partially quoted by Cope, *The influence of the free dispensaries*, p. 36.

¹⁰⁵ A.M. Wright Thomson, *The history of the Glasgow Eye Infirmary, 1824-1962* (Glasgow: John Smith 1963), p. 14: 'Patients were to be given free advice, surgical aids and medicines if they were recommended by a magistrate, minister or elder, or by a donor of five guineas and upwards, or by an annual subscriber... Operations were to be performed at the patient's own house and, if he were unfit to attend the Infirmary, visits were also to be paid to him at his home.'

¹⁰⁶ Christie, *The Medical Institutions*, p. 119.

Despite long-standing moral opposition, Glasgow Maternity Hospital (GMH) was found in 1834. Providing clinical teaching from 1844, it was a typically dual-purpose charity and home-visitation institution, operating both ‘in the interests of the deserving poor, and for the efficient teaching of medical students’.¹⁰⁷ Each year it had in excess of 100 medical students under training, with two-thirds to three-quarters of deliveries conducted outdoors.¹⁰⁸ All homeless women were of necessity admitted and treated indoors, although in the early years unmarried women were officially only admitted in emergencies. Difficult procedures, like caesarean section or craniotomy, were always much more likely to be carried out in the hospital than at home.¹⁰⁹ The workload of the hospital more than doubled between the mid-1870s and 1911, with 2,825 patients delivered of babies in 1908. 19,000-21,000 births annually were registered in Glasgow from 1871 to 1890, with 21,755 registered births recorded in 1911. Given these figures, staff of the GMH delivered between 5% and 15% of all children born in the city.¹¹⁰ The GMH staff included a number of specifically appointed out-door physicians who were employed to conduct visitations and to carry and organise the outdoor work. This was the most junior position filled at the hospital. Students were used as part of the service. Before any student was permitted to attend a case on their own account they were expected to have been ‘present at three cases with the out-door house surgeon’.¹¹¹

Whilst it did not provide any home visits directly, Glasgow Royal Infirmary (GRI) outpatient services did enable thousands of Glasgow’s poorer citizens to stay at home during treatment. That patients remained at home was said to directly affect the type of work that could be carried on in GRI outdoor departments. Presenting a survey of operations carried on at GRI outpatients from 1883 to 1892, senior Assistant surgeon, John Barlow, noted the connection between home-stay and medical work conducted:

For the last three years... I have operated rarely under anaesthetics at the Dispensary, and for two reasons. 1st. Owing to the number of patients seeking

¹⁰⁷ Hugh Miller, ‘History of Glasgow Maternity Hospital’ in GMJ (July 1876), pp. 429-31.

¹⁰⁸ For example, Glasgow Maternity Hospital Annual Report (Glasgow: 1895), this year the GMH had that year 112 medical students and 63 nurses listed attended for training.

¹⁰⁹ Christie, *The Medical Institutions*, p. 109: ‘It is evident, therefore, that in great part, the serious cases gravitate to the in-door department.’

¹¹⁰ For birth statistics see James Nicol, *Vital, Social, and Economic Statistics of the City of Glasgow, 1885-1891* (Glasgow: 1891), p. 48, and Registrar-General publication, *Supplement to the Monthly and Quarterly Returns of the Births, Deaths, and Marriages Registered in Scotland during the year 1911* (1912), p. xv.

¹¹¹ Christie, *The Medical Institutions*, pp. 110-11.

advice (an average of 15 new patients daily)... 2nd. The majority of the patients who came for advice were not living in healthy homes. They were poor, and badly nourished, and, in most cases, very dirty... With such surroundings a simple operation is very liable to be attended by complications, entailing worry and anxiety to the operator. For these reasons the applicants were advised to obtain permission to the wards...¹¹²

The notion that admittance to wards brought great relief to the overcrowded homes of the poor became one of the great selling points of hospital services.¹¹³

Glasgow's Victoria Infirmary (GVI), which opened in 1890, had its outpatients in West Graham Street. The outpatients of GVI became colloquially known as the "Glasgow Dispensary". Whilst the medical staff of the infirmary and dispensary did not conduct home visits, a domiciliary nursing service was established. It operated under the dispensary surgeon, James Nicoll.¹¹⁴ A second dispensary connected to the GVI opened at St James Street on Paisley Road in 1892. This again had no home visitation department. The origins of the GVI lay with the activism of south-side medical practitioners in the city. The medical service that evolved into GVI had first been mooted at a Glasgow Southern Medical Society meeting in 1866. A decade passed during which the population of the south side of Glasgow grew at a faster rate than anywhere else in Scotland, and the need for a south-side infirmary was readdressed with Dr Ebenezer Duncan's 1878 paper, published as: *'A Plea for an Hospital on the South Side of Glasgow'*.¹¹⁵ Although it failed to come to pass, per discussion surrounding Duncan's original plea published in the *Glasgow Medical Journal*, in the original plans for the infirmary a domiciliary service had been considered a central component. Indeed, Ebenezer Duncan ultimately had justified the whole south-side infirmary venture on the basis that: 'there was not in the South side any Dispensary which provided for home visits'.¹¹⁶ Why visitation was subsequently

¹¹² John Barlow, M.D., F.R.C.S., 'Statistics of Surgical Operations from 1883 to 1892' in GMJ, vol. 38 (1892), pp. 1-2.

¹¹³ Glasgow Lord Provost Chisholm, GRI annual meeting, reported in *The Scotsman* (29 Nov, 1901), p. 9: 'He always thought the relief they [the infirmary] gave to the crowded homes where otherwise they would require to lie, and for those responsible for them, permitting them to go about their usual work with comfort and success, were perhaps as great as the comfort and relief to the patients themselves'.

¹¹⁴ Per D.G. Young and R. Carachi, 'James H. Nicoll', in *Scottish Medical Journal*, 51(1) (2006), pp. 48-50: 'Over 7 decades the "Dispensary" as it was fondly known was an outpatients Department in West Graham Street. It treated a total of 750,000 patients who attended, a total of 2.7 million attendances.'

¹¹⁵ Slater and Dow, *The Victoria Infirmary*, p. 2.

¹¹⁶ GMJ (November 1878), pp. 524-8.

dropped when GVI eventually opened is unclear, although it may have been related to decisions made elsewhere at Glasgow's second infirmary at the end of the 1880s (and detailed below).

Glasgow Sick Children Hospital opened West Graham Street Dispensary in 1888. Whilst Edinburgh's equivalent children's hospital had abandoned home visitation in 1879, in Glasgow, visitation of patients was left from the first to nursing staff or 'surgical sisters,' and - as at other Glasgow institutions - to lady almoners. Sister Laura Smith paid visits to convalescing children on behalf of the institution for thirty years until 1922. Whilst domiciliary visits by the sisters ceased in 1926, one legacy of the service was a prominent commercial venture. In 1911, *The Sister Laura Infant Food Company Ltd* 'began commercial production' of a recipe directly borne out of the experience of visiting the poor.¹¹⁷

¹¹⁷ Derek A Dow, *The Dispensary of the Royal Hospital for Sick Children Glasgow: James Nicoll and the Dispensary* (brochure published in Dept. of Clinical Physics and Bio-Engineering, West of Scotland Health Boards, 8 November 1980).

3.4 Charity dispensary, domiciliary medicine and medical education

From the turn of the twentieth century, a new breed of career Whitehall doctor emerged to help shape welfare policy in Britain; through practitioners cum civil servants, public, private, professional and political initiative interlocked in the search for a more efficient, healthier nation. Sir George Newman was the archetype of the new medically qualified public administrator. Before accession to the newly formed Ministry of Health, as the Chief Medical Officer of the Board of Education, in 1918, Newman set about reviewing the state of clinical teaching.¹¹⁸ Although focused upon England, much of Newman's report was, in fact, a legacy of experiences gained as a student in Edinburgh, during training, in the homes of the poor.¹¹⁹

Newman's review of medical education highlighted three chief limitations or imperfections. Firstly, he said, there was a lack of inculcation of what he called a true scientific spirit of enquiry in students during medical training south of the border. Secondly, criticising the way clinical teaching was organised, Newman pointed to the lack of dedicated full-time salaried teaching staff at medical schools across Britain. Most importantly of all in the context of this thesis, Newman also drew attention to what he felt to be the distorted over-focus on the theoretical and on the laboratory, as well as upon the hospital ward, in the training of future general practitioners at medical schools across England. He reasoned that prevention and understanding of the 'beginnings of disease' also required practical experience, and that knowhow could only be gained through outpatient or outdoor work. In short, familiarity with 'the moment of [biological] invasion,' required an initial moment of domiciliary invasion on the part of the doctor, in order to form an understanding of the context of disease. Highlighting interdependencies between treatment and teaching, where provision for the poor and medical education intersected most, ideally, was with outpatient or home visitation work.

¹¹⁸ Sir George Newman, *Some Notes on Medical Education in England*, 1918 (B.P.P. Cd.9124). Sir George Newman's *Lancet* obituarist referred to the two reports on medical education written by Newman in 1918 and 1923 as: 'among the most valuable documents ever issued to the public by a government department'. See *The Lancet*, I (1948), pp. 888-9.

¹¹⁹ John Walker-Smith, 'Correspondence of George Newman, School Boy and Medical Student (1880-1907),' (Unpublished, originally due April 2006). Walker-Smith argues regarding Newman's later preoccupation with public health that: 'No doubt his experience of deprivation in urban Edinburgh as a medical student, recorded in his correspondence, influenced his thinking'

In the ward the student observes disease in its gross and serious form... But in his subsequent general practice it is the beginnings of disease which he must handle, the subjective symptoms... That is when disease should be recognised, for that is when it is amenable and when its sequelæ and issues are preventable. The hospital and the laboratory stand for ultimate results, the private practitioner is the outpost who ought to be expert and wholly adequate at the moment of invasion. How is this to be secured? The answer is by bringing the student into contact with the out-patient, with the patient in the receiving room or the dispensary, and with the child, for thus he will learn to recognise the beginnings of disease and can study its process. The out-patient department, *using the term for an idea rather than a place*, has not yet been fully utilised in the education of the student...

There are not half a dozen medical schools in the country where the student is continuously and properly taught in the out-patient department.¹²⁰

Newman's observations and his proposals for change in England had origins in practical experiences wrought whilst in Scotland; and in tying optimal educational requirements for would-be general practitioners to outdoor medical provision for the poor, the report was part of a greater historical continuum. The emphasis on preventive medicine in general practice pre-empted what became one of the central features of the health service after 1948. Newman's claim for the primacy of acute medicine, of intervention and the preventive role of medicine, reflected the influence of, and his influence on, the great champions of his career, Sidney and Beatrice Webb.¹²¹ Looking forwards, the Royal Commission on Medical Education, 1968, details the lasting legacy in Britain, traced back into the nineteenth century, of the development of practical aspects of medical training as a cost-efficient by-product of charity provision. The 'poor' – be they Victorian-Edwardian charity cases, national insurance, or NHS patients – had continued to provide the 'wet' examples to illustrate clinical teaching.¹²² Recent scholarship has gone further to claim that through the nineteenth and twentieth century medical educational requirements usurped the

¹²⁰ Newman, Notes on Medical Education (Cd.9124), pp. 74-5.

¹²¹ J.D. Hirst, 'The growth of treatment through the School Medical Service, 1908-18', *Medical History* 33(3) (1989): pp. 318-342.

¹²² *Royal Commission on Medical Education 1965-68 Report*, B.P.P. Cd.3569 (London, 1968), para. 287-9: 'Clinical education would be impossible without the cooperation of patients in two main ways. During his period of "clerkship" the individual clinical student, usually as a junior member of the firm or unit responsible for a group of patients, is expected to visit his patients regularly; he thus learns how to obtain information from sick people by history-taking and clinical examination. No teacher is usually present in this work, the patient's contribution to which is of the greatest value... The second way in which patients contribute to medical education is by providing examples to illustrate teaching... Clinical education in Britain usually coincides with, and is to some extent a by-product of, the care of patients. This kind of teaching has made medical education much less expensive than it would otherwise have been, and has made the most effective use of the time given to medical education by distinguished clinicians who have many other important commitments.'

original philanthropic objectives of all hospital services: and indeed it has been seen that both objectives competed for precedence in the Glasgow and Edinburgh medical charities developed before 1911.¹²³ The poor recipient of charity medicine has always stood in certain relationship to that provision:

‘While the paying patient had a legitimate right to object to being observed and prodded by a group of students, a person in receipt of charity was hardly in a position to complain about such invasions of his privacy.’¹²⁴

Newman, like Joseph Lister - who had left Edinburgh for London a decade before Newman arrived - enjoyed a devout Quaker upbringing. As an Englishman, and as a minister’s son with an earnest interest in the missionary’s vocation, he followed a trod and trusted path when, in 1887, age 17, he headed north to study medicine.¹²⁵ Recent scholarship has revealed that whilst a student at the University of Edinburgh, he, like other medical students in the Scottish capital at this time, found many outlets available through which to give practical expression to Christian zeal whilst also gaining practical medical experience. Whilst a student, Newman had undertaken medical missionary work in the Cowgate district of the city. This area, the location of the Edinburgh Medical Missionary Society dispensary, was notoriously poor and overcrowded with Irish immigrants. By volunteering, Newman in this way ‘gained firsthand experience of the city slums’.¹²⁶

¹²³ John Mohan and Martin Gorsky, *Don’t Look Back? Voluntary and charitable finance of hospitals in Britain, past and present* (London, ACCA 2001), p. 37.

¹²⁴ B. Abel-Smith, *The Hospitals, 1800-1948: a study in social administration in England and Wales* (London: Heinemann and Cambridge, 1964), p.18, quoted in Ivan Waddington, ‘The Role of the Hospital in the Development of Modern Medicine: A Sociological Analysis’, in *Sociology* 7 (1973), p. 219.

¹²⁵ Anne Crowther and Marguerite Dupree, ‘The Invisible General Practitioner: The Careers of Scottish Medical Students in the Late Nineteenth Century’ in *Bulletin of History of Medicine*, 70 (1996), p. 395: 31% of students in a cohort of those matriculated to study medicine in Edinburgh in 1871 were from England. Per discussions with Prof. Anne Crowther, Edinburgh had a tight-knit enclave of Quaker medical practitioners that included numerous homeopathic practitioners who provided an established and mutually supportive community for Quakers students in the city. Newman’s biographical details, and the idea that Newman’s later evangelicalism owed more to Scottish experiences than his Quaker upbringing, taken from Walker-Smith, Correspondence of George Newman.

¹²⁶ P.M. Dunn, ‘Sir George Newman, MD (1870-1948) and the prevention of perinatal disease’ in *Archives of Diseases of Children: Fetal and Neonatal Edition*, 90 (May 2005), pp. 278-80. Newman graduated Edinburgh University MB, CM in 1892, returning to acquire his MD in 1895. A direct correlation between Newman’s experiences as a medical student visiting the homes of Edinburgh’s poor and his future move into public health administration has been traced in John Walker-Smith, ‘British Society for the History of Paediatrics and Child Health,’ unpublished address (York, April 2002).

It was easy to see why some medical students found charity dispensary work appealing. There was a natural desire amongst poorer medical students to supplement education by increasing future earning potential, and starting early was a shrewd investment of time. There was a desire amongst others to gain the kind of extracurricular practical clinical or specialty experiences that a tight and traditionally shaped curriculum had not the space to offer. Clinical experience gained by serving at a medical charity not only provided a range of experiences that helped fit a student for the realities of later medical life, it offered opportunity to increase individual confidence in managing patient cases. It also offered for the more earnest, ardent, conscientious or zealous a natural outlet for philanthropic or religious expression. For the more pragmatically minded, there was an additional opportunity through volunteering to 'network': that is, to become known; to please, impress or catch the eye of teachers, and members of the local medical and social elite (by showing interest in pet projects); and, as well, an opportunity to rub shoulders with future would-be patients and patrons.

Edinburgh's arrangement of charity dispensary services was crucial in providing Newman and other Edinburgh medical students such opportunities. In his commemorative history of the Royal College of Physicians of Edinburgh, Professor Stuart Craig, in 1976, noted with sadness how, 'from the teaching angle, and more especially from the viewpoint of what is now commonly referred to as Community Medicine, the gradual disappearance of public dispensaries is an irreplaceable loss.'¹²⁷ Whilst it has not always been lamented, what this chapter seeks to explore is exactly this lost relationship, and the close tie that is identified that had formerly existed (alluded to by Newman) between domiciliary and dispensary medical charity provision in Scotland and medical educational arrangements. This was a tie that had its roots in Edinburgh in the eighteenth century; survived, flourished and strengthened over the nineteenth century - as the range of medical dispensaries expanded, and as the dispensaries grew more dependent upon student manpower and student fees -; and held through to the end of 1911. Change only came in the 1920s, during which time the Edinburgh dispensary and domiciliary training tradition gave way as

¹²⁷ Craig, Royal College of Physicians, p. 499.

reorganisation of academic priorities promoted by new forms of university funding pushed students towards a greater grounding in laboratory science.¹²⁸

Writing in 1969 - two decades after the advent of the NHS - Sir Zachary Cope also noted the very close relationship that had formerly existed between medical charity dispensary work and medical education, north of the border in Britain. This relationship, he said, had lasted in Scotland right up to the reorganisation of medical services and the close of the private dispensaries in 1948. Although he failed to identify in Edinburgh and Glasgow any differences, Cope made several valuable historical points. He argued, for instance, that: 'The part played by the free dispensaries in the evolution of medical education in Britain has not yet been adequately appreciated,' and that: 'In Scotland the Dispensaries [had] education function,' noting further that: 'dispensary work became part of the normal curriculum of the medical student'.¹²⁹

Home visitation work undertaken by medical charities was not just an important element of the range of medical provision made available for the poor during the late nineteenth and early twentieth century in Scotland, it was (and was seen to be) an essentially and intrinsically 'Scottish' approach to a recognised set of additional problems. Most especially, the use of senior medical students, organised under supervision to visit and treat the poor at home, was a strategic response to the challenge of how to bring those same medical students, as Britain's future general practitioners, out of the lecture room. It was home visits to patients that were understood to provide the hands-on practical clinical experience it was deemed they required for their future careers. Medical students that undertook home visitation during their education were said to graduate with a greater understanding of poverty and a more realistic expectation of general private practice, the mainstay for most of future medical work. Thus in September 1901, for example, the *Lancet* published reflections on "Medical Students and the Poor" in which it was argued that solely hospital-trained students entered the profession at a distinct disadvantage, with

¹²⁸ On the usurpation of traditional Edinburgh approaches to medical education in the 1920s with the advent of Rockefeller funding of laboratory clinical science university posts see Christopher Lawrence, *Rockefeller Money, the Laboratory, and Medicine in Edinburgh 1919-1930* (New York and Suffolk: University of Rochester Press, 2005), esp. chapter 4: 'The Organization and Ethos of Edinburgh Medicine'.

¹²⁹ Cope, *The influence of the free dispensaries*, p. 29 and p. 36.

unrealistic expectations and no real understanding of, or empathy with, the problems of poverty.¹³⁰ Echoing these thoughts, as a former medical student in Edinburgh in the 1890s and as the subsequently appointed superintendent of the Edinburgh Medical Missionary Society, Lechmere Taylor noted later how only students exposed to home visitation rounds learned at close quarters ‘the evils attendant on poverty, overcrowding and squalor.’ They also learned the ‘discipline,’ ‘disappointments and heartbreaks,’ which were mainstays of medical practice. Home visits were a test bed. Treatment in the difficult and disadvantaged conditions of the poor man’s home required patience and calmness to deal with variable, strained and sometimes outright dangerous circumstances. It required fortitude and flexibility, and the adeptness to adapt treatments to prevailing conditions. Essentially therefore, it was during domiciliary visits amongst the poor, Lechmere Taylor argued, that the would-be practitioners and medical missionaries of his generation learnt the three g’s necessary for a successful career, namely: ‘grit, grace and gumption’.¹³¹

This ‘Scottish approach’ – of sending students into the homes of the poor – came to be admired, and by the end of the 1880s was held up for emulation elsewhere in Britain: but whilst this was recognised to be a ‘Scottish’ approach and called such, the comparison between Edinburgh and Glasgow medical charity services already presented shows that there were, in fact, stark internal Scottish differences in application of home visitation services. Differences in approaches to domiciliary treatment in Edinburgh and Glasgow were due to differing local educational arrangements, institutional contexts and concerns, and traditions of care.

As stated, the oldest of the network of medical charities active in Edinburgh was the Royal Public Dispensary (ERPD). Building upon patient-centred clinical teaching methods as developed at Leyden by Herman Boerhaave, but with teaching conducted instead *out of the ward*, the ERPD pioneered the use of medical students in the supervised visitation of sick-poor persons at home. Richard Scott became Britain’s first professor of general practice when appointed in Edinburgh in 1963. His study of

¹³⁰ *The Lancet*, v. 2 (Sept. 14, 1901), p. 745: ‘The Medical Man fresh from the hospitals is apt to order expensive drugs unnecessarily and to have ideas on the subject of diet which are quite incompatible with a wage of 25s. a week and a wife and six children...’

¹³¹ H. F. Lechmere Taylor, *A Century of Service, 1841-1941* (Edinburgh: Edinburgh Medical Missionary Society Darien Press, 1941), pp. 16-18.

the history of general practice and of the general practice-focused requirements of an Edinburgh medical education published in 1977 followed Craig and Cope to note that before the NHS: ‘In Edinburgh the role of the dispensary in the provision of medical care and in the education of medical students was a particularly prominent feature’. More significantly, referencing the ERPD, Scott noted too that: ‘The deliberate establishment of dispensaries for undergraduate teaching purposes [in Edinburgh] was probably unique’.¹³² At the annual general meeting of the ERPD board in 1904, it was claimed of the service offered that:

It [the ERPD] helped in medical education by training students and by sending them to visit the poor at their own homes, under supervision. This was a very useful part of medical education, because it enabled the student to see patients in their ordinary surroundings, and he had to treat them with the difficulties which encumbered the ordinary medical attendant.¹³³

At the ERPD the domiciliary service was organised under the physicians and surgeons employed as medical officers, each of whom was assigned charge of a unique visitation district. Each medical officer was allowed to deploy two senior students. As a consequence, these were students they chose personally and whom they presumably therefore trusted. The students paid fees for the privilege and were rewarded, in turn, by a training experience confirmed by testimonial. Regulations stipulated that all students deployed ‘must have attended medical cases for at least two winter sessions and an hospital for at least one year’ prior to being allowed to undertake visits. Student duties included certain latitude to act independently in emergencies, and were:

To assist him [the medical officer] in registering the Patients, to visit at their own houses, and prescribe for such Patients the Medical Officers may direct; and to perform the dressings and lesser operations which may be required. If called to any case of emergency in the course of their visits, the Pupils may prescribe for it what may be immediately required. They shall afterwards report the case to the Medical Officer under whom they act...¹³⁴

¹³² Richard Scott, ‘Edinburgh and general practice,’ in Gordon McLachlan (ed.), *Medical Education and Medical Care, a Scottish-American Symposium* (O.U.P., London 1977). P. 59.

¹³³ *The Scotsman* (1 Feb, 1904), p. 6. This notion of the value of seeing a patient ‘in their ordinary surrounding’ belongs to the holistic concepts of treatment that classic theorists on general practitioner work continue to see as a crucial component of ‘the special psychological atmosphere’ of general practitioner’s work. See Michael Balint, *The doctor, his patient and the illness* (Surrey: Gresham Press, 1964), ch. XIII. On continuity in this way of thinking see also Peter G. Livesey, *The GP Consultation: a Registrar’s Guide* (Oxford, Butterworth Heinemann, 1996 2nd ed.), p. 3: ‘knowledge and understanding of the patient grows from a knowledge of the family and the home. Home visits invariably produce insights into problems seldom revealed in the surgery’.

¹³⁴ ERPD Royal Warrant, ECA ref: SL73/1/1.

One can explore the tie between medical charity, home visitation and medical education in Edinburgh over the nineteenth and into the early twentieth century - and set in train by the example of the ERPD - in a number of ways. One way that the relationship that existed between education and dispensary charity can be explored is by using student graduation records (which for Edinburgh University are thorough and well preserved).¹³⁵ These records confirm the extent to which charity dispensaries in Edinburgh provided an outlet for the training of students.

Table 3.12: Site at which was acquired the statutory six month outpatient experience required by each graduating student, per graduation records of Edinburgh University [sample year: 1896]

Total medical graduates in 1896:	<u>198</u>	
Recorded site of outpatient training:	no. of students	%
Royal Public Dispensary (ERPD)	45	22.7%
Western Dispensary	43	21.7%
Edinburgh Provident Dispensary	30	15.2%
EMMS Cowgate Dispensary	22	11.1%
New Town Dispensary (ENTD)	16	8.1%
at General Practitioners	9	4.5%
ERPD & Royal Infirmary outpatients	2	1.0%
Disp. Women and Children, Grove St	1	0.5%
ERPD & St Anne's Dispensary	1	0.5%
Western Dispensary & Royal Infirmary	1	0.5%
outside Edinburgh	9	4.5%
unspecified / unclear	19	9.6%

Source: Graduation records, University of Edinburgh (1896): University Archives Ref: Da 43.

Both university and extramural teaching school students were required to attend at dispensaries or at outpatient departments in order to satisfy requirements across four separate statutory strands of the medical curriculum. They attended for practical pharmacy instruction (or material medica), for practical midwifery, for vaccination instruction, and (most essentially) during the acquisition of the required standard of dispensary, outpatient or general practice training. Taking one sample year selected at random (Table 3.12), from amongst the 198 students graduating with an ordinary medical degree at Edinburgh University in 1896, 90% of the 179 students for which details are recorded had undertaken their six month training at one of the town's seven

¹³⁵ Bradley et al, 'Mobility and Selection', p. 6: the meticulous manner in which Edinburgh University student graduation records are kept is described as 'an indication of how thoroughly it implemented the regulations of the GMC'.

leading, identified home visitation dispensaries: the ERPD is shown marginally most popular, with around one-quarter of all graduating students attending. Students brought to the charities not just manpower but also vital revenue in terms of fees. The importance of the revenue that students brought to the dispensaries was shown in the dispute that arose in October 1882 between the university –which had just introduced a new in-house material medica course that threatened to monopolise the discipline – and the medical charities. The University Court was sent memorials by the directors of the four main Edinburgh dispensaries, complaining that: ‘The effect of the proposed change would be, in their view, seriously to cripple the resources of the dispensaries by depriving them of the students’ fees for these classes, and also seriously to effect their power to relieve the sick poor who came to them for advice and treatment.’¹³⁶

Another way the relationship can be explored is by looking at the instruction and advice given to students by their medical professors during inauguration and graduation addresses. Philosophically these addresses set the tone for the classes. In Edinburgh, the emphasis in these was regularly on the unique advantage of pursuing a medical education in that city. Thus in his opening address to the medical students in 1889, for example, John Chiene, professor of surgery, commended ‘dispensary work,’ by noting how it ‘readied the student for private practice... [teaching them] the need for courtesy and gentleness, more especially in their dealing with the poor.’ As a second year student in 1889, George Newman would have been present to hear this. Newman, at this time, was serving as a clerk to Chiene. Chiene was a mentor, a man Newman referred to in private correspondence to family as ‘the great Scotch surgeon’.¹³⁷ In 1889, the strength of dispensary work in Edinburgh had drawn recent national approval. The theme, however, was not a new one. Ten years earlier, at the opening of classes of the university in November 1879, Professor Douglas Maclagan had similarly claimed to the students that the dispensary: ‘was invaluable as giving him [the student] that self-reliance without which he could never succeed in practice.’

¹³⁶ *The Scotsman* (25 Oct, 1882), p. 5. On the time-bomb that it was felt was being created by the growing dependence of Edinburgh medical charity dispensaries on student fees see the speech by Edinburgh’s then Lord Provost, general practitioner, James Alexander Russell, on the rise of student fees to compensate for falling subscription revenues recorded in the ERPD Annual Report (1891) and *The Scotsman* (1 Feb, 1892), p. 6.

¹³⁷ George Newman, letter to parents (20th October 1889) (London: Wellcome Library Archives), ref: MSS.6201-7.

Knighthood and made president of the B.M.A. just after, addressing the university graduating class in 1893, Professor Thomas Grainger Stewart advised the students that Edinburgh medical charity dispensary work – to which he like the other professor's mentioned was closely associated – enabled earliest access to 'study cases'. It was only through such study of cases that the students could hope to acquire what he referred to as the 'mens medica': this he described as the moral, observant, attentive, discriminating, sympathetic, analytic, synthetic, and well-balanced mind necessary for independent medical judgement.¹³⁸ Giving the inaugural address to students of the Edinburgh School of Medicine in October 1879, Professor John Batty Tuke, then the General Medical Council representative of the Royal College of Physicians of Edinburgh, sparked a heated exchange with the retiring president of the Edinburgh Botanical Society by proclaiming:

The practical knowledge he spoke of was not to be obtained by merely walking the hospital. There they would only meet with the more grave forms of disease. It was in the dispensary where they could acquire an insight into those minor complaints which formed the staple of everyday practice, and in the proper diagnosis of which mainly depended their position in their profession. Speaking for himself, he would rather choose a man for an assistant who could show his dispensary book well and truly filled with the names of patients whom he had personally attended in the Cowgate and Canongate [sic!] than the holder of a gold medal for natural history...¹³⁹

The special relationship - identified also by Cope and Scott -, between medical education and the home visitation work of charity dispensaries in Edinburgh, is one that is absent from a number of more specialised accounts of medical education in Scotland for this period. This is a significant omission. One prominent recent example is Christopher Lawrence's study of 'Scottish medical education 1700-1939'.¹⁴⁰ In this, Lawrence makes much what he refers to as the special environment of a Scots education. He emphasises the aim of medical education in both Glasgow and Edinburgh in the nineteenth century, which he says was to produce rounded, generalist practitioners with a surgical and public service bent, describing 'a commitment among Scottish teachers to present medicine as a practical art'. For the later-nineteenth century Lawrence also points to a move towards what he describes as

¹³⁸ Chiene, MacLagan and Grainger-Stewart quoted from *The Scotsman* (5 Nov, 1879), p. 4, (16 Oct, 1889), p. 10, and (2 Aug, 1893), p. 8.

¹³⁹ *The Scotsman* (29 Oct, 1879) and (14 Nov, 1879), p. 4.

¹⁴⁰ Christopher Lawrence, 'The shaping of things to come: Scottish medical education 1700-1939' in *Medical Education*, 40 (2006), pp. 212-218.

a scientific 'pre-clinical curriculum'. He identifies this move with particular role played in the training students, after the mid-1870s, by the rebuilt Edinburgh Royal Infirmary and the newly found Glasgow Western Infirmary, which indeed became the central focal point of teaching in Glasgow. What Lawrence's account does not do is make any mention of one of the key factors that drove the expansion of the medical curriculum at the end of the 1880s: home visitation. Lawrence also makes no mention of the role of charity dispensaries in Edinburgh; and no mention therefore of just how it was that Edinburgh students in particular acquired important elements of this rounded, generalist, practical training. This is omission that is made all the more strange by the fact that from other writings it is clear that Lawrence is not unaware of the vital and peculiar role of home visits in Edinburgh training tradition. In an earlier publication - detailing the role played by Rockefeller money in transforming Edinburgh medicine from the 1920s - Lawrence makes much of the incredulity of the Dean of Harvard, David Edsall, who, during visits to Edinburgh in 1922, had critically commented of the town that: 'the most extraordinary thing about this school is the dispensary system... [where] the students are assigned to them [the patients] and actually take charge of them in their homes.'¹⁴¹

It should be noted that although much is made here of the support within the Edinburgh medical elites for the use of students to engage in home visitation, there were –as anywhere - stray voices. Thus Edsall's incredulity echoes the disquiet felt by at least one prominent Edinburgh surgeon of the period. Joseph Bell, M.D., was former editor of the *Edinburgh Medical Journal*, long-serving consultant surgeon at the Edinburgh Royal Infirmary, and director of the Edinburgh Medical Missionary Society from the 1860s (a society that made much use of student home visitation). Yet

¹⁴¹ Lawrence, Rockefeller Money, p. 96. In the monograph 'The Healers,' David Hamilton does make some mention of the teaching object of 'the first Scottish dispensary,' the ERPD, noting how it 'even extended to home visits'. However, in describing the evolution of medical education from the mid-nineteenth century he makes nothing further of this link and instead concentrates on three more recognisable issues: of battles with London over the value and legitimacy of a Scots medical education; of the impact of the growth of medical research and laboratory science on the curriculum; and the opening of medical schools to women. Helen Dingwall, 'History of Scottish Medicine,' (2003) focuses upon the evolution of the hospital rather than on what she describes as its corollary, the decline in 'aspects of medicine... practised or influenced wholly in the home'. Dingwall ignores the continuing role played by medical charity in medical education and medical treatment as described by Cope, arguing simply that as the nineteenth century progressed it was 'the hospital [that] became... the focus of professional medicine and surgery, medical and surgical training' in Scotland. On these arguments see David Hamilton, *The Healers: A History of Medicine in Scotland* (1981) (Edinburgh: republished Canongate, 2003), p. 107, and p. 207f. and Helen M. Dingwall, *A History of Scottish Medicine* (Edinburgh: Edinburgh University Press, 2003), p. 178.

in his written evidence to the Poor Law Royal Commission in 1907, Bell argued that whilst Edinburgh's voluntary charity dispensaries generally in his opinion 'fairly met the case of slight ailments in patients who can walk to the dispensary... sudden illness in children and the aged requiring attention at their own homes are not I fear adequately met.' This inadequacy was because, Bell claimed, 'visits are often delayed,' and, most tellingly: 'many cases are attended to by students of medicine.'¹⁴² Whether this was a view recently arrived at or one that he had always held is not clear (especially given his involvements in the Edinburgh charity system).

Prominent recent Glasgow-centric studies of Scottish medical education across the second half the nineteenth century have chosen to concentrate upon the period between Medical Acts, 1858 to 1886, when Scotland and Scottish medical education was largely looked down upon from London.¹⁴³ This again is a shame. The gradual wider diffusion of Scottish surgical breakthroughs; the successful defence of the integrity of plural Scottish medical education traditions against criticisms of it from London (typified in the Royal Commission into the Medical Acts, 1882); and the increasing colonisation of positions of political prominence south of the border by more Scots-trained medics: these developments mean the years immediately *after* 1886 are, in fact, also of much interest.¹⁴⁴ Indeed, it might be said that there was an about turn in the assessment of the value of a Scottish medical education from the central authorities shortly after 1886. A number of additional factors made the period of half a decade following the passing of the 'safe generalist practitioner' legislation of the Medical Act of 1886 of significance, for both Scottish medical education, and, ultimately too, for the 'Scottish system' of home visitation services.¹⁴⁵ The years

¹⁴² Joseph Bell, RC Poor Laws and Relief of Distress (Cd.4978), Appendix XV.

¹⁴³ For example, see Bradley et al, 'Mobility and Selection', and Andrew Hull and Johanna Geyer-Koydesch, *The shaping of the medical profession: the history of the Royal College of Physicians and Surgeons of Glasgow, 1858-1999* (London: Hambledon Press, 1999), chapter one. I suggest here that the negative view of Scotland and Scottish education had largely been turned around by the end of the 1880s (although fears of a southern invasion of students armed with Scottish medical degrees remained). Whilst it is a much longer study, Hull and Geyer-Koydesch have little to say of the years immediately after 1886 in terms of the development of medical education in Scotland, except that they were (p.52): 'momentous... for the growth of scientific medical disciplines'.

¹⁴⁴ The first is subject matter of the more recent M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge University Press, 2007).

¹⁴⁵ The Medical Act of 1886 had prohibited the registration of any person that had not qualified in all three subjects of medicine, surgery and midwifery, and coincided with the establishment of the triple qualification in Scotland. Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press, 1957), p. 194: the aim of medical education in Britain, as

1889-91 coincided with the peak in student numbers in Glasgow and Edinburgh (Table 3.1). In these years the Universities (Scotland) Act of 1889 opened the way, formally at least, for women to pursue study of medicine in Scottish universities on a par with men. After 1890, the standard medical curriculum across Britain was lengthened, to a modern format of five years. In addition, three separate decisions taken during the course of Glasgow's International Exhibition year of 1888, which are explored next, were to have important ramifications for the use of medical students in domiciliary work amongst the poor, at once strengthening the use of them in Edinburgh whilst dissolving the case for them in Glasgow.¹⁴⁶

Historians have accounted for the increase in the medical curriculum after 1890 in a progressive vein, by pointing to the failure of the four-year system to keep pace with new developments in medicine. Particularly highlighted are two issues: the rapid diversification and growing demands of different strands of specialist medical treatment, and the growing importance of science.¹⁴⁷ W.F. Bynum, for example, has argued: '[in Britain, over the nineteenth century] ...the minimum course lengthened, first from three to four years, and then from four to five, to take account of the newer demands of science (especially practical work in histology, physiology, and bacteriology) and introductory teaching in specialist clinical subjects'.¹⁴⁸ Whilst the needs of science and of competing strands of specialist medicine may explain *what it was* that happened after the curriculum expanded after 1891, it does not, in fact,

recorded in the Medical Act of 1886 was: 'to produce a doctor who, on the day he was registered, would be a *safe man to let loose on the public*, competent to practise all branches of his profession'.¹⁴⁶ The standard medical curriculum had been raised in Scotland from three to four years in 1825. This extension of the period of standard undergraduate study from four years to five years after 1890 was a crucial development, for it set medical training in Britain on a long held course, remaining little changed for the next one hundred years. On the longevity of the changes to the medical curriculum brought in under the guidance of Professor John Struthers - chair of the Education Committee of the General Medical Council from the mid-1880s to 1891 - see S.W. Waterson, M.R. Laing, and J.D. Hutchinson, 'Nineteenth Century Medical Education for Tomorrow's Doctors' in *Scottish Medical Journal*, 51, 1 (2006), pp. 45-9.

¹⁴⁷ John Struthers, 'The Medical School of the Future', in *EMJ*, 42 (1896), pp. 292-3: Struthers noted the key changes in the years to 1895 affecting general practice in Scotland were: 'progress in surgery [and] the ophthalmoscope and the laryngoscope... and the general use of the microscope.' Per Craig, Royal College of Physicians, p. 567, the fifth year came into force at Edinburgh University from an ordinance date June 1891. For Craig, the cause of change lay with the accompanying recognition of various new medical specialisms as acceptable subjects for individual study as part of the curriculum: physics, insanity, fevers, eye diseases, and childhood diseases.

¹⁴⁸ W.F. Bynum. *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge University Press, 1994), p. 219. Newman, *The Evolution of Medical Education*, pp. 217-8: 'The latter part of the [nineteenth] century saw the beginnings of the development of specialism, and as one special subject after another was elaborated as soon as it had achieved an independent status, its exponents began to clamour for its inclusion in the basic curriculum required for all doctors'.

explain *why it was* expanded at this time. To understand the true cause of change one needs explore the intentions of those who engineered that change. The key moments in the decision to increase the medical curriculum by one year occurred during meetings of the British General Medical Council (GMC).

Table 3.13: Qualifications of the 30 GMC members meeting in May 1888

Direct Representatives:	Area or Institution:	Education:
C. G. Wheelhouse	England	London
Sir Walter Foster	England	?
James Grey Glover	England	Edinburgh, MD Edinburgh
William Bruce	Scotland	Edinburgh, MD Aberdeen
George Hugh Kidd	Ireland	Ireland, MD Edinburgh
Elected:		
Sir Dyce Duckworth	RCP London	MD Edinburgh
John Marshall (pres.)	RCS London	London
R. Brudenell Carter	Apothecaries Soc. London	London
T. K. Chambers	Univ. Oxford	London, Oxford
G. Murray Humphry	Univ. Cambridge	London, Cambridge
G. Yeoman Heath	Univ. Durham	LRCP Edinburgh
Samuel Wilks	Univ. London	London, LLD Edinburgh
W. Mitchell Banks	Victoria Univ. Manchester	Edinburgh, MD Edinburgh
John Batty Tuke	RCP Edinburgh	Edinburgh, MD Edinburgh
Patrick Heron Watson	RCS Edinburgh	MD Edinburgh
Hector Clare Cameron	FPS Glasgow	Glasgow, MD Glasgow
Sir William Turner	Univ. Edinburgh	London, FRCS Edinburgh
John Struthers	Univ. Aberdeen	Edinburgh, MD Edinburgh
William Leishman	Univ. Glasgow	Glasgow, MD Glasgow
James Bell Pettigrew	Univ. St. Andrews	MD Edinburgh
Aquilla Smith	King & Queens Ireland	Dublin
Rawdon Macnamara	RCS Ireland	Dublin
Thomas Collins	Apothecaries Ireland	Dublin, London
Rev. Samuel Haughton	Univ. Dublin	Dublin
John Thomas Banks	Royal Univ. Ireland	Dublin
Crown Nominations:		
Richard Quain		London
Sir John Simon		London
T. Pridgin Teale		Oxford
Sir G.H.B. McLeod		MD Glasgow
William Moore		Dublin

Source: Medical Directory and Medical Register (1888).

The GMC (as it came to be known) was created under the Medical Act (1858). It had two main functions: it was the body charged with monitoring medical educational standards across Britain, and determining who it was should be put on the medical

register.¹⁴⁹ The newly arrived complement of 30 members of the GMC – including one representative for each of the seven Scottish medical corporations, one direct representative for Scotland, and one royal appointment for Scotland – met for the first time at the meetings on Oxford Street in London, during May 1888. It was over the five days of these meetings that the GMC set out the case for extending the medical curriculum.¹⁵⁰ Whilst nine members of the new complement represented Scotland directly, half of the members held Scottish qualifications (with eight with direct undergraduate experience in Edinburgh, and three with undergraduate experience in Glasgow) (Table 3.13). A kindly disposition towards Scottish educational interests amongst the new leaders of the profession was natural.

On the first day of meetings in 1888, the executive committee of the GMC presented its findings on one of the more pressing issues of the day, the question of the improper use of ‘unqualified assistants’. The issue of general practitioners using unqualified assistants came to national attention in March 1868, and had increasingly interested and vexed the GMC from the 1870s.¹⁵¹ Cases investigated gathered pace in the 1880s, and in 1887 the GMC advised through the medical press that it would take steps against all practitioners found guilty of using unqualified assistants. The resolutions agreed upon in 1888 had important ramifications for the future deployment of medical students whilst under training, particularly regarding locum positions. It was determined by the GMC that the key issue was whether or not a practitioner was using a student ‘either in complete substitution for his own services or under circumstances in which due supervision and control are not... exercised’. The key issue was what constituted ‘due supervision and control’. The year 1888 would become the first to see a medical practitioner struck off for using an unqualified assistant.¹⁵²

On the final two days of meetings discussion was given over to the issue of how best to incorporate the fresh demands of a host of competing specialist strands of medicine

¹⁴⁹ On the origins of the GMC see Russell Smith, ‘The development of ethical guidance for medical practitioners by the General Medical Council’, *Medical History* 37 (1993), pp. 56-67.

¹⁵⁰ For press coverage of the debates of the GMC during the meetings in May 1888 see *The Lancet* (May 1888), pp. 1030-36 and *The Scotsman* (22nd to 26th May 1888).

¹⁵¹ In March 1868, for example, the employment of unqualified assistants was brought into question in the pages of the BMJ. This was after the *Daily Telegraph* had ran the story of a poor law patient in Poplar, London, whose strangulated hernia complaint had suffered neglect when treated at the hands of an unqualified assistant of the local poor law medical officer. See BMJ, vol. 1 (1868), p. 226f.

¹⁵² Smith, ‘The development of ethical guidance’, pp. 56-67; and *The Scotsman* (25th May 1888), p.5.

into the standard undergraduate curriculum. The requirement that students be given more opportunity to become acquainted with fevers and infectious diseases, with a greater number of midwifery cases, and with the study of insanity were all issues discussed; but at this stage proposals that the curriculum be altered to accommodate more study of different specialisms faced significant opposition from within the ranks of the central authority regulating British medical education. The reluctance was summed up by Professor Humphry, member for the University of Cambridge, who argued: ‘Specialisation was all very well when a man had obtained the general knowledge necessary for practice of his profession, but to introduce it into the studies by which he was to secure his qualification was a new and objectionable principle.’¹⁵³

The key decision to alter the medical curriculum was not, therefore, made in order to accommodate specialist strands. The decision was actually taken on day two of the meeting. It was on this day, under the chairmanship of the professor of anatomy at Aberdeen University, John Struthers, that the education sub-committee of the GMC presented its recommendations to change to the standard undergraduate curriculum: these were accepted.¹⁵⁴ With Struthers, on the sub-committee, were two other Scottish GMC representatives, Glasgow’s Professor William Leishman, and John Batty Tuke, representative of the RCPE. Realising that return to a system of medical apprenticeship was a non-starter, and desirous nonetheless that students across Britain should undertake far more outdoor practical work and home visitation work during training, the committee put forward the following recommendation for all British medical students (which was agreed to): ‘That *all* candidates for the final examination be required to produce evidence that they have attended for six months the practice of a public dispensary, or the outdoor practice of an hospital, or have acted for six months as assistant to a registered practitioner.’¹⁵⁵

Supporting the motion to alter the curriculum, as well as the intentions behind it, and expanding on the principles that guided the decision, Dr. William Mitchell Banks,

¹⁵³ *The Scotsman* (23rd May 1888), p. 8.

¹⁵⁴ For recent assessments of the significance of John Struthers on British medical education reform during the later nineteenth century see, for example, Waterson et al, ‘Nineteenth Century Medical Education for Tomorrow’s Doctors’, and S. W. Waterson and J. D. Hutchison, ‘Sir John Struthers MD FRCS Edin LLD Glasg: anatomist, zoologist and pioneer in medical education,’ in *The Surgeon*, 2 (6) (Journal of the Royal College of Surgeons of England and Ireland, Dec 2004).

¹⁵⁵ *The Scotsman* (24th May 1888), p.6.

surgeon to the Liverpool Royal Infirmary and member of the GMC for Manchester, noted:

With regard to the practice of a public dispensary, or the out-door practice of a hospital, the idea had been taken from an existing practice in Scotland... It consisted, under proper supervision, on the out-door practice of a dispensary or hospital.

[Banks went on to clarify]... What the committee meant was not a mere attendance on the outdoor practice [for six months]... but attendance on the patients at their homes.¹⁵⁶

Dr Patrick Heron Watson of the RCPE supported the adoption of his hometown system, noting further that: 'If a student had the opportunity of going into the house of patients and seeing the wretched circumstances in which they were placed, he would have the opportunity of learning a lesson that he would never forget, and that would fit him for practice in any sphere of life.'¹⁵⁷ In also supporting the proposal, London based English representative, James Grey Glover, saw the shift towards outdoor work as desirable for it met a gap in educational provision. Glover argued (in the face of much modern historical analysis): 'There was a growing objection to hospitals being used for anything but the graver class of cases, and the teaching required by the student could not be learned in the out-patient department of a hospital; he could only learn it properly at the homes of the patients.'¹⁵⁸

The motion to alter the medical curriculum passed, as stated, but with compromises that ultimately defeated the central call for more visitation nationwide, put in place to accommodate the existing systems in place both in London and Ireland. Ireland had its own flourishing dispensary system. To appease London interests, with its array of long-established teaching hospitals, the stipulation became that the six months outdoor practice could still be spent in the outpatients of a hospital rather than at a dispensary. In summing up the changes initiated, Struthers noted with satisfaction that the passing of the recommendation was a significant validation for Scottish educational method. Scottish medical institutions, he recalled, previously had been 'very much criticised on the ground of their great deficiency in practical education... [Yet] today they were congratulated by English members of the Council'!¹⁵⁹

¹⁵⁶ *The Lancet* (May 1888), p. 1034; also quoted in *The Scotsman* (24th May 1888), p. 6.

¹⁵⁷ *The Lancet* (May 1888), p. 1036.

¹⁵⁸ *The Lancet* (May 1888), p. 1035.

¹⁵⁹ *The Scotsman* (24th May 1888), p. 6.

Given then, the decision by the GMC in May 1888 to endorse what it referred to as the ‘Scottish system’ whereby charities utilised students under training to visit the poor, and the decision to expand the medical curriculum as a consequence, the question becomes why then was there an absence of such a system in Glasgow in the years after 1888? - A clue to this puzzle is provided in the reaction of University of Glasgow member William Leishman to curriculum changes. Whilst ‘rejoicing’ at seeing the support of fellow GMC members for the wider adoption of student visitation, Leishman also noted that, to his regret:

an attempt had recently been made in Glasgow to establish a visiting department in connection with the dispensary of one of the large hospitals, but that the governing body of the hospital were *afraid of the responsibility*, and declined to give their sanction. [My emphasis]¹⁶⁰

Two distinct events that occurred around the time of the GMC meeting in 1888 had determined the fate of student led home visitation services in Glasgow. Whilst distinct, they were not disconnected. Both were entangled with the relocation of the university a decade earlier, and with the connected drift to the western outskirts of Glasgow of the main focus of medical teaching in the city. First, in 1888, Anderson’s College relocated nearer Glasgow University, forcing the closure of ACD, previously the only general dispensary in Glasgow on the Edinburgh model. Second, at the start of 1888, the managers of Glasgow Western Infirmary came to the decision that it was prudent to abandon hope of implementing a similar home visitation scheme.¹⁶¹

From the end of the 1870s, ACD had operated as the only dispensary offering a home visitation in Glasgow. Whilst the teaching staff of Anderson’s did not open a new dispensary when they moved to their new site, the older dispensary the college had created in the city centre did not disappear altogether. The directors of the old college dispensary had been made up of a number of elite personages, from the world of Glasgow business, industry, the church and medicine. As a group they expressed

¹⁶⁰ *The Scotsman* (24th May 1888), p. 6

¹⁶¹ Part of the reason behind the move of Anderson’s College closer to the university was the fact that students of the college were beginning to attend, of necessity, more and more university classes. Representatives of Anderson’s Medical College appeared before the Lord Advocate in Edinburgh in March 1888 regarding the Universities Bill recently introduced to parliament, noting that under it only 4 of 18 tickets required to proceed to examination at Glasgow University were allowed to be issued by Anderson’s professors. See *The Scotsman* (30th March 1888).

collective concern that the relocation and the prospective closure of the dispensary would leave a large void in Glasgow's network of medical services. Meeting under MOH, James Burn Russell, in September 1889, it was resolved that the dispensary should be re-found as an independent entity. This new charity became Glasgow Central Dispensary.¹⁶² Although re-found, and although the dispensary quickly resumed seeing an equivalent volume of cases as before, with the loss of students, the staffing and focus of the dispensary entirely shifted. Home visitation was abandoned and never reintroduced. An application to the Bellahouston Fund for monetary assistance to cover the costs involved in the re-founding and relocation of the dispensary pointed to financial restrictions rather than managerial preference in the abandonment of visiting services. It noted that with the loss of students previously used to underpin the service, any re-establishment of the home visitation service would require the appointment of a new staff member on 'a salary which we cannot presently afford'.¹⁶³ Being always difficult and tiresome work, it was not unusual across Scotland to find that in the absence of at-hand students to carry the bulk of the work, the only qualified staff member of most medical charities being paid was likely to be the surgeon charged with the visitation of patients.¹⁶⁴

Glasgow Western Infirmary (GWI) was the adjunct of the newly rebuilt university. Given its acquired importance in fashioning medical education in the city, hope that the gap in student home visitation services might be filled passed to it. Thus when Professor Leishman made claim at the GMC meeting that in Glasgow some had proven 'afraid of the responsibility' of providing student visitation services, what he was referring to was not the abandonment of the Anderson's scheme but to the fears

¹⁶² Glasgow Central Dispensary Minutes (30th September, 1889), Greater Glasgow Health Board archives, ref: HB48/1/1.

¹⁶³ Glasgow Central Dispensary Minutes (2nd March, 1892), GGHB HB48/1/1: '[Following our relocation] our expenditure will be greatly increased, owing to the very much larger rent which we have to pay, and the greater number of patients drawn from the destitute districts to which our new premises are more convenient than the old. Our funds have only recently permitted us to resume dispensing medicines, and we have not yet been able to take up home attendance on selected cases of gravity and indigence, which when the Dispensary was under the management of Anderson's College was undertaken by an out-door physician. This, of course, requires a salary which we cannot at present afford.'

¹⁶⁴ Glasgow Central Dispensary received £100 from the Bellahouston Fund in May 1893. It was not enough to kick-start the domiciliary service. Per Glasgow Central Dispensary Eighth Annual Report (1897): 'we have not yet been able to take up home attendance on selected cases... which, when the Dispensary was under the management of Anderson's College, was undertaken by an out-door physician'.

of the directors and managers of Glasgow's new showpiece infirmary. Surviving archival records for the GWI reveal the cause of this fear.

A dispensary-outpatients service was established in January 1874.¹⁶⁵ In 1877, Dr William Leishman, professor of midwifery at Glasgow University since 1868, was appointed to head a new department at the GWI. He became physician for diseases of women. Some years before this, he had also taken control of an institution in the neighbourhood of the old university site called the Glasgow University Lying-In Hospital and Dispensary for Diseases of Women. This had long been used to instruct students, being previously under the direction of Leishman's predecessor as professor of midwifery, Dr John M. Pagan. Following a puerperal fever crisis in the mid-1850s, Pagan had decided to take the work of the training institution out of the ward and into the homes of the poor; and here it stayed.¹⁶⁶ Following Leishman's appointment in 1877, negotiations began to amalgamate this Lying-In Hospital with the GWI dispensary. The managers of the GWI, lukewarm to the idea at first, eventually agreed to allow a system of what it referred to as 'professional attendance to poor women in their homes, at their confinement'. This was both on condition that Leishman agreed to take control and responsibility of the new department, and, as crucially, that he agreed to transfer to the GWI the £1,000 in funds that it was known was being held by him in the name of the Lying-In Hospital. The main broker in the arrangement was Professor John Gray McKendrick. McKendrick was a relatively new to the Glasgow medical scene, having a year earlier moved to Glasgow from Edinburgh.¹⁶⁷

Regulations for the new adjunct to the GWI dispensary, the midwifery visitation department, were established in 1878. Two 'outdoor physician's-accoucheur' were appointed: Drs Robert Kirk and William Loudon Reid. A year later these were joined by a third, Murdoch Cameron. Kirk, Reid and Cameron took charge of Partick, Anderston and what was termed 'the Northern district' respectively; together they

¹⁶⁵ Loudon MacQueen and Archibald B. Kerr, *The Western Infirmary, 1874-1974* (Glasgow and London: 1974), p. 5.

¹⁶⁶ Thanks to Mark Skippen, University of Glasgow, for pointing this out. See J.M. Pagan, 'Contributions to Midwifery and Practice' in GMJ, v. 1 (1854), p. 207f, and John M. Pagan, 'Statistics' in GMJ, v. 8 (1861), p. 198f. The University Lying-in Hospital had been in operation for at least twelve years by November 1852.

¹⁶⁷ Glasgow Western Infirmary Minutes (21st Dec., 1877), ref: GGHB HB 6/1/1: house sub-committee report.

oversaw the organisation of student visits to satisfy examination requirements. Although over the coming years the service remained small – with less than 400 cases recorded for whole of the next nine years – the scheme ran largely without any problems, save issues, quickly resolved, over the dependability of certain students.

Gradually proposals were mooted from different quarters that given the recognised general absence of non-midwifery home visitation services in Glasgow compared to Edinburgh, the GWI might pick up the slack. In 1884, for example, Professor McKendrick chose to speak on the issue of the efficacy of domiciliary services when addressing a meeting of the directors of the Glasgow Medical Missionary Society. More pointedly, in the same year, John Young, Professor of Natural History, raised the topic again at the graduation address of Glasgow University students. Here he argued: ‘If dispensary visitation was – and there could be no doubt of the fact – a very valuable means of future education for the practitioner, it ought to be provided’. Young then pointed out, logically: ‘it ought to be enforced by ordinance, as was attendance on midwifery cases,’ noting further that: ‘domestic visitation under the auspices of a Dispensary was the natural complement of clinical teaching’.¹⁶⁸

Using appointment to the House Committee of the infirmary in 1887, John Cleland, Professor of Anatomy at Glasgow University, finally got the committee to agree to consider the matter of student home visitation in full. A sub-committee of six was elected to weigh the issues. It included four men who together were representative of the major medical institutions of the city: Professor Cleland; Cleland’s fellow Glasgow University Professor, Dr Matthew Charteris; Glasgow MOH, James Burn Russell; and Thomas Lapraik, the nominated board member of the Faculty of Physicians and Surgeons, Glasgow. In November 1887, the sub-committee reported, unanimously recommending: ‘no obstacle [should be put] in the way of the speedy consideration of the institution of a Home Visitation Department by means of students under the supervision of the staff.’¹⁶⁹

With this green light, Professors Charteris and Cleland set about drawing up (what they titled) a new ‘scheme for managing the medical and surgical dispensary of the

¹⁶⁸ *The Scotsman* (1 Aug, 1884), p. 7.

¹⁶⁹ GWI Minutes (12th Nov., 1887), GGHB HB 6/1/1: medical sub-committee report.

Western Infirmary'. This put supervised student visits to patients right at the centre of the proposal (Appendix X). Rule IV of the scheme stated: 'The Physicians shall, in the case of Patients who are not considered suitable for admission into the Infirmary, but are too ill to attend at the Dispensary, appoint a Student to visit them at their homes.'

All seemed well. However, given that it was already late in the financial year, the GWI House Committee proposed to leave the implementation of the proposed new scheme for a new board, with the election due at the end of November 1887. Initially the new board of managers of the GWI also expressed approval of the scheme. Then, at the monthly meeting in December 1887, the scheme hit another delay. The matter was returned once more to the medical committee, who were again instructed 'to look carefully into the matter and report'.¹⁷⁰ The plans were passed eventually on to the GWI lawyers. And it was at this moment the scheme finally hit the rocks. On the 31st January 1888 law agent, Mr Hill, was passed the plans and instructed

to advise as to the nature and extent of the responsibility... which would attach to the managers in connection with such a scheme, involving the attendance of students upon out-door patients; also to the visiting physicians and surgeons and dispensary physicians and surgeons...¹⁷¹

Hill's response confirmed the fears of the more cautious managers. After considering the matter, Hill reported that, in his legal opinion, the scheme involved immeasurable financial risk to all involved at the GWI. He stated that any responsibility over the practice of unqualified medical students 'would attach to the managers' for their part in sanctioning the scheme. 'The nature of the responsibility,' Hill ruled, 'would be damages for want of professional knowledge, or skill, carelessness or neglect on the part of student as pupil practitioner, and the extent would depend on the measure of the default and amount of damages which might be awarded.'¹⁷²

This report proved final. On the say of the infirmary's legal department, the new scheme and the already quietly existing midwifery service were both immediately and hastily abandoned. The three physicians'-accoucheur that had manned the system were redeployed to in-house duties. Despite the resolution of the GMC three months

¹⁷⁰ GWI Minutes (27th Dec., 1887), GGHB HB 6/1/1: house sub-committee report.

¹⁷¹ GWI Minutes (31st Jan., 1888), GGHB HB 6/1/1: medical committee meeting.

¹⁷² GWI Minutes (21st Feb., 1888), GGHB HB 6/1/1: medical committee meeting.

later in favour of promotion of home visits by students, and despite too the seeming litigation-free success of ongoing equivalent services operating in Edinburgh, the idea of using medical students at the GWI dispensary to visit patients was not returned to.

In Glasgow, the medical professors of the university did try to seek an alternative to the problem, particularly of providing an outlet for students to continue to gain practical experience in midwifery cases. After returning from the GMC meeting, bypassing the GWI, in June 1888, various members of the professoriate and their assistants instituted, as a completely separate independent charity, what they called the *Medical Institute – Outdoor Visitation*. This was set up in the Anderston and Finnieston district of Glasgow. It was therefore strategically stationed at a suitable distance from the university and the GWI. Advertisements for it at the time made clear that its avowed purpose was: ‘for... home visitation on the sick poor by senior medical students.’¹⁷³ No sets of surviving records for it have been located, and the occasional references found indicate that this charity survived, probably, for no more than a couple of years. The Medical Institute’s disappearance from the records of Glasgow’s charities roughly coincides with the deaths of two of its known main proponents, Professor Leishman, in 1894, and Professor Charteris, in 1897.

One key factor in terms of difference between educational provision and the development of dispensary services in Edinburgh and Glasgow was the greater ‘collegiate’ culture that existed between institutions in Edinburgh. In Edinburgh, the elites of the medical royal colleges were fully integrated into the establishment as well as into the dispensary services, and the town council - which recognised the strategic importance to the town of the medical school - played an important roll as arbiter over the expansion of teaching services in the city, mediating between the separate claims of the university, the colleges, and those of the extramural schools. Edinburgh’s dispensaries therefore enjoyed important patronage and support. In Edinburgh, there was distinct encouragement ‘from above’ for the spread of medical charities, be they like elsewhere found as ‘entrepreneurial’ enterprises: this was because they served as valuable sites in an overcrowded student centre, offering training facilities in the numerous different aspects of medical curriculum. This relationship was only

¹⁷³ For example, see entries in Glasgow Post Office Directory (1890-1 & 1894-5).

beginning to be undermined in the 1910s, when following the advent of the national insurance, patients' use of medical charity changed, and ultimately the 1920s, when new sources of revenue began to take the focus of medical training in new directions. In Glasgow, over the nineteenth century, the different institutions rarely saw eye to eye in the same respect, and individual charities were far less co-operative in their endeavours. There were on-going territorial disputes, for example, between the royal college and the university, and between the relocated university and the abandoned royal infirmary. The focus in Glasgow – with its separate and distinct teaching culture compared to Edinburgh – was upon the founding of different forms of specialist free charities as an adjunct to the various generalist work of the infirmary outpatients, rather than upon establishment of a range of localised general dispensaries with the roots of those in Edinburgh. As Christopher Lawrence states (quoted earlier), from the mid-1870s the GWI became of over-arching importance in Glasgow in terms of the training of the majority of the medical students in the town; and the decision by its managers to steer clear of using students to visit patients at home with arms-length supervision for legal reasons after 1888 was seemingly therefore decisive in terms of the subsequent provision of such services in the town.

It is also interesting to ponder, though consideration of this question lies outside the remit of my thesis, why it was that it was in Glasgow, and not in Edinburgh – the city of lawyers, but where student-led home visitation had been long established –, that the poor of the city were seemingly more feared for their potential willingness to resort to litigation to defend their rights? Proper explication of this historical conundrum would require full micro-study of the legal records, and of local working class sub-cultures in both localities. Speculatively, there is some evidence, from statements relating to pauper attitudes to the poor law, for example, that amongst the poor there was many that knew, and would apply, their legal rights to challenge decisions made regarding relief in court, and that in this regard at least, it was the poor of Glasgow that were the most active across Scotland in making complaints to the LGBS.¹⁷⁴

¹⁷⁴ For example, see Local Government Board of Scotland Report of Departmental Committee on Poor Law Medical Relief (Scotland) 1904, vol. II (Cd. 2008, 1904), Appendix LX, p. 274: 'Complaints made to the Board of Scotland and Local Government Board against Parish Medical Officers in Scotland, 1855 to 1902'. Robert Lamond, RC Poor Laws and Relief of Distress (Cd.4978), Appendix LXXXI. Lamond, the legal adviser to Glasgow Parish Council, stated: 'The Scottish Poor Laws are now well understood both by those concerned in the administration and by the public.'

3.5 The Fourth International Home Relief Congress, in Edinburgh, June 1904, the treatment of tuberculosis, and infant-mother welfare.

The twentieth century brought renewed interest in different aspects of medical home visitation. This is shown by the series of International Home Relief Congresses, first meeting in Paris, in 1901, and moving on to Edinburgh, June 1904. The Edinburgh Congress is of particular interest for it threw the spotlight, particularly, on urban Scottish developments. The audience consisted of a gathering of mainly medical practitioners drawn from France, Ireland and the European lowlands, plus from Scottish town councils, the LGBS, and as well medical officers of health, parish councillors, and police representatives. The main reception was given by Royal College of Physicians. Consisting of 393 members, the key topics that were discussed over three days reflected current trends in home relief provision and included: ‘feeding of and prevention of cruelty to children, old age pensions, vagrancy, the treatment of consumption, and the care of the insane and epileptic.’¹⁷⁵

The President of the Congress, giving the opening address, was the Sixth Lord Balfour of Burleigh, the former Secretary of State for Scotland, 1895-1903. Burleigh began by pointing out a tradition of Scottish difference within a British context in matters of home visitation and relief provision, stating: ‘Scotland has always taken an independent line in all matters pertaining to the relief of the poor’. Speaking of what he referred to as ‘the Scottish ideal,’ Burleigh argued that strong communities were built on measures that sought to safeguard ‘the independence of the individual citizen in his own home’. Thus he said, referring to the poor law particularly, that ‘the Scottish system has always been, and probably would always be, mainly an outdoor system’.¹⁷⁶ Discussing the disorganised state of what he referred to as the ‘treatment of the poor on an eleemosynary basis,’ across Britain, Burleigh spoke of his desire to see implementation of a more joined-up voluntary charity medical system. This he hoped would be one in which, importantly, those medical practitioners that routinely

¹⁷⁵ Proceeding on the Congress held from June 7th 1904 to June 9th 1904 reported in *The Scotsman* (9 Jun, 1904), p. 7, and (10 Jun, 1904), p. 8, and (11 Jun, 1904), p. 10, and in the *BMJ*, v. 1 (June 11, 1904), pp. 1357-60, (June 18, 1904), pp. 1440-2, and (June 25, 1904), pp. 1492-4. This was a significant year for Congresses in Scotland targeted on home visitation issues relating to mother and child health with the Sanitary Institute Congress also meeting in Glasgow in September 1904. See *BMJ* (16 September 1905), p. 643.

¹⁷⁶ *BMJ*, vol. 1 (June 18, 1904), p. 1440.

paid visits to the homes of the poor would have a crucial and central role. Knowledge of medical cases was built on such visits:

inasmuch as he knows the home and habits of his patient, [he] is better qualified to advise than the over-worked medical attendant in the out-patients department of a great hospital.¹⁷⁷

Speaking on this issue of home visitation and hospital reform but from a Glaswegian perspective, whilst acknowledging instances of exception such as were prevalent in Edinburgh, and whilst overlooking, for the moment, the work of medical missions in his home city, John Glaister - professor of medical jurisprudence at Glasgow University since 1898 - reflected on the general lack of voluntary medical home visitation services outside of maternity services elsewhere.¹⁷⁸

The first day of the Congress was given over to issues of child health and infant feeding. Speakers included Dr. H. Wright Thompson, assistant surgeon of GRI Ophthalmic Institution. Thompson gave a paper that indicated that some home visits were found necessary to children with 'certain eye diseases'. Dr. Jardine spoke of the home visitation system of midwifery cases in operation at Glasgow Maternity Hospital. A.K. Chalmers, Glasgow's MOH, and Dr. Williaat Robertson, the MOH for Leith, discussed the Leith milk depot scheme (which pre-dated by a year a similar scheme in Glasgow under Chalmers' guidance).¹⁷⁹ In November 1905, Glasgow Corporation Infant Milk Scheme gained a medical practitioner. In this month the sub-committee on infantile mortality recommended the employment of a medical practitioner to assist with its programmes and 'among other duties... provide domiciliary attendance for those children supplied with depot milk who required professional assistance'. The salary was £160 per annum, and the post was filled by a succession of female medical practitioners: Dr Lily Smellie (November 1905-March 1907); Dr Mary Gallacher (to April 1908); and then Dr Florence Mann (from 1908). The extent of their domiciliary workload of visits is unrecorded in records found.

¹⁷⁷ BMJ, vol. 1 (June 18, 1904), p. 1441.

¹⁷⁸ *The Scotsman* (11 Jun, 1904), p. 10.

¹⁷⁹ Angus H. Ferguson, Lawrence T. Weaver and Malcolm Nicolson, 'The Glasgow Corporation Milk Depot 1904-1910 and its Role in Infant Welfare: An End or a Means?' in *Social History of Medicine*, 19(3) (2006), pp. 443-460. Dr. Jardine per *The Scotsman* (9 Jun, 1904), p. 7: 'after two months' hospital experience the nurses connected with that hospital attended women in their own homes under the supervision of two outdoor house-surgeons, who, in a difficult case, sent the patient into hospital. The great bulk of other cases in Glasgow were in the hands of "howdies" - most ignorant, sceptic old women from whose clutches every year patients in a hopeless condition are sent into hospital'.

Changing the focus of discussion at the Congress of June 1904 to the specific utility of domiciliary medical care for sick adults, Malcolm Morris, FRCSE based in London, stated ‘in his opinion the disease in which the home treatment of the sick adult in the existing circumstances was likely to be most useful was tuberculosis’. As it was deemed essential to try to identify the disease in its earliest, curable phase, Morris made the logical point that therefore ‘the problem of tuberculosis was therefore essentially a question of home treatment.’¹⁸⁰

The issue of the control and treatment of pulmonary phthisis forced a major re-evaluation of the utility of medical visitation. In the minds of prominent medical men like LGBS medical member Dr. W. Leslie Mackenzie, there was, by the mid-1900s, obvious and pressing necessity for local authority intervention in the homes of the poor for purpose of public safety. Intervention meant domiciliary inquiry, the distribution of information, disinfection, and the isolation of victims. All aspects affected or centred on the home. General practitioners on daily rounds, and during voluntary work at general charity dispensaries in Glasgow and Edinburgh, were encouraged to collect and forward bacteriological samples for analysis at the city chambers. Practitioners in sanitary departments in both cities were encouraged to impart advice to the public that included aspects that were both impractical and improbable for the poorest – such as separate bedrooms for the sick, routine carpet sweeping instead of ordinary brushing, open, sunlit windows, clean handkerchiefs, and suckling and kissing bans. Insistence upon each aspect would have impacted upon how patients viewed and trusted their doctors.¹⁸¹

Scotland was at the forefront of the development of schemes, within Britain, for tackling tuberculosis.¹⁸² Discussion at the Congress therefore turned towards the work of the Edinburgh system of medical visitation amongst tuberculosis sufferers. Dr Robert Willan Philip, founder and senior physician to what by 1904 had become the Royal Victoria Hospital for Consumption, delivered a paper titled “The organisation

¹⁸⁰ BMJ, vol. 1 (June 25, 1904), p. 1492.

¹⁸¹ See RC Poor Laws and Relief of Distress (Cd.4978), Appendix CLXI (C), pp. 912-6: ‘Paper handed in by Dr W. Leslie Mackenzie’. Best medical advice that rooms of the sick should have bare floor boards would have been easier to arrange.

¹⁸² For example, as well as Philip’s system described here, in 1900, in connection with Quarrier Consumption Sanatoria Dispensary, Glasgow saw the development of what was described as Britain’s first TB sanatorium.

of home treatment of pulmonary tuberculosis”.¹⁸³ In the paper Philip argued there existed ‘a clamant-need’ for local authorities to take control of tuberculosis services. This was two years before the matter was first formally discussed by Edinburgh Town Council; two years before the LGBS issued a Circular declaring it notifiable under the Public Health (Scotland) Act, 1897; and three years before compulsory notification of tuberculosis was adopted in Edinburgh, and the first municipal consumption dispensary was established in Scotland in Dundee.¹⁸⁴ For Philip, as for Morris speaking before him, central to the work of fighting infection was a proposed network of tuberculosis dispensaries based on the model he had established in Edinburgh; and central to this dispensary model was domiciliary visitation. The dispensary system he pioneered became the keystone of a British national strategy to fight infection.¹⁸⁵

The Congress paper is important here for in pointing out key aspects of his strategy, Philip repeatedly emphasised the point that home visits had multi-utility. Visits, he said, were necessary in the first instance for those too poor to pay the doctor; they were necessary to coordinate cleansing and disinfecting of households; and necessary too to facilitate the collection of samples for subsequent laboratory analysis. Home visitation also provided crucial case history information. Visits thus made possible better public policing, mapping and monitoring of the spread of disease. Visits were a knowledge-building exercise. Through them, medical staff learnt more regarding the context of the disease. The homes of the poor particularly were a key arena, Philip argued, for the poorest suffered more greatly the problems of cost associated with the infection, and from the impact upon families; the likely subsequent spread of infection were all greater there than anywhere else. During his paper, Philip noted that by the early 1900s, across Edinburgh, around 500 persons annually were dying from the disease, with an additional 4,350 each year succumbing to illnesses part attributable to the person also having tuberculosis. Speaking more specifically of his own work, Philip made the claim for the Victoria Dispensary that ‘so far as I am aware, this was

¹⁸³ *The Scotsman* (10 Jun, 1904), p. 8 and *BMJ*, vol. 1 (June 11, 1904), pp. 1357-60.

¹⁸⁴ *The Scotsman* (28 Mar, 1906), p. 7. The City of Edinburgh eventually took over the public management of the Royal Victoria in 1914.

¹⁸⁵ *The Scotsman* (10 Jun, 1904), p. 8.

the first attempt to deal in more systematized fashion with the great crowd of tuberculous city poor'.¹⁸⁶

Victoria Dispensary for Consumption and Diseases of the Chest, Edinburgh

Robert Philip graduated M.D. from Edinburgh University in 1882. This was the year that Robert Koch discovered the tubercle bacillus in Germany. Philip found the Victoria Dispensary for Consumption and Diseases of the Chest in 1887, in a flat on Bank Street, off the High Street, near the centre of the old part of Edinburgh. Initially a small project 'maintained by the efforts of one or two interested friends,' the institution became self-consciously an exemplar of entrepreneurial application of new scientific medical models of practice: study of physiology in Germany had led to bacteriological discovery which had led to a new pathological concept of the cause of a disease and this in turn had paved the way for new opportunities to create new specialist medical institutions (such as Philip's, in Edinburgh) where new therapeutic approaches could be (and were) introduced.¹⁸⁷ Focused was on 'poor sufferers,' and during the first three years Philip treated 1,317 such cases.¹⁸⁸ Altogether, from 1887 to 1905, 14,329 patients were reportedly seen at the dispensary.¹⁸⁹

Philip's work in Edinburgh gathered momentum after 1890. In this year much publicity was won for the 'able promoter' and his approach to the treatment of tuberculosis. Public clamour greeted Philip's introduction and initial use of Koch's newly developed lymph in the city. Philip brought the lymph from Berlin, and on arrival it was administered to selected patients at Edinburgh Royal Infirmary under the supervision of senior medical staff, including Professor Grainger Stewart and Professor Chiene. Notices to the effect that the experiments with the lymph had started were posted in the local press. As a consequence, in December 1890, *The Scotsman* advised that Philip found his home besieged by 'desperate sufferers' wanting to partake in trials. In response, the treasurer of the Victoria Dispensary

¹⁸⁶ BMJ, vol. 1 (June 11, 1904), p. 1359.

¹⁸⁷ Per *The Scotsman* (5 Nov, 1906), p. 9: Philip spoke of a 'marked change of thought [that] had... occurred among the younger generation of medical practitioners' at an address to the Edinburgh Sanitary society, in November 1906. This change, Philip pointed out, had led to 'great strides... on the therapeutic or curative side,' and had its origins in: 'the change which had come over the pathological conception of the disease...'

¹⁸⁸ On early work of the Victoria Dispensary see *The Scotsman* (20th Dec, 1890).

¹⁸⁹ *The Scotsman* (1 Jun, 1905), p. 9.

drafted a letter to the town council requesting that ‘certain number beds in the City Hospital be... devoted to the treatment of selected cases of consumption with Dr. Koch’s lymph’. Unlike the directors and medical managers of the Royal Infirmary - an institution where poor patients went ‘voluntarily’ - the health committee of the town council, under convener Bailie James Alexander Russell, himself a medical practitioner, declined the suggestion, pointing out that: ‘the Royal Infirmary was the proper place for carrying out such experiments’.¹⁹⁰ The clamour for Koch’s lymph demonstrates both how different institutions cooperated when mutual interests were assured, and the differing status and rights of the poor undergoing public versus private medical provision.

Having awoken public interest and support in the project, in 1894 the Royal Victoria Hospital at Craigleith opened. New premises for the dispensary were found in the city. The hospital was expanded in 1903 with the opening of new pavilions where inmates – both male and female - slept in the parkland around the main hospital building, in ‘out-of-doors shelters arranged in circular form’. Polton Farm Colony was also subsequently established, in 1910. McCrae has recently described Philip’s project as a ‘visionary concept,’ providing the blueprint of a service that was to be nationally adopted into the Sanatorium Benefit of the NHI Act of 1911.¹⁹¹

Philip’s system, MacCrae argues, was based on an idea of containment: by identifying and assessing the family and the immediate contacts of the infected, it was possible at the earliest juncture to isolate infected patients. As there was a lack of compulsion through which to force hospitalisation on the infected, many preferred to remain at home. Domiciliary visits were thus central in order to make an assessment of the environment and family, and for identifying the broader network of contacts of individual patients. Home or outdoor treatment was necessary also because the reluctance of patients, despite benefits, to accept indoor isolation if they still felt able to work or function in order to continue to provide for their family.¹⁹² In the early years, Philip visited poor homes in person, distributing literature regarding the

¹⁹⁰ *The Scotsman* (3 Dec, 1890), p. 7, (4 Dec, 1890), p. 5, (16 Dec, 1890), p. 4, and (7 Jan, 1891), p. 8.

¹⁹¹ Morrice McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950* (East Lothian: Tuckwell Press, 2003), p. 137.

¹⁹² McCrae, *The National Health Service in Scotland*, p. 138. For a recent history see J. Williamson, ‘The Royal Victoria Hospital, Edinburgh 1894-1994, a brief history’ in *Reports of the Proceedings of the Scottish Society History of Medicine, 1994-96*, pp. 28-39.

treatment of the diseases. By winter 1892/3, medical staff of the Victoria Dispensary were making three or four home visits per day to registered patients; and by the mid-1900s, a medical officer supported by dispensary nurses were together recorded as making, what had become, thousands of home visits per year.¹⁹³ In 1897, directors noted that the value of an aggressive home visitation policy was the fact that tuberculosis ‘is highly tractable when treated in the early stages’ and that therefore: ‘[the dispensary undertook] the visiting of patients at their own homes where too ill to be out of doors, and too poor to pay for medical attendance... bed-ridden patients, and those to whom the effort of coming to the out-patient rooms was too great’.¹⁹⁴ Later, the main value of home visitation was said to lie in the fact that it had enabled Philip and his staff to map the domiciliary conditions that enabled the spread of the disease. In this regard visits were treated as the handmaid of scientific endeavour. The process of visiting had revealed what Philip referred to as a series of ‘tubercular nests’ in the city:

The records of the Dispensary...show, for example, that in certain tenements every floor and almost every dwelling has had a case of consumption... The system of domiciliary visitation has emphasised the significance of change of residence on the part of the consumptive patient as a factor in the spread of consumption.¹⁹⁵

Central to the information gathering process that lay at the heart of visitation was a thorough schedule of inquiry that was signed off by both the dispensary medical officer and a reporter assigned to the task (Figure 3.3). Whilst Philip claimed that ‘no difficulty whatever has been experienced in obtaining the desired information,’ the schedule demonstrates the true extent of imposition on families of sufferers that visitation entailed. Judgement was made regarding the general aspect of the house, and those visited were probed as to whether they slept alone? How they washed their clothes? How much money they earned? What they ate? And whether they were ordinarily teetotal?¹⁹⁶

¹⁹³ Per Twentieth Anniversary Report in *The Scotsman* (26 Oct, 1907), p. 9.

¹⁹⁴ *The Scotsman* (27 Apr, 1897), p. 7.

¹⁹⁵ *The Scotsman* (18 Jun, 1908), p. 11. See also *The Scotsman* (12 Feb, 1909), p. 6.

¹⁹⁶ Quoted from RC Poor Laws and Relief of Distress (Cd.4978), Appendix CLXI (C): ‘Paper handed in by Dr W. Leslie Mackenzie’, appendix no. 2: R.W. Philip, ‘The erection of municipal dispensaries, and a complete organisation against tuberculosis’.

Figure 3.3: Royal Victoria Dispensary for Consumption Schedule of Inquiry regarding Dispensary patients

Name?	Age?
Address?	Married or single?
Occupation?	Has patient changed occupation?
Able to work full-time?	Or part-time?
If unable, confined to bed?	
How long ill?	
Situation of house (area, ground floor, 1 st , etc)?	
Number and ages of inmates?	
Number and description of rooms?	
General aspect of house (clean, damp, dusty, smelly)?	
Number of windows?	Can they open?
Are they kept open	(a) by day?
	(b) by night?
Have they always been kept open?	
Does the patient sleep alone	(a) in bed?
	(b) in room?
How is washing of clothes done?	
How long in present house?	
If has moved within two years, previous addresses?	
Have there been illnesses or deaths in house?	
	(a) In own time?
	(b) In previous occupancy?
Exposed to infection	(a) at home?
	(b) at work?
	(c) among friends?
Present health of other members of household?	
What precautions taken to disinfect?	
T.B. in sputum?	
T.B. in dust of room?	
General dietary?	Teetotal?
General condition (well-to-do, badly off)?	
Proximate income of household?	
Assisted by societies, church, friends, rates?	

Source: Royal Commission Poor Laws and Relief of Distress (PP Cd.4978, 1910), appendix CLXI (C): *Paper handed in by Dr W. Leslie Mackenzie*, appendix no. 2: R.W. Philip, 'The erection of municipal dispensaries, and a complete organisation against tuberculosis'.

Anderston District Health Association Dispensary, Glasgow

...One ought to have a reason for one's visit. And the best introduction to a home is, I think, through the children.¹⁹⁷

I have often visited in Anderston and have seen many of the very poor there, in their homes and outside of their homes. Most of those have been quite too poor to pay any fee to a doctor. I have often seen a poor, hard-working woman who has had a sick husband and small children to support. I have often urged such a poor woman to take her children to the Western Infirmary or the Sick Children's Hospital, and have been told that she could not do so, as it would mean the loss of half a day's work, and she could not afford it. For such people a dispensary near them would be a great boon. It would also be much easier to prevent the abuse of such a dispensary, *as the patients' homes could be visited easily*.¹⁹⁸

First announced a year earlier, introducing the scheme for a new dispensary for the Anderston area of Glasgow at a public meeting at City Chambers in October 1906, Lord Provost William Bilsland said it was planned that: 'The dispensary would be similar to those in other districts, but special attention would be directed to the treatment of women and children, thus endeavouring to mitigate the terrible evil of infantile mortality.'¹⁹⁹ It was announced that the founders of the dispensary aimed to adopt a 'bounty scheme' along the lines of one previously introduced in Huddersfield, England. This was to lay the groundwork for adoption of district health visiting in Glasgow with the key aim of reducing infant mortality. Anderston was identified as an ideal location, being a working class district of around 70,000 persons. The mechanics of the bounty scheme was advertised locally and across Scotland from January 1907, and handbills distributed to the effect in district.²⁰⁰

At a second public meeting called several weeks later, and where it was recorded that 'a considerable proportion' of a large public gathering were ladies, other key proponents of the scheme joined Bilsland to push the case. Support was drawn from across the local academic, medical, political, and industrial elite, including: John Carswell, certifying physician of lunacy cases for Glasgow Parish Council, having

¹⁹⁷ From an address at the opening of Queen Margaret College Settlement in the Anderston district of Glasgow by a London COS representative and recorded in Organised Help, Vol. 31 (Glasgow: Charity Organisation Society, 15/3/1901).

¹⁹⁸ 'Slum Haunter,' in *The Glasgow Herald* (Dec. 18, 1906), p.10.

¹⁹⁹ *The Scotsman* (11 Oct, 1906), p. 6.

²⁰⁰ *The Scotsman* (9 Jan, 1907). Per *The Glasgow Herald* (Jan. 8, 1907), p. 7, the handbill distributed read: 'The committee of the Anderston and District Health Association hereby make offer of a gift of £1 sterling to the mother of each child born between January 1 and June 30, 1907,' provided the child survives the first year of birth.'

begun parochial service as the PMO for the Anderston-Finnieston district in 1880; A.K. Chalmers, Glasgow's MOH, and vocal proponent for the extension of domiciliary medical services amongst the poor; J.P. Maclay, shipbuilding magnate, and later a Baron; solicitor Frederick J. Ferguson, who became the institution's first secretary; and Donald Macalister, British Medical Council president, and the incoming principal of Glasgow University.²⁰¹ Bilsland was an important local businessman and appointed Lord Provost of Glasgow in 1905. The Bilsland Brothers ran a successful bakery in Anderston. These men were thereafter joined by Diarmid Noel Paton, newly appointed to the chair of physiology in Glasgow University.²⁰² Other supporters of the scheme included the shipping and insurance brokers, P. Henderson & Co., and George Jardine Kidston, owner of the Clyde Shipping Company. Amongst the general population of Anderston were a large number of workers who would have been employed either at the dockside or at the Bilsland Bakery. Whatever altruistic intent, there was also much obvious vested interest in local support. Intrinsic to the successful work of the dispensary, Bilsland announced:

[T]he object of the meeting was to explain the purpose of the Association and to invite the co-operation of the workers in the district with a view to their becoming health visitors and reporting cases that came under their notice. The desire was institute an organisation that would be helpful to the various social and religious agencies in their effort to bring ameliorative influences to bear on the poor and sick and suffering. It was believed that the wants of the district could be best met by a scheme of home visitation, and also by a dispensary for medical advice regarding diseases caused by ignorance and neglect especially among women and children.²⁰³

Chalmers was even more fundamental on the main point. He claimed that what was wanted for the success of all preventative health measures was ultimately for the medical practitioners: '...to get inside the homes, and we cannot do this without a dispensary.'²⁰⁴

In order to rally the widest possible public support, verbal reassurance was given that the new dispensary, whilst it 'would cover generally the lines followed by similar institutions... would not compete with an existing agency, and that it would be

²⁰¹ *The Scotsman* (8 Dec, 1906), p. 10.

²⁰² Derek Dow and Michael Moss, *Glasgow's Gain: the Anderston Story* (Lancashire: Parthenon Publishing, 1986), pp. 87 to 88. Noel Paton's introductory lecture in Glasgow was on the diets of the poor and was given in support of the ADHAD project. See *The Glasgow Herald* (Mar.15, 1907), p. 11.

²⁰³ *The Scotsman* (8 Dec, 1906), p. 10.

²⁰⁴ *The Glasgow Herald* (Dec. 11, 1906), p.10

entirely undenominational and unsectarian.²⁰⁵ No mention was made of the effect on trade the dispensary might represent to local medical practitioners, and it was from this group that most vehement opposition was to come. Concentrating on the population of a carefully defined territory - 'lying west of Jamaica Street' - it was proposed that the dispensary would focus on medical problems that were the main issues tackled at the International Home Relief Congress in Edinburgh two years earlier, by 'aiding the Corporation in dealing with the serious question of infantile mortality, and that terrible disease of consumption.'²⁰⁶

Support was strong but opposition proved equally so. The proposed establishment of a new charity dispensary with local municipal support was highly controversial with aspects of the local medical profession. A bitter dispute ensued over several months. The main opposition came from medical practitioners, represented by the local medical societies and by the regional branch of the BMA. Particularly vocal in the press were two local practitioners, James Weir, M.B., and John Parlane Granger. Opposition also came from William Loudon Reid (as President of the FPSG), and local PMOs like George Bell Todd. A number of Glasgow's poor law officers were particularly chagrined at the support for the scheme given by 'fellow' parish council medical employee, John Carswell. Personal, political and medical interests interwove.²⁰⁷ William Loudon Reid's professional status made him a figurehead for opposition to the dispensary. It is interesting therefore that from 1909 Reid was to take over as the President of the Glasgow Medical Missionary Society. This was an agency that also operated through charitable medical dispensaries, providing the type of home visitation amidst poor areas of the city that ADHAD supporters' planned.

²⁰⁵ The Glasgow Herald (Oct. 11, 1906), p.8.

²⁰⁶ The Glasgow Herald (Oct. 11, 1906), p.8.

²⁰⁷ See RC Poor Laws and Relief of Distress (Cd.4978), Appendix No.CLXI (B). From January 1907, Carswell conducted the inaugural course of lectures organised in support of the new health association. This was not to be Carswell's only run in with fellow medical professionals this year. There were LGBS investigations led by Dr W. Leslie Mackenzie held the following month, in February 1907, into his conduct. These investigations concerned Carswell's perceived 'dictatorial' approach in dealing with pauper lunacy cases and his supposed 'unorthodox practices' in observation wards at the parochial hospital. These allegations were raised by fellow Glasgow PMO's and by medical practitioner parochial board member James Erskine. Carswell was shot and wounded later in 1907, giving evidence in court, by a member of the public disputing a certification of lunacy issued by him. See *The Glasgow Herald* (Oct. 25, 1907), p.9: Carswell's support for the ADHAD had bought him problems within the medical community but also powerful allies. Shortly after the shooting incident, Carswell was presented by William Bilsland, as the serving Lord Provost of Glasgow, with a cheque for £415 and a silver salver. The presentation at the City Chambers was made 'in recognition of his services to the community as a member of the Town Council and other public and philanthropic Boards...'

Opponents seized upon the ‘baby bounty’ leaflet scheme. They stated that leafletting was a clear and direct contravention of GMC rules regarding canvassing for clientele. Opponents therefore sought to use the power of the local BMA to secure a united medical professional boycott of the dispensary project. On February 2nd, 1907, the *Glasgow Herald* reported a meeting of the Glasgow and West of Scotland branch of the BMA regarding the newly opened dispensary. Members sought to undermine its viability through a strategy of local medical non-compliance. Those present agreed not to seek appointment there. Those opposed enjoyed initial success, as the first group of appointed medical staff opted to resign their posts when faced by the protests of fellow medical professionals. John Wishart Kerr, a Glasgow general practitioner with a practice across town in Bridgeton, summed up the proposed strategy of opposition:

If it were proposed by these directors, in spite of their [the local BMA’s] opposition, to have a dispensary, then those who staffed the dispensary would have to consider their position with regard to canvassing, which the General Medical Council had already pronounced to be infamous in a professional respect.²⁰⁸

Unfortunately for Kerr and the other opponents of the dispensary, despite securing the general support of the FPSG, the issue continued to divide the Glasgow medical profession.²⁰⁹ As a result, no unanimous approach could be agreed upon. With support secured from amongst university professorial staff, the dispensary project was able to push ahead. Fearing that new problems would be caused by the proposed parachuting in of medical practitioners from outside Glasgow to fill the new dispensary posts if local opposition continued, pragmatically, a leader in *the Glasgow Herald* called for aggrieved medical professionals to try to adapt themselves to the new conditions.²¹⁰ The scheme, once established, quickly settled down. In the first year of ADHAD, 137 babies were registered with the bounty scheme. Nine deaths were recorded. 2,300 patients were treated. These made 5726 visits to dispensary. ‘Doctors paid 359 visits to patients too ill to attend.’²¹¹

²⁰⁸ *The Glasgow Herald* (Feb. 2, 1907), p.9.

²⁰⁹ In the *Glasgow Herald* (Feb. 4, 1907), p.11, Dr. James Hamilton, the honorary secretary of the Glasgow and West of Scotland branch of the B.M.A. announced that the special meeting called to discuss the Anderston District Health Association Dispensary had only voted 37 to 17 against it, with a number abstaining.

²¹⁰ *The Glasgow Herald* (Feb.18, 1907), p. 5.

²¹¹ *The Scotsman* (29 Feb, 1908), p. 7.

Despite calls for mutual understanding and respect, some medical practitioners continued to voice grievances and harbour their resentments. Within medical circles, this became focused on the laymen that had provided the project its financial and political support. As the dispensary began operations, medical practitioner James Weir wrote cynically of their philanthropic motives and of appeasement proposals that visitation medical staff should receive a small salary for their work:

I wonder if the Lord Provost – that apostle of altruism to the physicians – expects that true altruism can be engendered in medical men at the price of £52 10s per annum. How altruistic some people are – with other people's bread and other people's brains!²¹²

The proposals for the founding of the new charitable medical dispensary in Anderston district of Glasgow led to broader disquiet. A spate of correspondence from local medical practitioners and others on all manner of issues and grievances attached to the provision of medical relief to the poor began to appear in the local press. In one example, the *Glasgow Herald*, in November 1906, carried correspondence from a reader signed with the traditional anonymous alias. 'Medicus' took the opportunity to complain generally as to the widespread nature of abuse of medical charities in the city by individuals, he said, were wealthy enough to pay. In response to this, a second correspondent, signed as 'Mercy', used the affair to bemoan what he in turn said was the poor standard of medical practice carried on at charity dispensary outpatients. Mercy pointed out that the growing press upon dispensary charity by the better-off of the working-classes meant that the outpatients and dispensaries had become, as he claimed, growingly ill-suited arenas within which a medical practitioner might learn the science of medicine.²¹³

²¹² The *Glasgow Herald* (Feb.20, 1907), p.5.

²¹³ The *Glasgow Herald* (29th Nov., 1906) and (8th Dec, 1906), p.5.

3.6 Conclusion

As has been demonstrated in the prospectus of medical charity provided, the range of outdoor services, in Glasgow and Edinburgh both, was suitably substantial that it constantly surprised everyone that looked at it. This growth of medical charity – notable from the 1870s – had both demand and supply-side impetus (Chapter 3.1). Whilst substantial, however, there were differences in emphasis between services in Edinburgh and services in Glasgow, a difference reflected in respective numbers of outpatients and domiciliary cases (Tables 3.2, 3.3, and 3.4). Differences in levels of charitable domiciliary care provision revolved around the place of the general charity dispensary system in medical education in Edinburgh, a series of events in 1888, and the decision taking in Glasgow at the main medical school to abandon plans for visits in conjunction with the Western Infirmary, through fear of potential litigation (Chapter 3.4). Use and support for domiciliary visits was also contingent on changing medical priorities, and as such, medical home visitation was given new lease of life in the first decade of the twentieth century as concern shifted to the fitness of the nation, and to treatment for tuberculosis, infant health and motherhood (Chapter 3.5)

The main charity dispensaries looked at was manned by practitioners as honorary positions, although staff specifically employed to conduct visits were often, of necessity, paid for that work (Chapters 3.2 and 3.3). As with poor law placements, there was always competition for dispensary appointment. British ‘dispensary doctors’ have enjoyed a mixed reputation. It was often complained that they were popularly - if be it mistakenly – seen as a cut above the regular medical practitioner, much to the chagrin of those medical practitioners without such honorary appointment. Claiming that charity medical dispensaries during the nineteenth century were always ‘less prestigious than hospitals’ and that they were staffed by ‘lower status professionals,’ Kidd also points out, less contentiously, that dispensaries were the body that ‘dealt most directly with the poor’. These direct dealings are nowhere more evident than during the act of undertaking home visits described in this chapter.²¹⁴

²¹⁴ Alan Kidd, *State, Society and the Poor in Nineteenth Century England* (Basingstoke: 1999), p. 94.

Edinburgh's main charity dispensaries were prestigious institutions, with staff and support from amongst the elite of the Edinburgh medical profession: Edinburgh Royal Public Dispensary was closely aligned with the two royal colleges (Chapter 3.2); and Edinburgh Medical Missionary Society was established and directed throughout the period by medical university professors (Chapter 4.3, below). Motivations for, and the objectives of, medical philanthropy were diverse (Introduction). As has been demonstrated, much medical charity, especially in Edinburgh, was deliberately and openly arranged in the interest of, and in conjunction with, the particular requirements of the local medical schools. Educational provision was a powerful and vitally important core industry in the city, and outpatient work was established as one of the abiding hallmarks of a Scottish medical education. For the subset of charity that can be classified as medical missions (Chapter 4), charity dispensary and domiciliary care for the poor was not just about education, but education with an even more specific focus in mind.

Charity institutions helped underpin civic life. They developed to reflect changing local priorities, serving the requirements of different local social-medical interests or interest group. Having said this, local interests were not always nor necessarily aligned. Neither, of course, did local members of the public or local cohorts of medical practitioners speak with one unified voice on any given particular issue. It is shown in this chapter how the establishment of a new charity dispensary like Anderston District Health Association Dispensary in Glasgow could prove highly divisive, and that controversies aroused could escalate to take in a host of attendant professional grievances (Chapter 3.5). Indeed, debates surrounding the establishment of medical charities throw up some of the most telling commentaries on the state of medical provision.

CHAPTER 4

PRIVATE PROVISION – MEDICAL MISSIONS

4.1 Historical overview of home medical missions

Of 1875-1911, it has been argued that the nature of religion in Scotland was transformed from this time, both with ‘the suburban exodus of the 1880s, 1890s and 1900s,’ and then a ‘crisis of faith... with evangelical-based social policy’.¹ Whether this is true it remains the case that Scottish society in the decades before World War One simply cannot be understood without substantial reference to religion. Ubiquitous, if not universal, serious if not unequivocal, religious imagery and rhetoric pervaded social and political discourse.² Presbyterianism provided structure and social organisation in Scotland. It provided motivation for most social action. It was at the heart of the administrative and educational systems. Although power became less concentrated after the Disruption of 1843, the church remained at the hub of the local community: symbolically, the church door remained a local information exchange.³ As late as 1909 it was possible to claim of Edinburgh, ‘a place of great activity in charitable matters,’ that it was a city still ‘containing 170 Churches of different denominations’: and that of Scotland’s second city that ‘the number of Christian workers in Glasgow is unlimited.’⁴ Schism begets competition. Whilst long-term religious decline in Scotland may have owed something to the growth of ecumenicalism in the nineteenth century, there was, in the short term at least, strength in diversity. The ‘fissiparous’ nature of Protestantism in Scotland in the second-half of the nineteenth century created an edge that encouraged commitment, activity and imaginative development of a spate of welfare and medical services.⁵ Challenges

¹ Callum G. Brown, *Religion and Society in Scotland since 1707* (Edinburgh: Edinburgh University Press, 1997), p. 133 and pp. 128-9.

² Texts like John Inglis, *A Victorian Edinburgh Diary* (Edinburgh: Ramsayhead Press, 1984), demonstrate an amount of religious equivocation amongst the Protestant middle classes of Scotland.

³ For example, church doors were posted with details such as parochial board meeting schedules.

⁴ *Royal Commission on the Poor Laws and Relief of Distress Report on Scotland* (London: P.P. C.d. 4922, 1909), part VI: Charity and the Poor Law, paragraph 29 & 42.

⁵ On religious decline and ecumenicalism see Brown, *Religion and Society in Scotland since 1707*, p. 7, and K.S. Latourette, ‘Distinctive features of the Protestant Missionary methods of the nineteenth century and twentieth century’ in *Evangelicalism: International Missionary Council Meeting at Tambaran, Madras*, vol. III (London: Oxford University Press, 1939), p. 19: ‘Protestantism is fissiparous’.

presented opportunities. Whilst mass immigration during the nineteenth century brought ‘heathens’ - Irish Catholics and others – into the cities on a large scale, changing the demographics of Edinburgh and Glasgow, this feature of changing Scottish urban life, added to other factors like the challenge of the rise of science, and the role played by Scots in the development of the empire project that helped carry commerce and civilisation to the corners of the globe, provided great fillip and focal points for organised religion.

There was a close link between charitable impulse and the revivalist evangelical movement. Speaking in 1884, a year before his death, and when serving as the honorary president of the Glasgow Medical Missionary Society (GMMS), Lord Shaftesbury, for example, noted that: ‘most of the great philanthropic movements of the century have sprung from the Evangelicals’.⁶ Evangelicalism radicalised religion across Britain during the nineteenth century. It provided an important stimulus to philanthropy. For the burgeoning Catholic middle-classes in towns like Glasgow and Edinburgh, counter-evangelicalism also became the prime motivating factor for social action.⁷ Important in the development of private voluntary institutions, religious men like medical men were also fundamental in shaping Scottish public policy. The debate in the early 1840s in Edinburgh between Thomas Chalmers and William Pulteney Alison over the future of Scotland’s poor relief embodied the at times uncomfortable fit of medical and missionary opinion regarding relief provision for the sick and poor. It is significant therefore that Chalmers and Alison buried differences when they came together in their support of the medical mission cause. In 1841 the two men were named jointly as the first Vice Presidents of the newly formed ‘Edinburgh Association for Sending Medical Aid to Foreign Countries’: this was the organisation re-launched as the Edinburgh Medical Missionary Society in 1843.⁸

⁶ Kathleen Heasman, *Evangelicals in Action: an appraisal of their social work in the Victorian era* (London: Geoffrey Bles, 1962), p. 21, quoting from Edwin Hodder, *Life of Lord Shaftesbury*, vol. ii (1886), p. 3.

⁷ Robert Kent Donovan, ‘The Denominational Character of English Catholic Charitable Effort, 1880-1865’ in *Catholic Historical Review* vol. LXII (Catholic University of America Press, 1976), pp. 200-223.

⁸ Alison was, in 1815, one of two physicians appointed to the newly opened ENTJ. See Olive Checkland, ‘Chalmers and William Pulteney Alison: a Conflict of Views on Scottish Social Policy’ in A. C. Cheyne (ed.), *The Practical and the Pious: Essays on Thomas Chalmers (1780-1847)* (Edinburgh: Saint Andrew Press, 1985), p.130-140; and R.A. Cage, *The Scottish Poor Law 1745-1845* (Edinburgh: Scottish Academic Press, 1981), chapter 7.

Despite the impact of evangelicalism on philanthropy, and the centrality of medicine both to missionary work and to European imperial endeavour - at its height over the period of interest here -, the work of medical missions remains largely overlooked in mainstream historical literature. Whilst there has been interest recently in overseas activity, this remains the case regarding the work of home medical missions. An exception is the now largely forgotten work of Kathleen Heasman. Heasman issued a rallying cry in *the Historical Journal* of 1964 regarding the importance of home medical missions in Britain's cities, but it was a cry that fell on deaf ears.⁹

Heasman had sought to rescue the home medical mission: from the silence history had cast around it by the 1960s; and from the scathing and dismissive assessment of the movement offered towards the end of the Edwardian era. After World War Two collapse of empire had meant, she said, a loss of interest in missionary endeavours more generally. In a not unfamiliar complaint, criticism by Sidney and Beatrice Webb had come to serve as a final word on the topic by the mid-twentieth century. Heasman quotes a memorandum offered to the Poor Law Royal Commission, 1909, in which the medical mission dispensary movement was said to be 'the worst of the lot' of all the outdoor voluntary medical services for the sick-poor. She quotes the Webbs' more directly that medical missions were responsible for the worst kind of 'gratuitous, indiscriminate, and unconditional medical attendance', and that therefore they represented in extremis the faults that attached to all forms of free charity dispensary. In bemoaning the lack of single system of outdoor medical service, the Webbs' went further in their condemnation. They claimed that medical missions, in 'mixing up medicine with religion... attract[ed] persons to religious services by the bait of 'cheap doctoring', and that they were responsible therefore for 'spreading more disease than they are curing'.¹⁰ 'Cheap doctoring' deliberately carried double meaning, castigating the standard of medical missionary recruit.

Whilst claiming focus upon England, Heasman admits that it was Scotland that was the true home of the home medical missionary movement. As a consequence much of the evidence used in her study comes from Scottish sources. Despite the confusion of

⁹ Kathleen J. Heasman, 'The Medical Mission and the Care of the Sick Poor in Nineteenth-Century England,' in *The Historical Journal*, vol. 7, no. 2 (1964), pp. 230-245.

¹⁰ Heasman, 'The Medical Mission', p. 230. Heasman quotes Sidney and Beatrice Webb, *The State and the Doctor* (London: Longmans, Green & Co, 1910), p. 134-5.

emphasis- whilst her understanding of specific developments in Scotland is not entirely clear - Heasman makes a whole series of important observations that are largely upheld here. She outlines the link between home and foreign work. She identifies the crucial support of the medical academic structure of Edinburgh in the development of home medical missionary services in that city. She points out the emulation of medical work by other charitable and religious organisations. Heasman also notes that medical missions plugged gaps in medical service left by the poor law for groups like women, children, the chronically sick and those in low wage and casual employment. Medical missions, she says, provided speedy, accessible and flexible care. Medical missions were not under-served in terms of the quality of medical officer attracted to the work. They also had a comparatively good standard of domiciliary nursing assistance available to them, and were especially strong at recognising the importance of provision of 'medial extras' to the sick-poor. Accusations that medical mission students enjoyed too free a hand over patients, Heasman argues, overlook the supervisory structures and mechanisms established to manage students. Where it was unremunerated, the work attracted necessarily the most dedicated or established persons. Medical missions also forged strong ties in localities with local voluntary hospitals through connections with the medical elite. The medical care that missions provided was not simply (even if ideologically) subordinated to religious aims; and 'quite an appreciable number of persons' benefitted from medical mission treatment services in different urban localities. Overall, medical missions took a more than usual holistic and co-ordinated approach to treatment, combining medical, nursing, and welfare visitation, and considering both the individual and the family, and as well the 'mental as well as the physical condition of the patient'. Importantly, all this built upon the fact, as Heasman stated: 'the [mission] doctor could base his treatment on his knowledge of home surroundings.'¹¹

Since Heasman in the 1960s, home medical missions have again received little attention, save in specialist literature or in what otherwise are largely uncritical, heroicised recounts of endeavour in memoir form by time-served medical missionaries. Whilst skewed by self-interest, histories 'from the inside' provide much

¹¹ Heasman, 'The Medical Mission, pp. 239-43. Heasman's explanation of the development of home medical missions in Edinburgh (p. 232) overplays the role of William Burns Thomson and completely overlooks the role played by Peter Handyside (Thomson's tutor).

data that would otherwise have been lost. They provide testament too of the beliefs, motivations and actions of medical practitioners that served. Interest in issues of empire and immigration plus the currency of arguments that British imperial attitudes to colonised peoples were largely the transference of ‘class attitudes to the poor’ only makes the continuing routine exclusion of study of the home medical mission movement from accounts of nineteenth century Britain all the more mysterious.¹²

A recent spurt of interest in overseas medical missionary work has culminated in the publication of *Healing Bodies, Saving Souls*.¹³ David Hardiman makes several robust observations applicable to all forms of medical mission endeavour. The medical missionary movement, he points out, was at its height from the 1880s. This correlates to a peak decade of British economic power and too to the decade that Callum Brown says evangelicalism was at its highest ebb in Scotland. The ultimate objective of medical missionary work was conversion rather than cure. Hardiman points out too that medical mission dispensary stations were deliberately and carefully planted to serve as ‘magnet[s], drawing people from near and far to the missionaries’.¹⁴ *Healing Bodies, Saving Souls* does not consider work undertaken in Britain’s cities; yet as the World Missionary Conference held in the city in 1910 made clear, the home base was always the foundation of overseas missionary enterprises.¹⁵ Like Hardiman, Alice Russell also observed that institutions for the poor were often deliberately set down amidst them in slum districts. Such institutions, including those offering medical

¹² Typical of hagiographic approaches is Stanley G. Browne, *Heralds of Health: the Saga of Christian Medical Initiatives* (London: Christian Medical Fellowship 1985). Jane Higgs, “‘A heart that has felt the love of God and longs for others to know it’: conventions of gender, tensions of self and constructions of difference in offering to be a lady missionary’, in *Women’s History Review*, vol. 7 no. 2 (1998), pp. 171-193, typifies what is a sparse literature in its Anglo-centric focus. Examples of historical studies of Scottish medical missions produced by former medical missionaries themselves include the self-congratulatory anniversary celebrations by H. F. Lechmere Taylor, *A Century of Service, 1841-1941* (Edinburgh: Edinburgh Medical Missionary Society Darien Press, 1941); John Wilkinson, *The Coogate Doctors* (Edinburgh: Edinburgh Medical Missionary Society, 1991); and that by bible-nurse Jane K. Lorimer, *Ten Years Medical Mission Work in Glasgow* (Paisley, Glasgow and Edinburgh, 1878). The argument that imperial attitudes were informed by *class attitudes to the poor* picked up at home was made, for example, by Patricia Barton, ‘Trends in Imperial Medicine’, unpublished paper presented to ESH50, Glasgow University Conference (7 September, 2007).

¹³ David Hardiman (ed.), *Healing Bodies, Saving Souls. Medical Missions in Asia and Africa*, Clio Medical/ The Wellcome Series in the History of Medicine 80 (Amsterdam & New York: 2006).

¹⁴ Arguments made by Hardiman in the opening address to a Medical Missions in Asia and Africa Conference, Warwick University, 2002. See report in *Wellcome History*, No. 21 (October 2002), p. 14.

¹⁵ W.H.T. Gairdner, *Edinburgh 1910: an account and interpretation of the World Missionary Conference* (Edinburgh and London: Oliphant, Anderson and Ferrier 1910), p. 240.

treatment, were, she says, designed to serve as 'broadcasting centres' or 'islands of endeavour' promoting communication, contact and consensus.¹⁶

Medical missions are exemplars of such 'transmitting stations,' being conceived (to use a popular contemporary analogy) as beacons of light, as citadels amongst infidels. It was exactly in this vein that celebrated Scottish ministers were said to have *pervaded* their ministry.¹⁷ Set down amidst the very poorest in the most under-served districts, medical mission stations that were most successful were also protean institutions. As finances allowed, many came to provide an array of add-on social, welfare and community services.¹⁸

Those who were eager to embrace the idea of mission work found it unacceptable that men should organise such work overseas, channelling large resources there, when there was so much ignorance at home in the now rapidly expanding industrial cities. Thus the home mission was born out of the overseas mission movement; indeed many of the missionary societies were dual in character, funnelling their resources both to overseas and home missions.¹⁹

The only recent general study of medical charity in Scotland to give credence to the work of home medical missions is Checkland (quoted above). For Checkland, medical missions were one aspect of an array of evangelical philanthropic responses to urbanisation, including the Church Extension movement, the founding of Religious Institute rooms, the Sunday School movement, the City Mission movement, the Temperance Movement, the founding of religious societies for young men and women, and the Boy's Brigades movement. These were all either peculiarly Scottish, particularly successful in a Scottish context, or were inspired by Scottish examples.²⁰

¹⁶ Alice Russell, *Political Stability in Late Victorian England* (Lewes: The Book Guild Ltd, 1992), p. 29.

¹⁷ The Salvation Army explicitly came to name their meeting places citadels. Roger S. Kilpatrick, *The Ministry of Dr. John Macleod in the Parish of Govan* (Edinburgh and London: Blackwood & Sons 1915).

¹⁸ Andrew L. Drummond and James Bulloch, *The Church in Late Victorian Scotland, 1874-1900* (Edinburgh: Saint Andrew Press, 1978), p. 191 point out that the Grassmarket, Cowgate and Canongate areas around the EMMS dispensary had the lowest standards of health and housing in late-Victorian Edinburgh.

¹⁹ Olive Checkland, *Philanthropy in Victorian Scotland: Social Welfare and the Voluntary Principle* (Edinburgh: John Donald Publishers 1980), p. 66.

²⁰ Checkland, *Philanthropy in Victorian Scotland*, p. 83.

4.2 The oft-repeated anecdote of William Burns Thomson's epiphany

There was always strong support for medical missions amongst the medical academic elite in Scotland. Thus, as they had since the society was first formed 48 years earlier, the directors and volunteers of the Edinburgh Medical Missionary Society (EMMS), drawn from the medical as well as the clerical and professional elite of the city, gathered at the comfortable and familiar surrounds of the Royal Hotel for their annual general meeting on a winter evening in January 1890. Here they heard the address of Reverend John Lowe. Lowe had been for eighteen and six years respectively the medical superintendent and secretary of the society.²¹ With some satisfaction, no doubt, they heard Lowe announce that over the three decades from when he had first graduated to practice after undergoing training with the society in 1861, the number of known British medical missionaries abroad had increased from fourteen to 125: approximately one-half of these, Lowe said, had passed through the dispensary established in the Cowgate. These had therefore all been trained under the auspices of the EMMS. Those gathered heard how home medical missionary activities amongst the sick-poor in their city continued to feed worldwide evangelical endeavour. Lowe's point, once again, was to remind that home and overseas medical missionary activity were intertwined, with Edinburgh at the forefront of both.

At the time of gathering, based at the training home operated in conjunction with the dispensary, and pledged to become medical missionaries on graduating, were 28 medical students. With varying degrees of approval those gathered would have had occasion to recall that the previous year Lowe had used the annual meeting to announce that these young men would shortly be joined by a few like-minded women. In 1888, the EMMS had decided henceforward, as funds allowed, that it would take an active role in supporting selected quotas of females desirous to pursue medical training in Edinburgh, thereby encouraging them away from the overcrowded

²¹ Reverend John Lowe graduated L.R.C.S.E. 1861, and worked for ten years as a medical missionary for the London Missionary Society in South Travancore, India, until his sick wife forced his return to Edinburgh. Lowe was appointed medical superintendent of the EMMS Cowgate Dispensary in March 1871, and later also secretary, from 1883. Lowe died in 8th May 1892. He found and edited the *Quarterly Papers of the Edinburgh Medical Missionary Society*, from May 1871 to his death.

domestic medical marketplace. In addition to these students formally undergoing training, Lowe announced a further 50 to 60 of Edinburgh's regular medical students had also attended to complete practical training aspects of the medical curriculum at the dispensary during the past year. Numbers of students attending during 1889 was not atypically high. In another full year sampled, 1896, more than one in seven (15.7%) of all university medical graduates in Edinburgh had passed through training at the Cowgate Dispensary.²² These students had sat in on consultations, assisted in minor operations, undergone midwifery training by attending at births, partaken of practical pharmacy instruction, and undertaken the home visitation of selected medical cases in the streets surrounding the dispensary. All had been conducted under the watchful eye of Lowe, his medical assistants, and his fellow staff. The staff had always included in its ranks a good number of the students' regular university professors who gave service gratuitously. Different students attending were thereby inculcated into missionary ways during their medical education. The gathering at the hotel were told that during the past year, 1889, the EMMS had treated over 10,000 of the sick-poor of the city, visiting over 3,000 of these in their homes (and each, on average, three or more times). This again was not atypical. With the exception of the parochial authorities and Leith Infirmary, no other single agency in and around Edinburgh was consistently responsible for as many medical home visits annually amongst the sick poor of the city across the half decade before 1911 (Table 3.5).

In the established manner a guest speaker was invited to address the 1890 meeting. Dr T. A. Pierson opted to regale the audience with what became an oft-repeated anecdote. It told of the epiphanic moment in the life of William Burns Thomson. Thomson, a contentious figure, was one of Edinburgh's earliest, and most influential medical missionaries, and a predecessor to Lowe in the post of EMMS medical superintendent.²³ The anecdote was amusing yet purposive; it reminded the audience

²² Per *Edinburgh University Medical Graduation records* (Edinburgh University Archives, 1896), ref: Da 43. See thesis Table 3.12.

²³ William Burns Thomson (1821-1893) was born in Forfarshire. Orphaned young and from modest circumstances, Thomson started out as a rural schoolmaster. He went to Edinburgh as a private tutor in 1847. Thomson became one of Dr Peter David Handyside's students and wrote a prize essay entitled *Medical Missions* published in 1854 by the EMMS. In October 1859 he was appointed superintendent and resident dispenser of the Cowgate Dispensary found by Handyside in 1858. Burns Thomson served for over ten years, resigning in 1870 in acrimonious circumstances. His departure followed disagreement with the EMMS board of directors over a matter relating to his authority over student

much about the nature and focus of the home medical mission movement. Through it all were reminded of the essential *modus operandi* of medical missions: that charitable medical provision, welcomed by the poor in as much as it addressed genuinely felt needs, could be utilised to invoke in patients a feeling of gratitude, thereby disarming resentment and prior suspicion of missionary endeavour, securing goodwill and domiciliary access for those imparting the gospel message.²⁴ Pierson recounted:

Dr Burns Thomson tells an amusing story of one of his earlier encounters with a very pronounced specimen of physical womanhood, who approached him with her red arms akimbo, ready for a muscular demonstration of her disapproval of his house to house visits. He was then but a student, seeking to do good among the destitute, degraded classes of the city population; and this broad-shouldered, deep-chested giantess, flushed with anger at his intrusion upon her premises, seemed to threaten her somewhat frail visitor with annihilation. Looking into her face, he ventured to remark that he thought she looked like one who was scarcely well, and thus evoked a confession that she was suffering from some physical disorder, a torpid liver, etc. He put on an air of confidence, and said that he thought he could administer a simple remedy that would relieve her; *and by a penny's worth of castor oil purchased both her goodwill and ever-lasting gratitude.* [My emphasis]²⁵

Behind the development of a medical arm of missionary endeavour was the realisation that precept required practice.²⁶ The claim that as little as 'a penny's worth of castor oil' could be used to purchase 'both her goodwill and ever-lasting gratitude' found

training. The departure was followed by a series of bitter recriminations between parties concerned. Thomson was accused of continuing to trade off of his association with the EMMS. On Burns Thomson career as a medical missionary see especially William Burns Thomson, *Reminiscences of Medical Missionary Work* (London, Hodder & Stoughton 1895). On his falling out with the EMMS see *The Scotsman* (21 Feb, 1871), p. 1. The ten years that Burns Thomson was in charge of the EMMS dispensary was a critical period in the development of the medical missionary training facilities in Edinburgh. The little historiography that there has been that address the subject of the development of the home medical missionary movement in Britain strongly champions the cause of Burns Thomson, seeing him as the single most influential figure in the development of medical mission services. On Burns Thomson as the guiding light of the home medical mission movement see, for example, Olive Checkland, *Philanthropy in Victorian Scotland: Social Welfare and the Voluntary Principle* (Edinburgh: John Donald Publishers, 1980), p.81-82; and Kathleen Heasman, *Evangelicals in Action: An Appraisal of their Social Work in the Victorian Era* (London: Geoffrey Bles, 1962), p.226. These views echo those expressed contemporarily by James L. Maxwell, M.D, Burns Thomson's biographer. ²⁴ Burns Thomson, *Reminiscences*, p. 63, describes the role of the medical missionary thus: 'the work of the doctor is to open the door that the evangelist may enter in and find a willing audience.'

²⁵ *Quarterly Papers of the Edinburgh Medical Missionary Society* [EMMS Quarterly], vol.5, p.277. For another example of the retelling of the same anecdote, see the report of Sir Thomas Grainger Stewart's chairman's address to the 1894 EMMS Annual Meeting in EMMS Quarterly Vol. 7, p.66: 'Sir Thomas then related how he had been told by Dr. Burns Thomson of his first connection with Medical Mission work by the purchasing of the friendship of an Irish virago with a pennyworth of castor oil'. See also the report of Sir Alexander R. Simpson's address at the Annual Meeting of the Medical Mission Auxiliary of the Baptist Missionary Society at Bloomsbury Church, London in April 1909 in EMMS Quarterly, Vol. 12, pp. 180-81.

²⁶ W. Burns Thomson, *Medical Missions* (Edinburgh: Johnstone & Hunter, 1854), p.18, 19 & 22.

echo in the apocryphal experiences of other medical missionaries across Britain as the home medical missionary movement spread. Edward Meacham, medical superintendent of the Redbank Working Men's Christian Institute and Medical Mission Dispensary, established in Manchester in 1870, for example, said that he had found that a gift of blankets had the same effect in softening a patient's attitude.²⁷

The 'deep-chested giantess' in the anecdote recounted by Pierson underwent transformation in each retelling of Burns Thomson's conversion, becoming an increasingly symbolic figure. She was the archetype of poverty as 'a hard old hag,' and represented the problem of access – to the home, the heart, the hearth – that medical missions sought to overcome. 'An Irish virago' is how the woman is more succinctly described in a version of the anecdote retold four years later by Sir Thomas Grainger Stewart. Stewart was an eminent Edinburgh physician with career long connections to the EMMS.²⁸ Seen as such, the woman represented the fact that the earliest focus of the work of the medical mission in Edinburgh was amongst the immigrant Irish Catholic community who had poured into the city in ever-greater number after the famine. In 1861, for example, Burns Thomson pointed out that that year, 56% of all EMMS patients were Catholic.²⁹ The woman's (exaggerated) physical presence in Pierson's retelling was a figurative expression of the obstacles faced by visitors working in the homes of the urban poor. She was a physical manifestation of the hard-learned lesson that many of the poor were resistant to 'empty-handed' endeavour. Pierson's version can be juxtaposed with Burns Thomson's original recounting of this the crucial moment when he realised the efficacy of medicine as a means to advance the missionary cause.

[As an arts student and missionary] I went into one of the lowest houses [in Ponton Street]... to invite the inmates to a prayer meeting... I had scarcely got into the house when a sharp little Irishwoman came springing into the middle of the floor, and, approaching me, abruptly said, "what do you want, sir?"... Although it was only twelve o'clock, her son was lying on a low settle at the side of the room the worse for drink... "You are not looking well." The

²⁷ EMMS Quarterly, Vol. 1, pp. 85-6; and Burns Thomson, *Reminiscences*, pp.32-3. Sir William Muir, then principal of Edinburgh University, also made a similar point in John Lowe *Medical Missions: Their Place and Power* (London: Fisher Unwin 1886), Introduction: 'Mr Lowe has well illustrated... in the instances he has given of the benefits of the healing art in abating suspicion and prejudice, disarming hostility, and bespeaking the confidence of the people toward our Missionaries.'

²⁸ EMMS Quarterly Vol. 7, p.66. Sir Thomas Grainger Stewart, M.D., was President of the EMMS from 1893 to his death in 1900. In 1898 (whilst serving President of the EMMS) Stewart was also elected President of the B.M.A.

²⁹ *The Scotsman* (19 Nov, 1861), p. 2.

thought seemed to flash upon her that perhaps I was a medical man, and in an instant her manner changed, and she answered quite kindly, "Sure, and it's not well that I am, sir." "I think you would be the better of a little medicine," said I... Why I was led to make such a remark I cannot conceive for I knew absolutely nothing of medicine, and the thought of becoming a doctor had never entered my wildest dreams... away I went to the nearest druggist and got a dose of castor-oil. I brought it back and presented it to the poor woman, and she received it amidst many expressions of gratitude... I got access to that house ever after, and was freely permitted to tell of the great salvation offered by Christ.³⁰

As described by Burns Thomson, the woman cut an altogether less imposing figure. Burns Thomson originally described 'a sharp little Irishwoman;' curt, defensive, and reluctant to accede to his invitation for her to attend a local prayer meeting. Though the woman had resented his uninvited entry into her 'low' house, in Burns Thomson's own account, the immediate physical threat to him as an unwelcome midday intruder came not from the woman herself, but rather from the presence of her drunken son. Home visitation amongst the poor was always a hazardous part of medical business. The threat of physical violence was ever present. It was one that, for example, the students of the EMMS sought to overcome in the period under study by the undertaking of medical calls in pairs³¹. Alcoholism was a touchstone of many commentaries of the lives of the Victorian urban poor. The districts of Calton, Cowcaddens and the Gorbals were, for example, the three most prominent areas of medical mission focus in Glasgow: and surveys in the mid-1900s found that each of these three areas had twice as many public houses per head of population than licensing laws had recommended.³² From the earliest years of the medical missionary movement many of the clergy and the medical practitioners involved were amongst the most vociferous advocates for temperance.

³⁰ Burns Thomson, *Reminiscences*, p.19-20.

³¹ Clement Bryce Gunn, *Leaves from the Life of a Country Doctor* (Edinburgh and London: Ettrick Press Ltd, 1947 (1st published 1935)), p.17.

³² The Citizens' Vigilance Association, *Facts Regarding the Drink Trade* (Glasgow: pamphlet c. 1906), in Glasgow City Archives (GCA): Mitchell Library ref: T PAR 1.4.21: The CVA counted 102 public houses in Calton at 1 to 386 of the local population; 104 in Cowcaddens, at 1 to 372; and 92 in Gorbals, at 1 to 388. In drafting the Licensing (Scotland) Act, 1903, Lord Peel had recommended maximising licenses to one license for every 750 persons.

4.3 Edinburgh and the EMMS

Although John Wesley opened a religious-inspired free dispensary in Britain in 1745, the systematic development of home medical mission movement of the second half of the nineteenth century originated in the Edinburgh drawing room of Dr. John Abercrombie.³³ Abercrombie (1781-1844) was the son of a minister. He graduated Edinburgh University in medicine in 1803. He was an important figure in the orientation of nineteenth century Edinburgh medicine towards domiciliary service, being subsequently accredited also with doing much to advance the home-visitation based medical student training scheme of the leading and oldest charity of the city, the Edinburgh Royal Public Dispensary.³⁴ Rev. Peter Parker, M.D., an American medical missionary temporarily driven from China with the closure of the country to foreign nationals during the first Opium War, passed through Edinburgh as the guest of Abercrombie in November 1841. Influenced by what Parker had to say, Abercrombie and his medical friends - including numerous Edinburgh medical luminaries such as Professor's William P. Alison, James Miller, George Ballingall and James Syme – immediately formed an auxiliary association with a view to promote medical missionary work. The following day, a public meeting on medical missions was held. Then Lord Provost Dr William Beilby - an original EMMS director, president of the RCPE from 1844-49 - played a significant part in these early proceedings.³⁵

In its early years the EMMS concentrated on widening publicity for the work.³⁶ Its main concern was how to provide a solid sustainable base of financial and practical support for ongoing missionary endeavour. In Scotland, the utility of bringing medical relief services to the homes of the countries' own poor had been identified in theory,

³³ The Wesley Dispensary noted in Stanley G. Browne (ed.), *Heralds of Health: the sage of Christian medical initiatives* (London: Christian Medical Fellowship, 1985), p. 11.

³⁴ Robert Chambers (orig. ed.), Rev. Thomas Thomson (revision), *A Biographical Dictionary of Eminent Scotsmen*, Vol. 1 (London: Blackie and Son 1875), p.2.

³⁵ On the history and origins of the EMMS see, for example, E. Sargood Fry, *The Edinburgh Medical Missionary Society* (undated publication extract) – bound by Edinburgh Central Library, ref. no. YR722 B3117; John Lowe, 'Historical Sketch of the Old Medical Mission Dispensary, 39 Cowgate' in *EMMS Quarterly*, vol. 2, pp.129-40; and editorials in *EMMS Quarterly*, vol. 3 (August and November, 1880), p. 121f. and p. 145f.

³⁶ *The Scotsman* (1 Feb, 1845), p. 3: 'The object of the society is to circulate information on the subject of medical missions... The society has not yet been able to send out any missionaries of its own.'

but had not yet been acted upon.³⁷ City missionaries who tried to evangelise empty-handed had long found they failed to gain much headway in targeted populations. As Professor Pirrie as chairman of Aberdeen Medical Mission reflected in 1871: ‘practical sympathy with human suffering, is unquestionably the key, to unlock the entrance to many a heart, otherwise closed to the truth.’ Or as Sir Alexander Russell Simpson also noted in 1909: ‘the medical missionary finds his way where every other means of mission agency has no entrance.’³⁸ Focus changed with events at the end of the 1840s.

On October 30, 1848, Dr Handyside – one of the first Directors [of EMMS] – received a note from the Rev. P. McMenamy, then a missionary to the Irish in Edinburgh, asking him if he would kindly undertake to visit professionally some of his sick poor...³⁹

Ireland, that foreign land at home, provided the opportunity and rationale for subsequent development. Responding to a direct request for help, and recognising the potential for expanding the scope of their enterprises, in August 1848 - at the height of the famine -, the directors of the EMMS sent a medical practitioner into rural Ireland. Alexander William Wallace – the man sent - set up practice in Parsontown, Birr. Wallace thereafter remained active on behalf of the Irish Presbyterian Church until depopulation was said to have finally reduced his effectiveness, in 1854. The Irish example, judged a success in terms of converts – despite the chagrin of the Catholic Church - was fundamental. By gaining the trust of the patient, the practitioner was able to gain access for missionaries to the homes of the poor, a private world from which they might otherwise remain debarred. The equation was simple. As Glasgow’s first full-time medical missionary superintendent, John Lyell, reiterated in 1872:

The state of [the patients’] minds, owing to their bodily sufferings, naturally predisposes them to listen to the things which concern their peace, and

³⁷ Mr. Douglas of Cavers, *Hints on Missions* (1822), quoted in EMMS Quarterly Vol. 3, p.121: ‘If, with scientific attainments, missionaries combined the profession of physic, it would be attended with many advantages. The character of a physician has always been highly honoured in the East, and would give an easy and unsuspected admission to a familiar intercourse with all classes and creeds. He who is a physician is pardoned for being a Christian – religious and national prejudices disappear before him – all hearts and harems are opened.’

³⁸ Pirrie quoted from an appeal for support by the London Medical Mission, printed in EMMS Quarterly Vol. 1, pp. 66-7. Sir Alexander R. Simpson quoted in EMMS Quarterly Vol. 12, pp. 180-3. Anon., *The Autobiography of a Scotch Lad* (Glasgow: David Bryce & Son, 1887), pp. 56-7: as early as the 1830s and 1840s the realisation was dawning that successful missionary visits often depended upon the visitor showing direct interest in the welfare needs of the poor person visited.

³⁹ *The Scotsman* (27 Jan, 1849), p. 2.

therefore [are] most likely to receive the news of the plan of salvation as revealed in the Gospel.⁴⁰

Two months after Wallace had begun operations in Ireland, Dr Peter Handyside set about provision of a similar service for the poor immigrant Irish flooding into Edinburgh. Handyside had served his medical apprenticeship under James Syme, and had followed Syme by joining the EMMS as a director. He was appointed a surgeon at ERI in 1839, and had in 1841 been appointed teacher of anatomy. Originally as his own enterprise, in 1853, Handyside established the Main Point Dispensary. He began offering mission-based medical treatment to the poor and training facilities for medical students then making contact with the EMMS in growing numbers. Location mattered. In 1858, the EMMS settled its new direction, and assisted Handyside in relocating his venture into an old whisky shop on the Cowgate. Recorded patient numbers grew steadily: 952 in 1858; 1,271 in 1859; 3,240 in 1860. The EMMS, which had originally limited its responsibility for the project, saw the success. It assumed full financial control of the Cowgate dispensary in 1861. In this year, the dispensary treated 5,332 patients, and had already ten medical students under training.⁴¹ In 1862 a ‘museum of material medica’ was added to the facilities at the new dispensary. This followed a donation of a cabinet of specimens by pathology lecturer Dr Grainger Stewart. Well patronised, strategically positioned, from this time the dispensary became the main focus of EMMS work in Edinburgh. It was steadily integrated into the network of training medical charities in the city.⁴²

Other home medical missions in Edinburgh

Along with the EMMS, in Edinburgh, six other home medical mission organisations providing domiciliary medical care for the poor have been identified in operation before 1911 (Table 3.5). Whilst surviving details about workloads are sketchy, records identify that most – although independent of it - had links to the EMMS. Two (as in Glasgow) were specifically targeted upon the immigrant Jewish population.

Carrubber’s Close Mission established as Edinburgh’s second home medical mission service and began its work around 1863. Whilst evidence has only been found to

⁴⁰ GMMS Annual Report (Glasgow: 1872), p. 5.

⁴¹ Burns Thomson quoted in *The Scotsman* (19 Nov, 1861), p. 2.

⁴² Burns Thomson, *Reminiscences*, pp. 49-50.

confirm medical services during the 1860s and early 1870s, the mission remained active into the twentieth century. It relocated to new premises adjoining the landmark John Knox House in the High Street in 1883. In the two years to February 1865, the mission reported 3959 patients, of which ‘about 1200 were visited at their homes by either the students or the medical officers’: 72 midwifery cases were reported. Medical treatments were carried out without charge, financed through subscription and donations.⁴³ Dr. Alexander Russell Simpson – already mentioned, and later the professor of midwifery and diseases of women and children at Edinburgh University following the death of his namesake in 1870 - was one of several high profile medical men associated with the mission. The medical officer in the 1860s was a Dr. Linton.⁴⁴ During jubilee celebrations in June 1908, it was reported that Simpson (knighted in 1906) was now president of the mission. He had also served as president of the EMMS, between 1887 and 1893, and was a founder of the GMMS in Glasgow. It is known from *Medical Directory* entries that Stewart Stirling, the founder of Edinburgh Dispensary for Skin Diseases, and later an elder of St Cuthberts Parish Church, served as a medical officer at the Carrubber’s Close Mission for sometime after graduating in the early 1870s, before going to Russia as surgeon to British Seaman’s Hospital. Carrubber’s Close Mission in Edinburgh and the Grove Street Institute in Glasgow were ‘sister’ ventures.⁴⁵

Two further home medical missions were established in Edinburgh in 1874. These were both largely the projects of single men. After acrimonious departure from his position as medical superintendent of the training home and dispensary of the EMMS in 1870, the aforementioned William Burns Thomson began operating in Edinburgh as an independent medical missionary. In 1874, he established the rival Medical Mission Training Institute and Dispensary on St. John Street in the Canongate, assisted by Dr. W. Thomson Crabbe. Crabbe had been the first medical superintendent of Aberdeen Medical Mission. Later, in 1876, he went on to establish Birmingham Medical Mission (where he served as medical superintendent to his

⁴³ *The Scotsman* (28 Feb, 1865), p. 2. A new building for Carrubber’s Close Mission was built and opened in 1883 but medical service were not mentioned, per *The Scotsman* (25 Apr, 1883), p. 7.

⁴⁴ Also present at the annual meeting of the Carrubber’s Close Medical Mission in February 1865 were the Dean of the Faculty of Medicine at Edinburgh University and vice-president of the EMMS, Professor John Hutton Balfour; and Professor James Young Simpson, who was also an EMMS director. See *The Scotsman* (28 Feb, 1865), p. 2.

⁴⁵ *The Scotsman* (10 Oct, 1891), p. 10.

death in 1899). The new Burns Thomson Dispensary was a short-lived affair. He resigned from dispensary work in 1878 due to ill health, going to France to recoup. Over the few years of its operation the *Medical Directory* recorded 2,500 to 3,000 patients per year. No breakdown has been found of home visits conducted, although in his published papers Burns Thomson makes much mention of this aspect of the work. In characteristically melodramatic descriptions, terminal and chronic illness were standards of visits; as were emergency callouts and dangers caused by excessive drinking; confrontations with despair; and the popular fear of the infirmary.⁴⁶

In February 1874 - again at a suitable distance from the sphere of operations of the EMMS (although this time with its blessing) - David Brodie, M.D., LRCSE (1845) also established an independent medical mission in the Liberton area, south of main city centre of Edinburgh. The Causewayside Medical Mission Dispensary was again short-lived, operating until sometime before Brodie's retirement in 1883. Few mentions of it have been found, and, again, accurate patient caseload numbers are unknown. Established on Grange Court, off Causewayside, the medical mission handbills circulated to the local residents advised that the area from which the sick poor might be treated stretched as far into the city as Buccleuch Street, and therefore, by arrangement, to the border of the districts that were detailed as being within the range served by the EMMS. A blanket of coverage had therefore been thrown over this part of the city. Brodie resided at Liberton where he and a German born wife ran a Private Home for Young Imbeciles. In the census in 1881, Brodie is listed with nine unrelated boarding children at home. He resided with one medical student, and eight servants. As well the care and education of imbecile children, Brodie had a standing interest in the question of medical missions: this is demonstrated by the authorship in 1859 of a monograph entitled '*The Healing Art: the Right Hand of the Church, or Practical Medicine an Essential Element in the Christian System*'.

At the closure of Burns Thomson's dispensary in 1882, in the same year, a new medical mission opened on the Canongate to replace it. The Canongate Christian Institute Medical Mission was an adjunct of that institute. It was both modelled on the work of, and enjoyed publicly the support of, the EMMS. By the 1880s this would

⁴⁶ Burns Thomson, *Reminiscences*, pp. 72-3 and p. 216.

have mattered considerably were it to gain wider acceptance. It originally had a dispensary that opened three days a week, from 10.30 a.m. No record has been found of medical workload although it was noted in 1882 that at this time ‘more than a thousand persons came each week under the beneficent influence’ of the institute.⁴⁷

An Edinburgh Jewish Dispensary was established circa 1895 at High Riggs. It too was short-lived. It remained active only until around 1901, at which time its founder was fatally injured on holiday. Per the second annual report published February 1897, founder Dr Catherine Urquhart said of what was quite a small-scale operation that: ‘over 120 patients have come to the dispensary, and over 200 visits have been paid to these patients. I have seen between 80 and 90 in their own homes, and 373 prescriptions have been ordered by me.’ As in Glasgow, immigrant Jews attracted much missionary attention. The Urquhart enterprise was a distinct venture from the Jewish Medical Mission Society in Edinburgh. Per Kenneth Collins, this latter venture operated from 1889, and remained active until the 1920s. Around 1905, the Jewish Medical Mission Society dispensary relocated, to Lauriston Place. From the mid-1890s to the late-1900s, there was an estimated increase in Edinburgh’s immigrant (mainly Russian) Jewish population from 1,000 to around 2,500.⁴⁸ The controversial ‘Jewish Missionary’ Leon Levison was recorded to have treated 852 and 1,308 patients at the dispensary in 1904, and 1905, respectively: in 1905, 800 prescriptions were issued.⁴⁹ This level of workload suggests that a significant proportion of the Jewish population fell within the orbit of the mission. The Jewish response to the challenge posed included (again, per Collins) a Jewish Lying-In Society, established in 1875, and the Edinburgh Jewish Board of Guardians, established in 1899 (thirteen years after the equivalent in Glasgow).

The EMMS

With rivals and complementary services equally short-lived, medical mission work in Edinburgh remained overwhelmingly the work of the EMMS. Although established in the Cowgate on 1858 where it was thereafter to remain, the EMMS dispensary was in fact rebuilt and expanded twice over the following half-century. The history of the

⁴⁷ *The Scotsman* (17 Jan, 1882), p. 4.

⁴⁸ *The Scotsman* (9 Mar, 1907), p. 8.

⁴⁹ *The Scotsman* (24 Mar, 1905), p. 4, and (22 Mar, 1906), p. 4.

EMMS between the mid-1870s and 1911 resounds in these two rebuilds. Reflective of the increasing practical and utilitarian intent of medical missions, between 1876 and 1877, the site was rebuilt for a first time in order to improve the on-site training facilities. Reopening saw a rebranding of the dispensary site as the Livingstone Memorial Training Institute. Livingstone had died in 1873, and his fame and status as a medical missionary and national hero was then at a height. The EMMS medical facilities were once more substantially overhauled and upgraded in 1903. The premises were again extended. With the second rebuild the primary objective became the facilitation of expansion into auxiliary social-welfare services. This presaged the main focus of much missionary activity during the twentieth century.

Meetings and appeals for the first rebuilding began in 1874. The directors set a target of £10,000 for the project, a prodigious amount.⁵⁰ Support was nonetheless strong. By the middle of 1876, £6,000 of the total had already been raised. After protracted negotiations, agreement was reached with the directors of the Protestant Institute – the proprietors of the Cowgate premises – for the rebuilding to commence. Plans were made to incorporate an adjoining Chapel into the project. Attached to the EMMS dispensary, the Protestant Institute Chapel of St. Mary Magdalene had been built in 1503 and was a landmark of the old city. The memorial stone for the Livingstone Memorial Medical Missionary Training Institution was laid in June 1877. The first hymn sung by the medical mission’s children church at the founding celebrations in 1877 was “Tell it out amongst the Heathen” – this was a particular medical mission favourite being also that sung to celebrate the founding of the GMMS Oxford Street Dispensary in Glasgow in 1884. The following description of the newly built Training Institution was printed in February 1878. As with the more substantial extract that follows for the second rebuild in 1903, it shows how form reflected function:

The new Training Institution for Medical Missionaries and Nurses...adjoins the old Magdalen Chapel in the Cowgate, and the outside is in keeping with the chapel. It is solid, simple, and unpretending... Inside it is commodious, and convenient for all the purposes it is to serve. The ground floor contains the porter’s residence, the laboratory, a consulting-room, and a handsome waiting room, capable of accommodating 150 patients... On the second floor are the Resident Surgeon’s parlour and bedroom, the housekeeper’s rooms, the kitchen, servant’s rooms, and the dining-hall, which will serve also as a museum. There is accommodation also on this floor for the senior student on

⁵⁰ *The Scotsman* (7 May, 1874), p. 4.

duty at the Dispensary, and for another student. The third floor contains, in the front building, rooms for five or six nurses, and in the back building (entirely separated from the nurses' quarters) there is accommodation for eight or nine students.⁵¹

Technological developments, which moved apace over the late nineteenth century (and included things like electric lighting, the telephone, and roller-blackboards); evolving medical diagnostic procedures (including recognition of the need for easily washable, dust-free surfaces, and for plumbed hot water in consulting rooms); plus the growth in the regular numbers of students under training at the Cowgate: all added to a sense that, by the beginning of the new century, the EMMS dispensary needed further expansion and modernisation. Plans for upgrading the EMMS premises were published during the jubilee year of 1902. This involved further extension of the Cowgate dispensary institution via purchase of adjacent ground from Edinburgh Corporation. Costs were put at a marginally more modest £5,000.⁵² As with the previous build, this was still a substantial sum for any medical charity to find.

Inauguration of new premises took place in December 1903. The new dispensary facilities were state of the art and served to highlight thinking as to what was required in a 'modern' turn of the twentieth century teaching-based dispensary facility. Per *The Scotsman*, the new dispensary included introduction of a new heating system, hot-water supply, and 'electric light, electric bell communication, speaking tubes, &c.'⁵³ Rebuilding had included transformation of part of the premises into a recreational facility nicknamed 'the Rock'. This saw the existing medical dispensary extended to enable the development of the premises into a multi-functional temperance, leisure and missionary health and welfare institute. 'The Rock' became 'the social wing' of the dispensary. Its development reflected the broader shift in focus in preventive medicine from public to individual health. It provided an array of leisure facilities for working lads and men of the district. Auxiliary evangelical work done at 'the Rock' included: 'Sunday Schools, Bands of Hope, singing-classes, meetings in lodging houses, and the like.' It also included provision of an on-site temperance restaurant, a reading and games room, and a gymnasium: 'which will probably be restricted to

⁵¹ EMMS Quarterly, vol. 2 (1878), pp. 184-5.

⁵² *The Scotsman* (2 Dec, 1903), p. 9. On the plans for the extension of Cowgate see EMMS Quarterly, vol. 8/9 (1902), pp. 312-14.

⁵³ *The Scotsman* (2 Dec, 1903), p. 9.

members of a specially formed club.’⁵⁴ In 1907, the EMMS main publication noted that ‘Dr Williamson, [of the] City Sanitary Department’ was actively encouraging local use of the new facility. Where interests’ coincided, co-operation between public and private initiatives duly followed. By the end of the first year ‘the Rock’ had established a local membership of seventy-four working lads.⁵⁵ The sick and poor abiding in the surrounding wynds would have been suitably struck by the show of modern conveniences.⁵⁶

Visits to the homes of the poor were conducted throughout the period 1875 to 1911, including during periods of temporary dispensary closure for rebuild, and during the month of summer (when EMMS students even followed the local poor into the countryside for harvesting). The average total number of home visits conducted by EMMS staff and students for all years between 1882 and 1902, per annual reports, calculates to 11,254 per year. Totals ranged from 7,908 visits made in 1890, to 15,840 in 1898. Enlargement and improvement of the dispensary in 1903 meant a reported peak in students under training and was followed by a peak in home visits conducted in 1904. From 1877 to 1911 (for years when data is known) each year an average of 3,300 individual patients were visited at home by the EMMS (Table 3.5). Of these, each year, between 174 and 454 were midwifery cases. Each midwifery case was said to have typically required between three to six visits until conclusion. Most of the home visits were conducted by medical students and were carried out in pairs. This was made possible by the fact that between 1877 and 1911 there was, at any one time during the academic year, between fifteen and 40 medical missionary students under training. In addition to the students formally undergoing medical missionary training there were also dozens of additional local medical students in attendance. From 1882 to 1892, each year, 50 to 100 additional students were reported to have attended at the Cowgate. From 1877 to 1910 - based on all years except 1880 - the average total number of new patients reported either attending at the dispensary or treated at home was 10,350. With a given average estimate of two to three consultations per patient, the average number of dispensary consultations given for years between 1892 and 1902 was 45,840. Approximately one in three (31.9%) of all patients treated by the

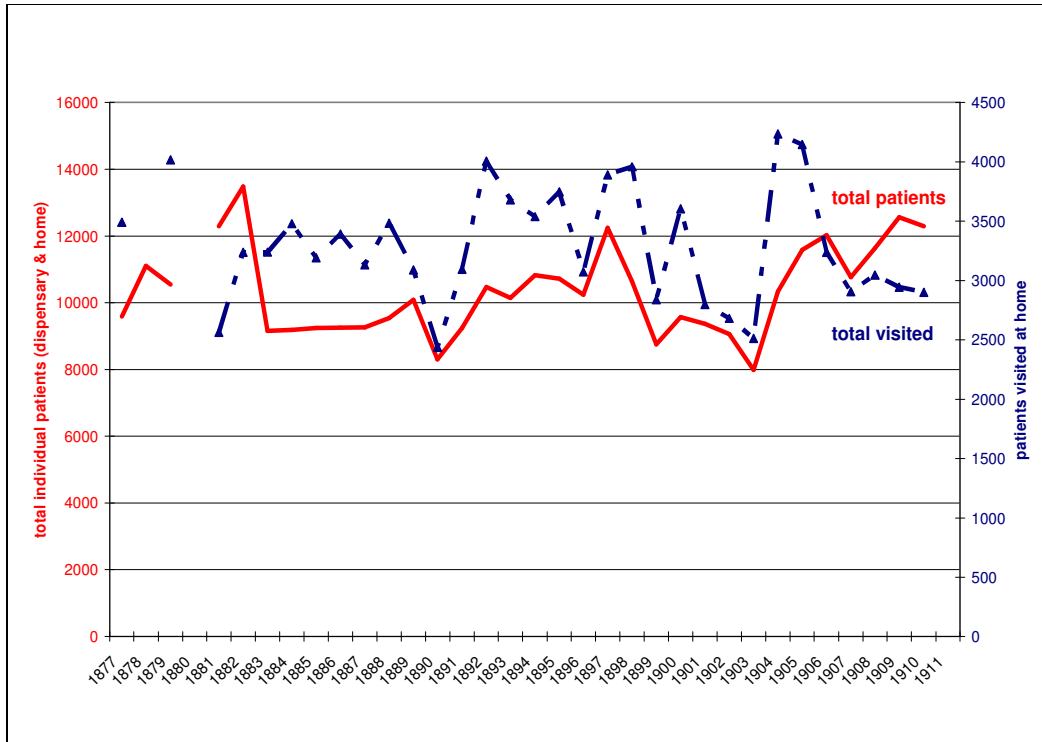
⁵⁴ *The Scotsman* (2 Dec, 1903), p. 9.

⁵⁵ EMMS Quarterly, vol. 11 (1907), p. 344.

⁵⁶ EMMS Quarterly, vol. 11, pp. 6-8.

EMMS were therefore visited at home; with all home cases typically requiring three or four visits per case (Figure 4.1).⁵⁷

Figure 4.1: Number of patients visited at home by the EMMS, 1877 -1911



Source: Annual Reports

The EMMS and the use of medical students:

The candidate must have passed, or be prepared to pass, the preliminary examinations required by the General Medical Council, and which qualifies for registration as a Medical Student. He must be in good health, have a sound constitution, and of an irreproachable moral and Christian character. His views of Divine truth must be such as are known as evangelical, and he must be a member, in full communion, of a Christian church. We expect him to be fired with missionary enthusiasm, and constrained by the love of Christ and love for perishing souls to devote his life to this service...⁵⁸

As mentioned, the training and production of medical missionaries was central to the work of the main medical mission society in Edinburgh. By the re-opening of the newly extended dispensary in 1903, over 100 men and women had been sent abroad

⁵⁷ The point on the number of repeat visits typically required was made at many of the annual meetings. See, for example, *The Scotsman* (21 Nov, 1884), p. 4, and (29 Jan, 1897), p. 9.

⁵⁸ EMMS Quarterly, vol. 5 (Feb. 1888), p. 97.

as medical missionaries after training at the institution. Despite murmurings that its training services might be open to abuse by the unscrupulous seeking a cheap route through medical education by false show of faith, EMMS directors remained adamant that checks and processes ensured all who trained under it were committed to the undertaking of missionary work on graduating. As the quote above, and below, make clear, the qualities and qualifications expected of a medical student wanting placement for training as a medical missionary were clearly spelled out.

No young man is admitted as a student of the Livingstone Memorial Institution until his personal religious history, his missionary spirit, and his general qualifications have been carefully inquired into; his medical studies thereafter are pursued at the Edinburgh School of Medicine – either intra-mural or extra-mural – and all the time (four years) while breathing, so to speak, a mission atmosphere.⁵⁹

Whilst some students erred during training and fell out of the scheme, attempts were made to minimise leakages.⁶⁰ Investments were protected. All applicants to the EMMS were carefully scrutinised. Those accepted into the training programme and who thereafter received financial support during their education were expected to pledge to undertake medical mission work after graduation for an agreed period of time; they were, in fact, legally contracted to do so.⁶¹ As processes settled into routines every medical missionary student taken on by the EMMS completed a similar, contractually binding application. In 1889 the application document had two parts. The first contained eleven questions, designed to test the background, faith, commitment, earnestness and potential of the applicant. The second consisted of regulations that the prospective student was obliged to agree to. The eleven questions were laid out as follows:

1. Concerned place of birth, age, parents, dependents, and approval of family for desire to become a medical missionary
2. Medically certified state of health of the applicant.
3. Educational credentials.
4. 'What has been your occupation? Are you able, at present, to obtain a comfortable maintenance, and have you the prospect of doing so in the future?'

⁵⁹ Lowe Medical Missions, p. 40

⁶⁰ EMMS Annual Report (1886), p. 18: 'One of the students accepted last year has resigned his connection with the Society, in order to go out as a lay missionary to the New Hebrides Mission; and we have felt it to be our painful duty to dismiss another, at the close of his first year of study. While we have been disappointed by the failure of one or two of our students in one or other of their Professional Examinations, still such failures are exceptional...'

⁶¹ *The Scotsman* (2 Dec, 1903), p. 9.

5. 'As it is indispensibly necessary that he who undertakes to teach Christianity should himself be an earnest Christian, state the grounds on which you conclude that such is your character, and add memorable circumstances connected with your religious impressions.'
6. 'Of which church are you a member, and how long have you been in Christian fellowship?' – References were required to be attached from the pastor, plus two or more from others on the applicants 'character and aptitude for missionary work'.
7. 'What are your views regarding the leading doctrines of Divine Truth?'
8. 'Have you been accustomed to conduct religious services – or to engage in efforts for the spiritual good of others?'
9. 'How long have you entertained the desire of becoming a Missionary, and what lead you to that desire? State also the grounds of your preference for the work of a medical missionary.'
10. Concerned additional evidence of qualifications for medical missionary work.
11. Ability to meet personal cost of board [£40] and personal expenses of studying.⁶²

Space was given for approximately 100 words per answer, except question 7, for which 500 words were allowed. The regulations in part two of the application were five (here presented with my emphasis):

1. That acceptance at the Training Institute was subject to six months probation.
2. The students agreed to work towards medical qualification.
3. 'The student shall devote himself *exclusively* to his education and training, and shall not be at liberty to undertake private teaching or other extra work; he shall take his classes in due order, according to the direction of the Superintendent, to who he shall be subject during his connection with the Society.'
4. 'When his studies are drawing to a close, the student shall place himself at the disposal of one or other of the Missionary Societies, with a view to an engagement, and he may rely upon receiving the counsel and help of the Board in all the needful negotiations.'
5. 'If the student shall, either during his curriculum, or *within eight years after receiving his qualification*, relinquish his purpose of becoming, or cease to be, a medical missionary, or by his conduct, or departure from evangelical views of Christianity, render it necessary for the Board to break their connection with him, *he shall be under a legal obligation to refund to the Society the outlay incurred on his behalf.*'⁶³

The medical students were not only trained in an environment where it was claimed they were 'breathing a missionary atmosphere' but were given specific individual elements of theological training; the skills and successes of both ends were seen as

⁶² Pro forma contract of Mr. T as completed and signed in March 1889 seen from the private archives of Edinburgh Medical Missionary Society (Glasgow: in private collection).

⁶³ Pro forma contract of Mr. T signed March 1889, EMMS private archives (Glasgow: private collection).

fundamentally interlinked.⁶⁴ One former superintendent described a theological component consisting of ‘short, intensive vacation courses... given by selected teachers just before the beginning of each academic session.’⁶⁵ Until the early 1890s this process remained, however, largely ad hoc. Some small courses of theological lectures were arranged. In 1893, for example, Rev John Laidlaw, professor of systematic theology at the Free Church College, was employed to deliver six lectures to all the students – ‘full and varied enough to give [the] students a bird’s eye view of subjects having an intimate relationship to missionary work’. By 1893, all students accepted for medical training by the EMMS were expected to pass both a preliminary medical examination and a preliminary examination in scripture knowledge. Six Edinburgh ministers, one from each of the main denominations, were employed to examine the potential candidates on the latter.⁶⁶

The EMMS, in common with both the GMMS and Grove Street Institute in Glasgow – but unlike some of the smaller medical missions in each city - characterised itself by its spirit of Protestant ecumenicalism. All ‘men of grace,’ it claimed, could apply to serve the institution, or undergo the medical training offered. Former medical superintendent Lechmere Taylor pointed to the fact that ‘well over 300 students’ were actually trained by the EMMS between 1841 and 1941, and that these represented all ‘the leading churches and missionary societies of Great Britain,’ including: the United Presbyterian and Free Churches of the Church of Scotland; the London Missionary Society; The Church Missionary Society; The English Presbyterian Church; the Baptist Missionary Church; The Irish Presbyterian Church; and the Methodists.⁶⁷ This aspect of the medical missionary work was widely advertised. Denominational inclusiveness widened the net regarding prospective practitioners, directors, donors and subscribers.

⁶⁴ Rev. Edward Chester, M.D., ‘Medical Work of Missions,’ in EMMS Quarterly, vol. 5, p.165: ‘The more skilful the Medical Missionary as a physician – the more clever as a surgeon, the better for the work and for making it a success, as far as popularity goes. But it will not be a success, as a mission work, unless the saving of souls is ever brought to the front as the main object.’

⁶⁵ Claimed by Lechmere Taylor, *A Century of Service*, p. 18.

⁶⁶ EMMS Annual Report (1893), p.22.

⁶⁷ See Lechmere Taylor, *A Century of Service*, p. 19. Per *The Scotsman* (23 Nov, 1878), p. 6, at the EMMS Annual Meeting in November, 1878, the then president and Free Churchman, William Brown, spoke of the un-sectarian nature of the society, and how it dealt with the theological training of medical missionary students of different sects: ‘[T]he Chairman explained that after training missionaries the society presented them to the Churches, asking them to deal with them according to their own views of ecclesiastical polity. Was it not good, he asked, that Churches of all denominations should work together, in a cause which was common to all?’

Mentioned in the previous party of this thesis, the medical professors in Edinburgh played a significant role in attracting students to dispensary and domiciliary work during their studies. With the interest in the work of medical missions of many of the academic staff, it is not entirely surprising therefore that the directors of the EMMS who were well placed used their academic profile to promote the cause of medical missions amongst students. Thus was the case with Dr Alex Gordon Miller, in 1881 president of the Royal College Surgeons in Edinburgh. Ten years earlier, Miller had begun his medical career as a medical assistant at the EMMS Cowgate dispensary. In his opening address to the medical students of Edinburgh School of Medicine at the start of new academic session in October 1881, Miller recommended to his audience that they both adopt temperance as a way of life and that they give specific consideration to the claims of medical missions when choosing a career path. Miller suggested that the medical missionary, practicing his profession ‘without regard to fee or reward, but out of pure interest in and love for those attended to,’ was the highest grade of medical practitioner: this kind of assertion directly flew in the face of subsequent Webbian barbs of ‘cheap doctoring’.⁶⁸ A medical missionary was said to need sympathy, judgement, common sense, enterprise, versatility, tact, ‘vigorous health,’ and ‘thorough training’.⁶⁹ *The Scotsman* reported:

He [Miller] specially directed attention to the Edinburgh Medical Missionary Society, in connection with which he said 10,000 cases were annually attended to. It was said that the dispensaries tended to pauperise the people; but it would be impossible to make the class of people who attended the Cowgatehead dispensary worse than they were by the mere tendering of charity to them. He had brought the mission under their notice in the hope that some of them might be led to devote themselves to this most noble branch of their profession.⁷⁰

Whether drawn to the work out of desire to emulate their professoriate, by the inherent wisdom of their advice or simply out of desire to ingratiate themselves with men who in likelihood would play an important role in shaping their future careers, many Edinburgh students passed through the dispensary of the EMMS. The medical

⁶⁸ EMMS Quarterly, vol. 3, pp. 247-50.

⁶⁹ Dr Green of Ceylon, medical missions paper published in EMMS Quarterly, vol. 1 (May 1874), pp. 194-96: a medical missionary – ‘as a pioneer agen[t] of the first rank [should have]... 1. Earnest sympathy with the redeemer... 2. Sound judgement and common sense. 3. Enterprize, versatility, and tact. 4. Vigorous health and active habits. 5. Thorough education and training in his profession.’

⁷⁰ *The Scotsman* (25 Oct, 1881), p. 4.

missionary students who trained in Edinburgh came from diverse backgrounds, and from across the country and colonies. Jamaican born Theophilus E. S. Scholes was one who trained as a medical missionary with the EMMS in the early 1880s. Whilst little has been said of this period of his life previously, Scholes is considered a major figure in black British history. An Edwardian intellectual heavyweight, he has been described as ‘the most prolific Black Edwardian author,’ by the chronicler, Jeffrey Green.⁷¹ It is interesting to speculate upon the reaction of the Victorian Edinburgh poor to a black medical practitioner coming into their home. Scholes hinted strongly, later, of racial prejudice experienced both from the public, and from fellow medical students in Edinburgh.⁷² It is interesting to speculate too upon the reaction of students to calls to missionary arms in the later decades of the nineteenth century, given the intellectual ferment of Darwinianism and other scientific ideas, posing challenges to Christianity at this time; and given too the natural propensity of one generation to rebel against the previous. Whether an accurate statement, or one that was deluded and out of touch, as late as January 1899, the chairman of the EMMS, Professor Sir Thomas Grainger Stewart, declared with satisfaction that the ‘missionary spirit was now so strong amongst the youth of the country.’⁷³ A continuing strong disposition amongst the student population towards missionary aims is also suggested in other developments, such as in the subsequent growth of the work of different student settlement associations, although actual motivation, of course, is typically complex.

⁷¹ Jeffrey Green, *Black Edwardians: Black People in Britain, 1901-1914* (London and Portland, Oregon: Frank Cass, 1998), pp.241-246.

⁷² Theophilus E.S. Scholes, *Glimpses of the Ages, or the “Superior” and “Inferior” Races, so-called, Discussed in the Light of Science and History*, vol. 2 (Haymarket: John Long, 1908), pp. 234-5: “‘it is natural that white people should prefer to be treated by white physicians,” by which Englishmen would justify the insult and injury... it must also be an unnatural thing, and therefore an improper thing, that white doctors should practise among coloured peoples’; and p. 263: here Edinburgh-trained Scholes refers to: ‘the cases of persecution and porcine snobbery that describe the conduct of English and Scotch students towards their coloured fellow students.’

⁷³ *The Scotsman* (27 Jan, 1899), p. 7. On science and Christianity in this period see, for example, Thomas H. Huxley, *Science and Christian Tradition: Collected Essays, volume V* (New York: D. Appleton and Company, 1902). Addressing the annual meeting of the directors of the ERPD in the early 1890s, Edinburgh Lord Provost and medical practitioner, James Alexander Russell, noted ‘the faith of the community, judged by the number of its churches and the popularity of its religious meetings, is great and increasing.’ Russell quoted in *The Scotsman* (1 Feb, 1892), p. 6.

4.4 Glasgow and the GMMS

As in Edinburgh, seven different medical mission organisations can be identified in Glasgow from the 1870s. First hand accounts of numbers treated and visited have only been found for the two, the dispensaries of the Glasgow Medical Mission Society (GMMS) and for Grove Street Institute (GSI). Fortunately these organisations were far and away the most significant. Three independent but connected, smaller medical missions operated for different periods of time between 1875 and 1911 in the separate poor districts of Anderston, Cowcaddens and Bridgeton. There were also at least two Protestant medical missions at work amongst European Jewish immigrant groups. These were the Glasgow Jewish Medical Mission, a Church of Scotland venture operative from 1896; and the Bonar Memorial Mission to the Jews, connected to the Glasgow United Evangelistic Association, operating from 1893.⁷⁴ Deliberately sited in underserved locations and away from the main infirmaries, Glasgow's medical missions greatly broadened the spread of medical services in the city (Appendix XII).

In addition to the dedicated medical mission dispensaries discussed here, there was welter of other sick-poor focused evangelical organisations. Many of these, whilst not concentrated upon provision of medical relief, either facilitated access to medical treatment for some, or specifically targeted physically impaired groups during visits. The Glasgow Mission to the Outdoor Blind (instituted 1859), and the Mission to the Deaf and Dumb (established in 1822) are two examples. These predominantly home-based Christian-*welfarist* societies targeted on the poor occasionally utilised medical practitioners to treat as well as assess clients.⁷⁵ Glasgow City Mission (established 1826) was the largest missionary organisation in the city. It claimed, for example, during 1873 to have visited 174,130 persons. Though not offering medical treatment directly, it did organise a Sick and Funeral Savings Society for those able to afford it. The Glasgow City Mission also worked, at different times, in direct cooperation with

⁷⁴ *The Scotsman* (11 Mar, 1896), p. 6, and Kenneth Collins, *Aspects of Scottish Jewry* (Glasgow: 1987), p. 16.

⁷⁵ A non-exhaustive list of missionary organisations from the *Glasgow Post Office Directory* c.1890s includes: the National Bible Society; YMCA; various dedicated Temperance and Anti-Gambling Missionary Groups; the London Evangelisation Society (Scottish Branch); the Glasgow Auxiliary of the London Missionary Society; the United Evangelistic Association; the Glasgow Working Man's Mission; the Mission to the Friendless and Fallen and Women's Industrial Organisation; the Glasgow City Mission; the Glasgow Seaman's Evangelistic Mission; the Glasgow Home Mission Union; the Mission to the Italians in Glasgow; the East End Gospel Mission; the Cripple Children's League; the Lascar Mission; the Slum Reform Mission; the Glasgow Slum Mission; and the Glasgow University Missionary Association.

the GMMS. It recommended cases for GMMS medical practitioners to visit. During the 1870s, the Glasgow City Mission also hosted GMMS medical missionary staff for evening consultations at different venues in the city.⁷⁶ Loose handbills catalogued as part of surviving archival material also shows that GMMS medical staff attended ad hoc church meetings across the city to hold evening surgeries: one extant flier shows that Robert Laidlaw, for example, attended Dennistoun United Presbyterian Church Mission at Campbellfield Hall in November of an unspecified year in the 1880s.⁷⁷ These arrangements with the GMMS provide further example that where mutual interests of different voluntary organisations could be served cooperation could be secured.

Little trace has been left in the historical record of the work of the numerous smaller independent medical mission ventures that operated sporadically in different districts of Scottish cities in the decades before the passing of the NHI Act, 1911. One, the Bridgeton Medical Mission (BMM), presumably typified the type. Per Gemmell, the BMM was '[a] public charity... begun in 1896 in this district, which, from its large working-class population and distance from the infirmary and other free medical dispensaries of the city, seemed to require a special agency for the relief of the deserving sick poor'.⁷⁸ Other sources suggest BMM operations began half a decade earlier, in 1891. It operated until at least 1910. One source notes of it '[a] Dispensary [was] held [at this time] in Mission Hall, William Street, on Tuesdays and Thursdays at 2 p.m.,' and that 'students of the Bible Training Institute' offered assistance to the serving medical officer.⁷⁹ The BMM treasurer, circa 1906-10, was Charles Campbell Edgar, 'missionary'. The BMM president, Rev. J. Anderson Watt, was church minister of the London Road United Presbyterian Church. It was here the dispensary was situated. The medical mission was therefore a direct adjunct of the welfare work

⁷⁶ Per GMMS Annual Report (Glasgow: 1874), pp. 8-9; GMMS Annual Report (Glasgow: 1876), p. 12; and Glasgow City Mission Annual Report (Glasgow: 1873).

⁷⁷ Glasgow Medical Missionary Society Archives (Glasgow). Archive held at Headrick Inglis Glen & Co., Glasgow. Material viewed in December 2002. Access kindly granted by Pastor Jim McLaughlin, Gorbals Christian Centre.

⁷⁸ Matthew Gemmell, *The Societies of Glasgow* (Glasgow: The Citizen Press, 1906), p. 13. Alternative founding date in Archibald Kerr Chalmers, *RC Poor Laws and Relief of Distress* (Cd.4978), Appendix no CLXXXVI.

⁷⁹ *Glasgow Post Office Directory* (Glasgow: 1900-01, 1909-10, 1910-11). John Campbell White (Lord Overtoun) found the Bible Training Institute in 1892, after being influenced by Moody and Sankey. See details in footnote 118. From 1885, White was honorary president of the GMMS. The Bible Training Institute provided trainee-nursing staff for the GMMS dispensaries too.

of this church. Numbers of home visits conducted are generally unknown although during 1906 there were a reported 2,600 outpatient cases.⁸⁰

Although Checkland states that Cowcaddens Medical Mission was found in 1875, the Charity Organisation Society *Handbook of Glasgow Charities* claimed that the Cowcaddens Free Church Medical Mission (CFCMM) began operations some years later, in October 1884. The Handbook is more reliable. Entries in it were a form of paid advertising promoting the listed charity. Factual details were therefore contributed directly by the charities.⁸¹ As with the BMM, the CFCMM was closely tied to the activities of a particular church group. Cowcaddens Free Church was on Maitland Street. The President of CFCMM was the church minister. The church was said to sit 'in a most populous and destitute district of the city,' where 'a large stratum of population... is utterly unprovided for'. The Handbook claimed that, in 1888, 'upwards of 9,000 have been helped since the institution of the [medical] mission,' and that 'all have been brought within reach of the gospel'.⁸² An average annual figure of approx 2,250 patients being treated tallies.⁸³ The CFCMM opened thrice weekly, on Monday, Wednesday and Friday, at 2 p.m., offering 'free advice and medicines given to the deserving poor: [and with] visits made where necessary'. Cowcaddens was a major overspill district, absorbing the poor removed by redevelopment from the city centre. The cordiality of relations between the Free Church sponsors of the CFCMM and the nearby United Evangelist Grove Street Institute are unknown.

Although attached to church congregations of different denominations, the medical officer of both BMM and CFCMM through the period was the same person, Alexander Muir Smith: hence the reason they opened on alternate days. Little is known of Smith or his medical career other than what can be gleaned from entries in

⁸⁰ Thomas Ferguson, *Scottish Social Welfare 1864-1914* (Edinburgh & London: Livingstone, 1958), p. 444.

⁸¹ Per *Handbook of the Glasgow Charitable and Beneficent Institutions* (Third Edition) (Glasgow: Charity Organisation Society, 1888), preface, on the Handbook: 'great care has been taken in its preparation to admit nothing which, in their [COS] opinion, is not of a *bona fide* character...' That all entries were paid for can be seen from Glasgow Central Dispensary Minutes (Glasgow: 13th October 1896) (Greater Glasgow Health Board Archive) ref: HB48/1/1: In October 1896, for example, the GCD agreed to pay the Charity Organisation Society £3 10s for advertisement space in the next edition of the Handbook.

⁸² *Handbook of Glasgow Charitable and Beneficent Institutions* (1888), p. 91.

⁸³ Ferguson, *Scottish Social Welfare*, p. 444.

the *Medical Directory* and from university and census records. Smith graduated M.B., C.M., from Glasgow University in 1875. At this time he was already 40 years old. He had been born in Glasgow. To approximately 1884, Smith - married but childless and resident on Govan Road - was also medical officer of a third medical mission. This was Anderston Medical Missionary Dispensary. The medical mission in Anderston appears to have been closed when Smith opened the Cowcaddens Free Church Medical Mission. In 1900, Smith, then aged 65, was residing away from the two medical mission stations, in the smart, middle-class, district of Kelvinside in the west-end of Glasgow. Medical missionary work was not for him, as it was for the salaried medical superintendents of the bigger medical missions, a full-time occupation. Smith maintained a regular medical practice alongside his mission commitments, working, for example, for various local friendly societies. Of an advanced age in the 1900s, in all likelihood the work of the two medical missions died with him.

Grove Street Institute

In the *Report on the Religious Condition of Glasgow*, published 1871, the GSI was held to represent the epitome of the successful missionary organisation.⁸⁴ The movement that culminated in the building of the GSI started as an enterprise by which ‘aggressive’ evangelical work could be carried on amongst the mill girls and female foundry and factory employees of the district. The grand institute building was opened in 1865, with an extension in the form of a new purpose-built medical wing opened in May 1895. Although it treated male patients and provided a range of facilities for men - including sporting and leisure facilities that enabled, for example, the male gymnasts of the GSI to be declared Scottish champions in 1905 -, the local female population and the children of the area were to the forefront of its services. Thus the new GSI medical facility aimed, the Duchess of Sutherland declared on opening it, to provide new facilities for ‘young women... counteracting the danger of ill-spent leisure time.’⁸⁵ At the opening ceremony – overseen by Lord Overtoun, then President of GMMS - it was reported that:

Over 200 patients receive free medical advice and medicine each week at the Institute, and several nurses and students also visit and care for the wants of the sick poor. This work will now be extended considerably, and a new

⁸⁴ *Report on the Religious Condition of Glasgow* (Glasgow: the Association for Promoting the Religious and Social Improvement of the City, 1871).

⁸⁵ *The Scotsman* (15th May, 1895), p. 9 and (20th March, 1905).

dispensary and consulting room have been provided on the ground floor of the new building. The cost of the building was £3500.⁸⁶

In 1907, GSI committee member T.A. Boyd, owner of a Shettleston Ironworks, declared that the institute aimed to reach and treat: ‘the children of drunkards. There were thousands of children growing up in the Cowcaddens district who, in eight or ten years, would be the hooligans of our city.’⁸⁷ The surrounding ‘street arabs’ are much mentioned in surviving reports.

From the expansion of the building in 1895, the organisation became known as the Grove Street (Home Mission and Medical) Institute: this cemented the new direction of the mission. The building was an imposing standalone structure and became a major local landmark. It provided not only a mission and medical hall but also an important public facility for the area. A range of local bodies and associations used the GSI building. Election rallies and political meetings (by Liberal, Conservative, Unionist and Labour candidates all) were held there. Marches set off and returned there. Public meetings in the building are regularly mentioned in *The Scotsman* between the 1880s and 1900s, raising the profile of its medical mission work.

Involvement of the GSI in provision of medical care began with the establishment of a GSI Friendly Society in 1882. This was a dividing society. It had 50 members at the end of its first year. Each paid 17s 8d for the year, and were entitled to 1s 4d per day’s sickness. The beginnings of gratuitous medical work at the institute started a decade before the new wing dispensary was added. In 1886, recent Glasgow medical graduate, James Anderson Robertson, ‘gynaecologist,’ started to provide weekly medical attendance for the women and children connected to the GSI ‘Mother’s Mission’. Robertson was warmly received. His presence led to a quadrupling of the Mother’s Mission, and within a short space of time, it had swelled to 300 members. For at least ten years before Robertson began providing service, different Glasgow students had engaged in volunteer work at the GSI. The Glasgow University Missionary Association had provided students to run the morning Sabbath school. Whether any medical students offered medical assistance before Robertson’s

⁸⁶ *The Scotsman* (15 May, 1895), p. 9.

⁸⁷ Grove Street (Home Mission and Medical) Institute Annual Report 1907 (Glasgow: 1907), p. 4.

involvement is unclear. No structures of systematic supervision of medical provision have been found in place. The medical work continued into and beyond the First World War, uninterrupted by the passing of managerial control from the Scottish Evangelistic Association in Edinburgh to the Evangelization Society in London in 1891.⁸⁸ Medical staff and bible-nurses both made home visits in the immediate Cowcaddens and St. Georges area throughout this time. James Anderson Robertson's involvement changed the orientation of the institute. With the subsequent opening of the new facilities, by the 1900s the GSI medical mission dispensary opened five days a week, operating from 2pm to 5pm each afternoon. Evidence suggests that each year, before 1911, the medical staff routinely engaged in thousands of consultations. The medical staff saw several hundred patient cases per week pass through the dispensary. The bible-nurse students of the Lady Missionary Training Institute visited hundreds of these cases at home each year.⁸⁹

Qualifying from Glasgow University in 1896, three years later David Dinwoodie assumed the new position of medical superintendent at the GSI. Dinwoodie served as medical superintendent for over twenty years. Fellow Glasgow University graduate, James Wilson Cameron, assisted him. Cameron graduated in 1889, had acquired his D.P.H., and was a bacteriologist by speciality. A jotted note on an admissions receipt attached to an annual report for 1907-8 and held in the libraries collection of Glasgow's Mitchell Library records a weekly account of cases treated at the dispensary. Over 297 days period it records 5,100 consultations; with 2,774 individual cases; and around fifteen home visits conducted each week. For the whole year to October 1907, 3,400 cases and 'over 7,000' consultations were treated, at a cost of £58 12s 2d (excluding salaries). This can be compared to the reported 14,278 GMMS cases treated at its two dispensaries that year; with 37,510 consultations; 158 visits per week conducted; at a cost of £184 14s 8d for medicines and £862 19s 2d for medical

⁸⁸ Passing of managerial control in *The Times* (7th January, 1891) p. 6. Last found Glasgow Post Office Directory entry for the *medical* work of Grove Street Institute in 1918-19, although a 1925 Charity Organisation Appeal shows that medical work continued up to, and beyond, this date. The obituary of David Dinwoodie states that he was a medical superintendent at the institute for twenty-two years: this confirms a medical service into the 1920s. See *Glasgow Medical Journal*, vol. 104 (1925), p. 91.

⁸⁹ Checkland, *Philanthropy in Victorian Scotland*, p. 83; Ferguson, *Scottish Social Welfare*, p.444; *The Scotsman* (15 May, 1895), p. 9: 'Over 200 patients receive free medical advice and medicine each week at the [Grove Street] Institute, and several nurses and students also visit and care for the wants of the sick poor. This work will now be extended considerably, and a new dispensary and consulting room have been provided on the ground floor of the new building. The cost of the building was £3500.'

salaries: at little more than 4d. per case, the GSI notion of ‘cheap doctoring’ was much for little.⁹⁰

The GMMS

The GMMS was Glasgow’s pre-eminent medical missionary society. Though a medical mission venture had been mooted for several years in the city, the society was found at a meeting at Glasgow’s Religious Institution Rooms in May 1867. Its aims echoed those of the EMMS, although the focus in Glasgow was on the second objective:

1. To co-operate with kindred spirits in training and supporting medical missionaries.
2. To carry on medical mission work among the poor in Glasgow.
3. To encourage a missionary spirit among medical students in Glasgow.

From the outset the society cultivated local professional, clerical and medical support. Prominent persons from across the city were encouraged to become acquainted with the work by attending at the dispensary. It made clear that its intention was avoid upsetting the vested interests of already established and practising medical and church groups, emphasising the uniqueness of its hybrid medical-evangelical purpose:

The mission is essentially a Christian institution for the benefit of man’s whole being, bodily and spiritual, but peculiar in this, the agency is ONE... At the outset, it must be distinctly understood that this institution entirely disavows all conflicting interests, either with the clergy or medical men. Its purpose, on the one hand, is to work harmoniously with every soul-winner for Jesus; and on the other, to take up the class of unpaying patients, unprovided for by other means. Cosmopolitan and Catholic [i.e. in the ‘universal’ sense], for all the City and all its creeds, its purpose is to Christianize, not to proselytise; and as the prescribing papers proclaim it, for the benefit of those who require but are not able to pay, a doctor, and are not provided for by the parish.⁹¹

Beginning medical work amongst the Free Bridgegate Congregation, GMMS services proper began in 1868. The first dispensary was found on the Trongate. Through the next decade the society operated from a succession of different sites, but focused upon the old city centre and east end of Glasgow. The GMMS dispensary relocated several times, as and when capacity became overstretched, or as opportunity and finances allowed. The sale of the premises it occupied for six years on Havannah Street to the

⁹⁰ GSI Annual Report (1907), Mitchell Library collections, ref: G266 022 GRO & HOM.

⁹¹ Lorimer, Tens Years Medical Missionary Work, pp. 6-7.

North British Railway Company allowed the directors of the GMMS to contemplate more permanent facilities. £4,000 was made from the sale. Monies raised were therefore considered sufficient to enable consideration of the expansion of its work into other parts of the city. The Moncur Street Dispensary in the Calton became the first purposely-designed dispensary building established by the GMMS. The premises cost between £2,700 and £2,800 to develop, with local architects and law-agents giving services without charge to the project. The Earl of Glasgow opened Moncur Street Dispensary in June 1879.⁹² The site provided a permanent base. It survived well into the twentieth century, only ceasing to operate as a medical dispensary in 1954. The sale of the Havannah Street property to the railway company left a healthy reserve of funds. A second, south-side dispensary was found in 1875. After a couple of relocations, a permanent home for the second dispensary was found in Govan. Opened by the mission's then honorary president, the Earl of Shaftesbury, on 1st October 1884, and built for a cost of £2,500, the Oxford Street Dispensary 'consist[ed] of a Hall calculated to accommodate about 200 patients, with Medical Attendant and Nurses' Rooms and Laboratory adjoining; also [a] Caretaker's House, with apartment for the use of Lady Visitors attached'.⁹³ The GMMS dispensary on Oxford Street in Govan provided a missionary-based medical service until the area was levelled and redeveloped in the 1960s. Respective costs indicate that both GMMS dispensaries were conceived on a far smaller scale than the EMMS rebuilds.

Whilst never integrated into the mainstream of medical circles in the manner of the EMMS in Edinburgh, the GMMS still received significant and solid support from prominent members of Glasgow's medical community. Amongst its founders was Alexander Russell Simpson, already mentioned. The first GMMS president was Andrew Anderson, then surgeon of the Glasgow Eye Infirmary. From founding, through and beyond 1911, over half of the all directors of the GMMS board were medical men. The first four presidents were all important local medical figures. GRI physician, James Duncan Maclaren, became president following Anderson's death in 1870, and presided to 1901. Former president of the FPSG, Gartnavel consultant, and Glasgow University lecturer on insanity, David Yellowlees, served to 1909. Medical missionary work being often a family affair, Yellowlees' wife was also a director.

⁹² On opening see *The Scotsman* (19 June, 1879), p. 4.

⁹³ GMMS Annual Report (1884), pp. 9-10.

After Yellowlees, and until his death in 1932, William Loudon Reid held the post. Reid was a reputable obstetrician and gynaecologist. He had acquired hands-on experience of outdoor medical services for the poor having started his medical career as a PMO in Glasgow.

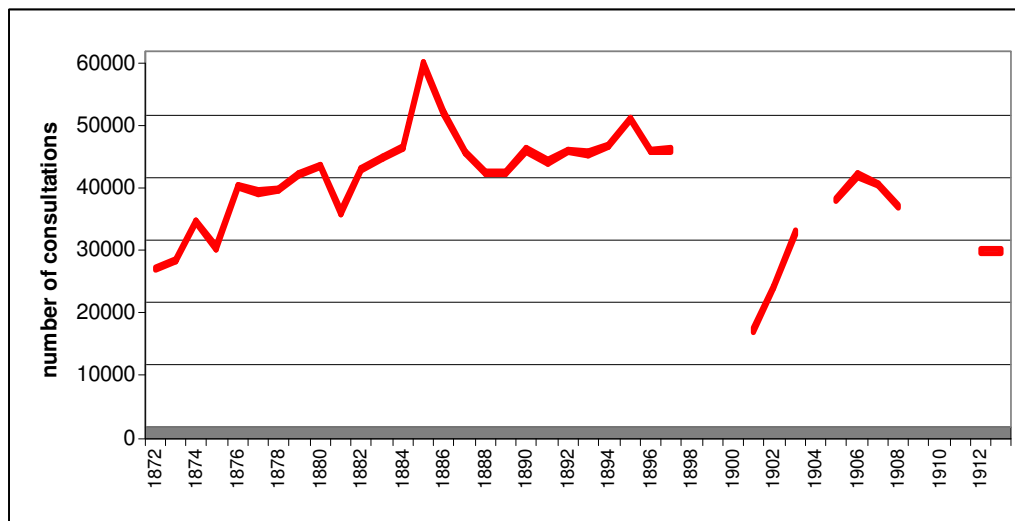
At the first GMMS dispensary in the Trongate, founder member, John Pirie, M.D, provided what began as part-time medical service. With him, as the first medical assistant, was a Rev. James Dalzell. Dalzell exemplified the career path of many of the auxiliary hands that were to work for the society thereafter. He graduated in medicine from Glasgow University in 1870, and went on to found the Gordon Memorial Mission of the United Free Church of Scotland in South Africa. Pirie, the first medical superintendent, remained associated with the GMMS after he stopped serving when the post of superintendent became a full-time and salaried one in 1870; he remained as a director to his death in 1907. As evidence of his rising star and of the ability of the medical mission to attract interest from the elites of the local medical profession, amongst the men who early accepted the invitation to guest preside over the annual meeting of the GMMS was William Macewen. Macewen presided over the meeting in December 1874, and used the occasion to bemoan the ‘deficiency of nurses, as well as the want of liberality on the part of the public’: outdoor nursing had begun at the GMMS two years earlier.⁹⁴ Other guest speakers who showed the extent of sympathy with the cause of the medical missions in Glasgow included, in 1889, George H.B. Macleod, professor of surgery at Glasgow University.

The development of the GMMS over its first fifty years can be summarised by decades. The 1860s was the decade in which the idea of a home medical mission in Glasgow was actualised. The 1870s saw significant expansion of the scope of medical mission work in Glasgow. During the 1870s the directors and supporters openly envisioned the possibility of a fully integrated, city-wide medical missionary service, consisting of what they proposed should become a network of dispensaries, with additional services such as convalescent homes and a children’s dispensary tacked on. In the event, only one more dispensary was added. The idea for a dedicated GMMS children’s dispensary, although it did not come to pass, predating the founding of the

⁹⁴ *The Scotsman* (9 Dec, 1874), p. 4.

Sick-Children's Dispensary in Glasgow by some years.⁹⁵ The 1880s saw an adjustment of expectations and a narrowing of horizons in the light of changing economic realities, and with it the consolidation of the medical service against growing competition from elsewhere in the voluntary medical sector. Yet harsher economic climes meant that during the 1890s, a thorough retrenchment and rationalisation of the service became necessary. Bank debt grew, and levels of income stagnated. The 1900s brought adjustment to newly straitened circumstances and a change of operational emphasis. This was marked by the growing use of medical assistants in order to overtake home visitation commitments, as permanent staff concentrated instead upon maximising throughput of cases at the dispensary. Medical assistants used for visits in the 1900s were mainly sourced from amongst female medical graduates attending Queen Margaret College. Finally, the 1910s saw the further 'feminisation' of the service, with a tightening of focus upon those groups not catered for in the NHI Act, 1911.

Figure 4.2: Number of medical consultations - either at the dispensary or at home - reported by GMMS, 1872 -1912



Source: Annual Reports

⁹⁵ See GMMS Annual Report (1874), p. 4: 'Your Directors venture to hope that they may soon see their way to extend the benefits of the Medical Mission by means of branches, so as to be more accessible to those who live in the large outlying districts around the city'. *The Scotsman* (19 June, 1879), p. 4: 'Lord Collins moved that in addition to the two centres a further extension in the city of the work of the society was highly desirable'.

Growth and change analysed by decennial chunks is reflected in the changing patterns of patient throughput reported (Figure 4.2). A series of key events and decisions marking the development of the GMMS can be identified: these are plotted against statistical returns in order to mark their impact on home visitation (Figure 4.3).

When a second south-side GMMS dispensary opened, in September 1875, the impact on patient numbers was immediate. The reported total of (non-nursing) medical consultations leapt dramatically: from 29,571 in 1875, to 39,357 in 1876 (Figure 4.2). Subsequent relocation of the new service to purpose built premises on the south-side in 1884 was coincident with severe economic depression at this time in Glasgow. New capacity and fresh demand account for the main spike in data in 1885. Consultations reached 58,908 for the year, with 24,057 patients treated. Growth in demand forced a rethink of the way the service was staffed, and the manner by which home visitation, especially, was carried on. Medical superintendents faced a Sisyphean task in overtaking visiting schedules. In order to concentrate its resources, and in order to more precisely delineate its catchment area, in 1879 the directors announced that the GMMS would henceforth only visit a case if the sick-poor person lived within a mile radius of either one of its two dispensaries.⁹⁶ Necessity to bring in hands to help meant a change of heart in the deployment of students. Despite previous recorded reticence on the use of any unqualified person, from the summer of 1881, deployment of final-year medical students at the dispensaries began. George Johnston was the first recipient of what was a newly established £20 GMMS studentship. From this time other finals-students followed in steady stream, one or two at a time. Johnston's initial placement was funded from collections taken during a lecture tour embarked upon for purpose by board member Rev. Alexander Wallace. Johnston eventually graduated from Aberdeen University in 1883, and went on to work at a Presbyterian Medical Mission in Liverpool. As published returns show, from 1882 to 1884 the medical students deployed by the GMMS came to account for roughly one-quarter (23.5%) of all home visits by non-nursing medical staff.

Services fell back considerably after 1897. Whilst there were 41,756 consultations in 1897, within four years there were only 16,365 consultations undertaken (Figure 4.2).

⁹⁶ GMMS Annual Report (1874), pp. 8-9.

Although patient numbers recovered during the first decade of the twentieth century, former workloads were never matched again. As the quote below shows, the dramatic fall in patients after 1897 was a mediated one. New policies aimed at dampening demand to more manageable and responsible levels. In the 1897 GMMS annual report the directors announced that:

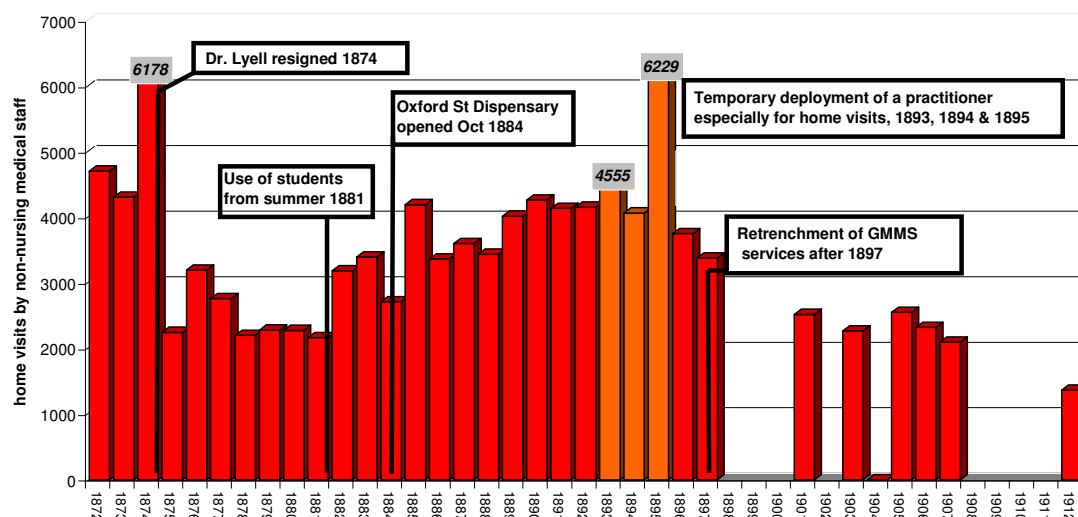
After a full report from medical members of the Directorate and careful discussion, it was resolved *to open the two dispensaries on alternate and different days, and to [introduce a] charge [of] one penny for every consultation or renewal of medicine.* This charge... will reduce the excessive number of patients... will permit of reduction in the paid staff, and will concentrate the efforts of the mission on the really suitable and deserving cases.⁹⁷

With income in decline and bank debt, by 1897, sitting at 47% of the ordinary annual revenue, retrenchment became imperative for the survival of the institution and its two dispensaries. Cutbacks to the medical service resulted in a fall of expenditure by around one-quarter. When the position of medical superintendent fell vacant in 1898, and again in 1908, the salary paid to the new appointee was each time reduced. All services were affected. Home visits carried out by medical staff fell by around one-third (Figure 4.3). There is evidence from amongst the ephemeral papers attached to the Poor Law Applications for Relief ledgers in Glasgow that GMMS medical staff positively assisted the society reduce its workload burden after 1897 by more actively weeding out cases they felt more suited to public assistance. Medical staff began advising certain applicants to seek poor law medical treatment instead of staying with the mission's services. Dated, headed notepaper bearing the signature of the attending GMMS doctor was used to smooth the process of in-formal referral. The mother of Agnes Welsh - aged two, and the daughter of carter James Welsh -, for example, was handed a referral recommendation in May 1907 to take to the parish. It certified that in the opinion of then GMMS medical practitioner, Kate Fraser, that the child Agnes was 'a fit person to be sent to [the poor law] Hospital as a patient'.⁹⁸

⁹⁷ GMMS Annual Report (1897), p. 4.

⁹⁸ See Govan Parish Application For Relief (Glasgow City Archives (GCA): Mitchell Library) ref: D-HEW 17/591, app. No. 91115. The referral was successful. Agnes Walsh was admitted to the poorhouse hospital and stayed there over four months.

Figure 4.3: Number of home visits made to patients by GMMS medical staff, 1872 -1912



Source: Annual Reports

Note: Visits counted here are those that were conducted either by the medical superintendents, students or by qualified medical assistants, and therefore exclude all additional nursing visits

Approximately 8.6% of all medical consultations conducted by GMMS medical staff over the period 1872 to 1912 were in the form of home visits. The average annual number of home visits by *non-nursing* GMMS medical staff for all known years between 1872 and 1912 was 3,376. In peak years, 1893-95, visits averaged 4,952 per year (Figure 4.3). These non-nursing visits were conducted by either the medical superintendent, by other qualified medical assistant, or by medical students. Over all known years, the average number of home visits that were visits to new patients was 52.9%.⁹⁹ The service spread thinly. Many of the patients visited, therefore, were seen only once or twice by medical staff. All subsequent visits during convalescence were left in the hands of the nursing staff and bible-women. Visits by nursing staff doubled the number of total visits carried out as reported here. Although the number of visits conducted each year fluctuated, and whilst workloads expanded or contracted as prevailing circumstances changed, overall the mean average number of different patients visited at home each year from 1875 to 1911 was 2,100 (Table 3.3).

⁹⁹ Annually reported number of medical visits is known for all years except 1898-1900, 1902, 1904, and the period 1908-1911. Between 1886 and 1902 the number of individual patients visited is not recorded in the annual reports.

4.5 The medical work of medical missions; visiting and finance

Almost every kind of disease is treated at the Dispensaries, and a great amount of suffering is relieved. In many cases, of course, the disease has become chronic, and the conditions in which the people live make it difficult to effect a cure, but in all cases much can be done to help and comfort the sufferers.

GMMS Annual Report (1913)¹⁰⁰

Whilst medical missions before World War One tackled a range of medical work, much of the time focus devolved onto palliative treatment of already chronic conditions, cases not readily picked up on in the infirmaries. Although details of individual cases are rarely extant in charity records, caseloads categorised by general disease classification can be found. Summarised here are the types of medical condition treated at the two GMMS dispensaries between 1877 and 1885 (Table 4.1).

Table 4.1: GMMS medical cases (dispensary and domiciliary), 1877-1885

Breakdown of GMMS Cases:	total number of old and new GMMS cases reported									
	1877	1878	1879	1880	1881	1882	1883	1884	1885	total (%)
Diseases of the:										
i. Constitution	8514	10006	9234	9208	7639	8848	8672	9285	11736	23.0%
ii. Nervous System	1314	1619	1453	1870	1563	1826	1788	2110	2375	4.4%
iii. Respiratory Organs and Passages	13333	10904	13452	11344	8407	9144	10866	10457	14330	28.2%
iv. Heart and Great Blood Vessels	647	650	688	849	613	718	879	1007	1183	2.0%
v. Stomach, Intestinal Canal, Liver and Spleen	3957	5263	4848	6175	5045	6540	6821	7714	9564	15.5%
vi. Kidneys and Genito-Urinary Organs	1509	2088	2012	2478	2042	2650	2369	2491	3497	5.8%
vii. Eye and Ear	791	466	950	934	834	1001	932	981	1179	2.2%
viii. Skin, Muscles, and Bones	4231	4842	5552	6576	5181	6412	6771	7495	8466	15.3%
Cases Receiving Operative Treatment:-	<u>1347</u>	<u>796</u>	<u>842</u>	<u>964</u>	<u>1795</u>	<u>1769</u>	<u>1540</u>	<u>1348</u>	<u>2380</u>	3.5%
1. Teeth Extracted	556	388	432	563	707	787	798	703	1243	1.7%
2. Abscesses Opened	391	225	216	283	224	338	314	287	396	0.7%
3. Wounds and Sores Dressed	359	124	122	88	816	571	346	312	660	0.9%
4. Other/Graver Surgical Operations*	41	59	72	30	48	73	82	46	81	0.1%
total dispensary and domiciliary cases:	35643	36634	39031	40398	33119	38908	40638	42888	54710	

Source: GMMS annual reports (1877-1885).

Note: 'Other/Graver Surgical Operations' included 'the application of splints and bandages', 'fracture cases', and 'the removal of...[cancerous] tumours'. From 1881 (the Annual Reports note) full details of all 'Graver Surgical Operations' carried out were recorded into a 'Special Case Book' kept at the dispensaries for the purpose. These do not survive in the archives.

¹⁰⁰ GMMS Annual Report (1913), p. 8.

As can be seen, respiratory and constitutional complaints predominated, accounting for over half of the cases in this period. Operative treatment was generally the exception, accounting for less than one in twenty (3.5%) of all consultations carried out. Minor operations, of the type familiar in contemporary general practice, were undertaken: teeth were extracted, abscesses opened, and wounds and sores dressed. Major operations were understood as those that normally required an anesthetic. For these, a 'special case book' was kept as a log in each dispensary. From 1877 to 1885, it is known that 532 operative treatments described as 'cases treated by mechanical appliance' were carried out. This equates to around one per week. Fractures, tumours, 'large abscesses', and haemorrhoids were the stock of these. The 1896 annual report notes that some operations performed 'under chloroform' were performed in the homes of patients. Administration of chloroform required a second pair of trained hands, and the mission's visiting surgeon, Robert Jardine, therefore normally accompanied the medical superintendent.¹⁰¹ Salaried senior nursing staff, responsible for follow up work in the homes of the poor after operations, 'under the direction of the medical staff,' dealt mostly with any convalescent care. They were made responsible for overseeing the dressing of ulcers, wounds and burns.

The autobiographic memoir of Scottish medical practitioner, Clement Bryce Gunn, provides a valuable snapshot of the routine of daily rounds of medical mission work. Gunn had trained at the EMMS dispensary, and was in attendance there in the early 1880s. Although written sometime after events, Gunn's memoirs of practice provide an ordinary student and a dispenser's point of view of the nature of the work. He reflects on a series of issues, including: the scope and nature of supervised instruction of students in Edinburgh; training in practical pharmacy; the types and range of medicines dispensed; the contemporary method of use of stock medicines in medical practice; the teaching and practice routine at the medical mission; the importance of dentistry work; and the nature of the clientele. Writing of a time when his second round of medical examinations neared, Gunn noted of his schedule that taking 'practical pharmacy' at the dispensary

meant evening visits thither, to dispense the various prescriptions ordered during the afternoon consulting hour. Infusions, pills, plasters, powders, and

¹⁰¹ GMMS Annual Report (1896), p. 13.

mixtures all passed through our 'prentice hands; but providentially were supervised by our kindly and sagacious Head Chemist. ... We had one stock mixture for bronchitis; another for gastric catarrh, and two more, containing no poisons, and incapable of doing much harm if mistakenly prescribed for the wrong malady.¹⁰²

Gunn noted the medical life-lessons learnt undertaking Saturday night emergency service at the Cowgate:

The customary Saturday-night rows diversified our course at the Cowgate Dispensary. These served to train us in resourcefulness, calmness in the face of accident and danger, and presence of mind when menaced by excitable and drunken patients. We learned also when to be silent, and never to hazard any opinion in an assault case, which might prove to be of serious or criminal importance. Also we learned never to interfere in a row between husband and wife, as in every case, if we attacked the man, either verbally or by force, his suffering helpmeet would invariably take her husband's part...¹⁰³

Medical mission work could be dangerous work. For dispensaries stationed amidst the poorest, roughest neighbourhoods of Glasgow and Edinburgh, incidence of violence, theft, misadventure and other brutal or drunken disturbances were rife. On numerous occasions the press reported break-ins or theft at the EMMS Cowgate Dispensary.¹⁰⁴ The location of medical mission dispensaries within slum neighbourhoods increased the dangers for staff and students, and as well for attending patients. In April 1893, for example, *The Scotsman* carried report of one woman robbed whilst waiting for the dispensary in the Cowgate to open.¹⁰⁵ In July 1891, and again in May 1895, the same paper carried reports from the local police courts of physical violence done to medical mission dispensary staff by persons attending at the dispensary, the worse for drink,

¹⁰² Clement Bryce Gunn, *Leaves from the Life of a Country Doctor* (Edinburgh and London: Ettrick Press Ltd, 1947 (1st published 1935), pp. 34-5.

¹⁰³ Gunn, *Leaves from the Life of a Country Doctor*, p.39.

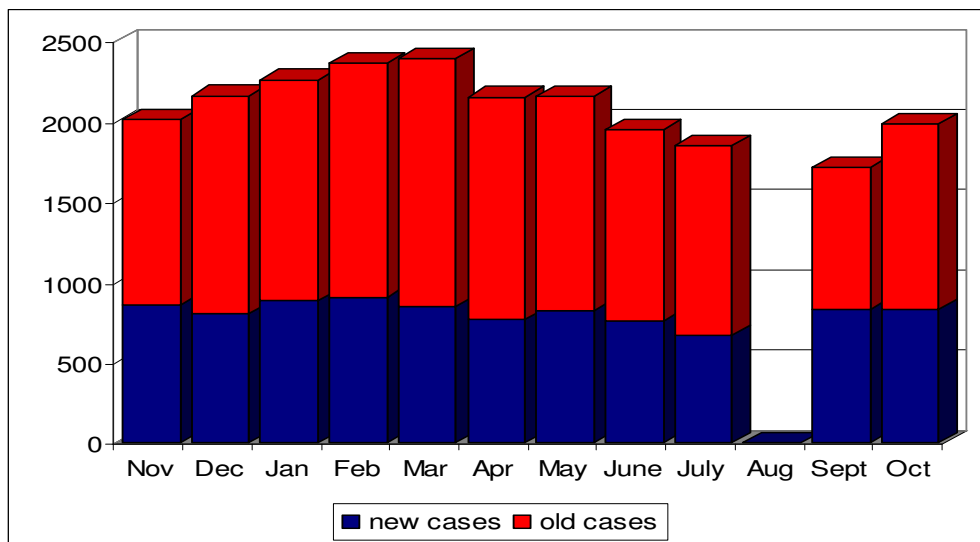
¹⁰⁴ For example, *The Scotsman* (28th March 1871), p. 2: recorded that 'a woman named Flynn' was taken into custody after 'a number of surgical instruments' was stolen from the Cowgate dispensary; (15th July 1872) p. 3: 'Yesterday morning it was discovered that the Cowgate dispensary had been broken into by thieves, and a quantity of clothing and other articles carried off. The thieves had gained admittance by raising a back window, and made their exit by the front door...'; (23rd March 1883) p. 4: 'Mary Kelly or Brown was sentenced to six months imprisonment for having stolen some bed-room linen and some clothing from the Livingstone Memorial Medical Missionary Training Institution'.

¹⁰⁵ *The Scotsman* (April 1893): 'Samuel Brown and James Kecheran pleaded not guilt to a charge of having on the 10th March, in Cowgate, stolen from a woman named Catherine Stevenson, a bag containing a purse, 2s 6d... It was shown by the evidence for the prosecution that the woman, when proceeding to the Cowgate Dispensary, saw the two accused parties watching her. Fearing for the safety of her bag, she crossed over to the other side of the street. She had to wait until the Dispensary opened, and while doing so Brown crossed the street, snatched the bag out of her hand, and ran up an adjoining pend.'

demanding treatment.¹⁰⁶ The dangers to staff were more than just from threats of physical violence. Medicine was a dangerous profession. Practitioners and students plying trade amongst the poor routinely faced increased risk of exposure to infection. In November 1894, star EMMS student, Henry Shelly Brockway, came down with acute appendicitis contracted whilst working at the Cowgate dispensary. He died in the set aside ‘student’s ward’ of the Royal Infirmary.¹⁰⁷ Again, in August 1903, another EMMS student died, from a ‘sharp, sudden illness,’ also contracted during his studies.¹⁰⁸

A feature of medical work amongst the poor, workload varied with the climatic seasons. Medical missions were no exception. During the year to October 1888, a monthly breakdown of the caseload dealt with by the Moncur Street Dispensary of the GMMS showed that January through March it was the busiest, and June to September the quietest (Figure 4.4). No cases at all were seen in August, during when the dispensary traditionally was closed to allow the superintendent a break.

Figure 4.4: Monthly breakdown of cases dealt with at the GMMS Moncur Street Dispensary (Nov 1887-Oct 1888)



¹⁰⁶ *The Scotsman* (17 July, 1891), p. 4, and (15 May, 1895), p. 8.

¹⁰⁷ See EMMS Quarterly, vol. 8/9 (Feb., 1895), frontispiece, and *The Scotsman* (29 Nov, 1894).

¹⁰⁸ EMMS Quarterly, vol. 10 (1903), p.419: Henry George Smith, the student who died, was described in the Quarterly Paper editorial as hailing from Limerick, and influenced towards his choice of vocation from a Dr Long, ‘the medical missionary in that city, who has had to endure considerable persecution at the hands of the Roman Catholics.’

...but it is obvious that in many cases a proper supply of nourishing food will be more useful in restoring to health, than all the productions of the Pharmacopoeia.¹⁰⁹

Portending mainstay issues of modern inner-city general practice, the practitioners of the medical missions of the Cowgate and Canongate in Edinburgh and the Calton and Govan in Glasgow found themselves devoting much time and energy to 'preventative' problems associated with poor diet and poor lifestyle (which, with resulting chronic illness, are great markers of narrowed choices associated with poverty). Whatever the ultimate value that might be ascribed to medical treatments offered, advice was an area of practice that held out at least the possibility of a genuine improvement in health. Providing advice on diet and the provision of basic foodstuffs had advantage of being relatively cheap for the mission to administer (even if the advice itself was not necessarily practical). The medical staff of the medical missions reported that most of the families that they were called upon to treat at home were often severely under-nourished. Mission practitioners therefore had cause to prescribe much 'cod-liver oil and various kinds of chemical food [syrup].' In 1881, the GMMS claimed that 'no medical treatment, short of dietetic, is able to cope with the wasting and debilitating diseases induced by... dire want.' Also that 'about one hundred and twenty gallons of cod-liver oil... and nearly as much various chemical-food syrups, have been dispensed during the year.'¹¹⁰

Foodstuffs, along with dressings and bottles, were amongst the types of item persons most often donated to the society. At the annual meeting of the EMMS in 1865, Burns Thomson claimed 'it was not medicine so much as nourishing food and warm clothing that were needed.'¹¹¹ Similar concerns were voiced in Glasgow. In the mid-1870s, when the GMMS medical staff broached the need for a 'children's missionary hospital' in the city, it was held that this would need have as its focus the 'dietetic treatment of diseases'. In reports published in 1875 and 1876, then GMMS Moncur Street Dispensary medical superintendent, Robert Laidlaw, drew a direct connection between the observed phenomena of universal tea and bread diets amongst the poor and whole range of complaints coming before medical missionary doctors. These

¹⁰⁹ Dr Weir, GMJ (May 1828), p. 220, quoted in A.C. Cheyne (ed.), *The Practical and the Pious: Essays on Thomas Chalmers* (Edinburgh: Saint Andrew Press, 1985), p. 132.

¹¹⁰ GMMS Annual Report (1876), p. 11 and GMMS Annual Report (1881), p. 12.

¹¹¹ *The Scotsman* (16 Nov, 1865), p. 2.

included: digestive disorders and childhood bone diseases, ‘caries of the spine, caries and neurosis of the bones of the limbs and strumous joint-disease,’ and consumption.¹¹² As a play upon the temperance movement, an often repeated attack on the tea-drinking culture of the poor in the reports of medical missions was taken to its logical conclusion with a call, in 1879, for the founding of an ‘Anti-Tea League’! Both Laidlaw, and his successor, George Muir Connor, pondered how the working-poor of Scotland might in future be better fed:

Very frequently the fourth, or even the third, of the hands in a large work are unable, through distance, to have their breakfast and dinner at home, and for the most part these meals are partaken of in a room set apart for the purpose in the work, and consist of, with few exceptions, *steamed tea, bread and butter*. The result is that a very large number, chiefly growing young women, are obliged to live on teal meals (strong astringent infusions) three or four times daily... we believe that the multiplication of cooking depots... in which cheap and nutritious food could be readily had, could do twenty times as much for those for whom we plead.

Robert Laidlaw (1876)¹¹³

It is remarkable that a large percentage of them [referring to working women who came to the dispensaries on Sundays] suffer from stomach ailments, due in large measure to the great quantities of tea they imbibe. It would be a great boon if factories had restaurants attached to them, where a properly cooked diet could be procured...

George Muir Connor (1896)¹¹⁴

What the second honorary president of the GMMS, Lord Overtoun, would have made of this suggestion from the mission’s medical practitioners as to how he might improve conditions in his Glasgow’s factories can only be speculated upon!¹¹⁵

¹¹² GMMS Annual Report (1876), p. 11. Laidlaw quoted in *The Scotsman* (8 Dec, 1875), p. 6: ‘In a number of the consumptive cases the commencement of the disease might be traced to the objectionable practice of mill-workers making tea their principle article of diet, and from enquiries it seemed in a large number of the factories the operatives had no opportunity of cooking anything else’

¹¹³ GMMS Annual Report (1876), pp. 10-11.

¹¹⁴ GMMS Annual Report (1896), p. 13.

¹¹⁵ Callum Brown gives Lord Overtoun as a ‘celebrated example’ of what he calls the ‘vice-presidential class’ of middle-class businessmen, professionals and entrepreneurs who were the patrons, benefactors and managers of Scotland’s voluntary organisations (including medical missions). See Callum G. Brown, *Religion and Society in Scotland since 1707* (Edinburgh: Edinburgh University Press, 1997), p. 127. On Overtoun see also Drummond and Bulloch, *The Church in Late Victorian Scotland*, p. 200. Lord Overtoun was John Campbell White. White was raised to peerage in 1893 thanks to his support of the Liberal Party. Keir Hardie pilloried Overtoun in 1899 for conditions at his chemical works, at Shawfield, outside Glasgow. Overtoun’s interest in charity and religion had originally been piqued by the 1859 revivalist movement and as the subsequent chair of the Glasgow United Evangelistic society he was responsible for the founding of the Bible Training Institute. Through provision of nursing support in exchange for training opportunity, this enjoyed close connections with GMMS after Overtoun became president in 1885.

Home Visiting

Despite financial difficulties, for at least five clearly discernable reasons, the home visitation service, though often both the most tiring and time-consuming aspect, continued to be an integral component of the medical mission relief service. Home visitation fitted best the medical mission holistic approach. Many of the sick-poor who used the medical missions were bed-ridden. Access to the home was felt to represent the best method through which to influence the habits of the poor.¹¹⁶ A home visit was seen as the best way to determine the true deserts of each applicant for medical relief. Additionally, access to the home was viewed as crucial to the dissemination of the gospel amongst families. These final two points was spelled out in the 1874 GMMS Annual Report by the then Acting-medical superintendent:

A very important element in the work of the mission is visiting the sick-poor at their homes. By this means alone can we form a pretty accurate opinion as to who are only impostors. Herein lies one superiority of the mission over other medical institutions throughout the city, which only give advice to their patients, but take no further interest in their welfare. Not only are we thus enabled to discover who are the really deserving, but much kindly sympathy may be shown, and friendly advice given at their own firesides...¹¹⁷

Home visits also broadened understanding of issues of poverty amongst medical missionaries. Sometimes sympathetically, sometimes less so, reports by medical mission officers detailed an array of coping strategies employed by the poor. Some, it was claimed, had become adept at playing visiting agents against each other.

One case (in which I knew the rent was paid, 5s. given weekly, and invalid food provided by the dispensary, actually from five visitors besides) received 4s., and beef, bread, tea, sugar and rice in one week, yet professed to a sixth visitor to be starving, and that a neighbour gave her a penny to get skim milk, as she had not got a bite to eat.¹¹⁸

In Glasgow, at the dispensaries of the GMMS, whilst he was not unassisted, most medical home visitation responsibility before the 1890s fell on the shoulders of the medical superintendent in charge of the dispensary concerned. The GMMS medical superintendents were full-time employees of the mission. Visitation duties could consume a considerable part of each day. Therefore attempts were made to limit the hours engaged in this line of work. In 1876, the medical superintendents of the two

¹¹⁶ GMMS Annual Report (1884), p. 7.

¹¹⁷ GMMS Annual Report (1874), pp. 8-9

¹¹⁸ *The Scotsman* (1 Apr, 1895), p. 2, quoting from Burns Thomson, *Reminiscences*.

GMMS dispensaries claimed that they mainly tried to limit visits to ‘about two hours daily as a rule’: with a reported 3,202 visits that year (or 62 weekly), were the rule strictly applied then this would have allowed no leeway to the statutory 20 minutes per case visited including travel time.¹¹⁹ Visits were necessarily conducted during the hours the dispensary was closed. In Edinburgh, greater manpower, plus the more readily accepted use of students to overtake the bulk of visits, enabled both visitation and dispensary treatment to continue round the clock. The EMMS focus upon the student and upon the training requirements of would-be missionaries contrasts with the approach in Glasgow, where the mission managers made a virtue of the fact that students were little used by it (at least in the early years). In 1879 they noted ‘it is to be observed that these visits [to the sick at home who are bedridden] are all paid by qualified practitioners, and not by students of medicine.’¹²⁰ The GMMS emphasis on the use of the qualified medical staff in the conducting visits is a point of fundamental difference between the two cities, and one that echoes attitudes within each city towards the balance of care provision against the requirements of medical education.

The GMMS annual report of 1872 gives detail of what is claimed a thorough picture of the standard daily routine of the medical practitioner working in the Glasgow mission dispensary. The time and labour necessary each day to overtake domiciliary treatment of the sick-poor is clear. At this early juncture in its history, the GMMS had just one dispensary. The medical superintendent was John Lyell. Lyell, who had originally qualified to practice medicine in 1829, had acquired his M.D. from St Andrews in 1850. He had operated as a regular medical practitioner for more than four decades and had been a PMO in Fifeshire before taking up employment in Glasgow in 1870. Being already quite senior in terms of age on appointment, Lyell was to resign, ‘after repeated premonitions of approaching paralysis,’ in 1874. He retired from practice altogether. His invalidity, he claimed, being brought on by the exhaustion of his visiting work as a medical missionary. During 1871 he had caught relapsing fever whilst carrying out his rounds of house calls.¹²¹ Lyell had been the

¹¹⁹ GMMS Annual Report (1876), pp. 11-12. This visitation workload was largely the same a decade later. Per GMMS Annual Report (1884), p. 17, Dr Archibald Templeton of the GMMS Oxford Street Dispensary in Govan claimed that ‘10 cases a day on an average were visited each day the dispensary was open, or the day following.’

¹²⁰ GMMS Annual Report (1879), p. 10.

¹²¹ Lyell caught relapsing fever during a visit in 1871 and thereafter had to curtail home visitation activities for a period. EMMS Quarterly, vol. 1 (1871), p. 22 and p. 68.

GMMS's first full-time medical superintendent. He was paid a then-competitive salary of £300.¹²² The medical mission at this time also employed a medical assistant, a (female) dispenser, and a handful of 'bible-women nurses'. Early in 1872, the mission directors had invited and funded a Mrs McLaren to travel from London to work in Glasgow for three months in order to oversee the successful implementation of a bible-nursing training scheme. Thereafter the GMMS typically employed one to three salaried nursing staff per dispensary (on a salary of around £40 each).

For the year 1872, the GMMS reported that 21,453 sick-poor attended at its dispensary. With a noted lack of alternative charity medical dispensaries in Glasgow at this time, the patients, it was claimed, were 'drawn from all parts of the city and suburbs'. The annual report that year records that a total 4,711 home visits were made, with an average of nearly three visits made per patient visited. During these visits Lyell and his auxiliary medical staff dealt with 644 vaccination cases. They experienced 178 patient deaths (a death-rate of over 10% of patients visited). This reinforces the point that medical missions were called to attend to a large percentage of terminal, chronic cases. As the 1874 annual report reflected stoically: 'death is life to the Christian'. Figures quoted meant that on average that year 413 patient cases were seen per week at the dispensary, and 91 home visits undertaken. Visits were necessarily carried on every day. This included Sundays, although actual treatment was avoided during Sabbath calls. On the representative nature of the extent of the medical workload undertaken by the mission amongst Glasgow's poor that year, Lyell notes that 1872 was actually a fairly economically prosperous year.¹²³

On a typical day visits were conducted through the morning. Exact time taken was obviously dependant on the number of different cases to be seen on a given day, the nature of each case, the streets to be visited, and the total travelling involved. On one day detailed in the annual report by Lyell he took around four hours to make thirteen house calls. These were made mainly to what Lyell says were Catholic families, or to women patients. Similarly, it was also 'mothers with their young charges' that

¹²² This was also the sum of money paid to the one full-time PMO in Glasgow, appointed in 1877 to work roughly the same district. For salary comparisons see Chapter 9: 'Workloads; salaries; and locum tenens' in Part Two of this thesis.

¹²³ GMMS Annual Report (1872), p. 12.

typically were said to fill the dispensary.¹²⁴ On days other than the Sabbath, immediately after home visits, Lyell returned to base to conduct surgery at the dispensary. This typically consisted of half an hour of evangelic service and gospel address followed by around an hour or so of official consultation time. Patients were expected to attend service before waiting in turn to be seen by the practitioner or delegated assistant. In a separate discourse that says more, perhaps, about the attitude of the commentator than the people described, GMMS nurse Jane Lorimer details the typical dispensary scene in vivid terms:

What a motley gathering to behold! Poverty and suffering are common to all; but there is every variety in other ways, from those who have made the most of their poor clothing, with clean faces and tidy hair, to those in tatters, who look as if soap, water, and combs were by them unknown. Restless, battered faces, battered not only with toil but with vice; [and] quiet, contented faces, telling of the hard struggle of life sustained and cheered by the peace of God. Breadwinners – husbands and fathers, young girls and youths – long out of work from illness, or struggling on with work while under disease... chronic complaints... consumptives... mothers, “not so strong as they would like to be”... children of all ages, and infants... with claw-like, emaciated limbs and old wizened faces.¹²⁵

Finishing at the morning dispensary around 2.30 p.m. on a typical day, Lyell would return once more at five. Of surgery conducted on Sunday 17th November 1872 Lyell noted:

In the evening at 5 p.m. met at the hall – gave half an hour’s address on the verse “To me to live is Christ and to die is gain,” then retired to examine patients, while Mr Black [Lyell’s then assistant] spoke to the people. There were 74 in all present, and I examined 25 patients, concluding at 6.30 our Sabbath day’s work.¹²⁶

Following Lyell’s departure the GMMS directors resolved that henceforward it would seek to appoint as its medical mission superintendents only much younger men. The priority at appointment therefore became recent graduates, ‘fresh’ for the onerous task of visiting. The GMMS directors largely stuck to this policy over the next four decades. Thus Robert Laidlaw, appointed in 1875, had been qualified to practice just two years on taking up the position. Laidlaw’s replacement in 1885, George Muir Connor, was employed straight from Glasgow University, although coming ‘highly recommended, and with four years’ experience in connection with the City Mission’.

¹²⁴ GMMS Annual Report (1874), p. 9.

¹²⁵ Lorimer, *Tens Years Medical Missionary Work*, pp. 12-13.

¹²⁶ GMMS Annual Report (1872), p. 16.

He served to 1898. Connor's replacement was appointed early in 1899.¹²⁷ Edward Wright had served briefly at Dublin Medical Mission before accepting the appointment, having qualified to practice only in 1896. Wright served for slightly less than ten years. His replacement, after 1908, William George Macdonald, had been slightly longer in practice than his three predecessors on appointment, having qualified in 1903.¹²⁸ The second GMMS dispensary, opened in 1875, had originally employed John Davidson Reid. Reid, like Connor, had been employed straight from Glasgow University. When Reid died from an 'acute inflammation' five years later, he was replaced by Dr. Rev. Archibald Templeton. Templeton was an unusual appointment for the GMMS. He was much older and far more experienced. He was also from a wealthy Glasgow family. He was thoroughly dedicated to the life and vocation of medical missionary work. Most of the other men mentioned and employed at the medical mission in Glasgow had undertaken regular medical careers out-with their period of time engaged in missionary work, either before or after serving the medical mission. Templeton, on the other hand, served as the medical superintendent of the GMMS Oxford Street dispensary for over 30 years, until 1918. He was a qualified cleric and had served as a medical missionary in India for a number of years before returning to Glasgow.¹²⁹ Templeton's career-long dedication to the cause of medical missions more closely resembled the men who were selected to appointment as medical superintendent in Edinburgh, at the EMMS dispensary and training home, than it did fellow GMMS medical staff. Templeton aside, differences in approach to staffing appointments at the GMMS and EMMS dispensaries reflect differences in emphasis between the practical and ideological requirements of the medical mission task in Glasgow and Edinburgh.

¹²⁷ *The Scotsman* (7th Jan, 1899), p. 5 and (14th Jan, 1899), p. 12: 'Medical Missionary – Superintendent wanted for Moncur Street Dispensary... must be a qualified medical man, with some experience of missionary work: salary not to exceed £250.'

¹²⁸ *The Scotsman* (10 Aug, 1908), p. 1, and (17 Aug, 1908), p. 1: 'MEDICAL MISSIONARY - RESIDENT MEDICAL SUPERINTENDENT required for MONCUR STREET DISPENSARY of the Glasgow Medical Missionary Society. Applicants must be qualified medical practitioners and interested in Christian work... Salary £200, with coal, gas, and partially furnished house.'

¹²⁹ GMJ, v. 100 (1923) p. 27: 'Rev. Dr Templeton was well known as a medical missionary in the Glasgow Medical Mission... work which he undertook on his return to this country after service as a missionary in India. He was the son of Mr. James Templeton, the founder of the great carpet manufacturing firm in the East-End of Glasgow, and therefore belonged to a family whose name stands high in the records of philanthropy and hospital service in the city of Glasgow... He had lived some years at Mearns in retirement'.

Finances

Both the main medical missions of Glasgow and Edinburgh have left a solid record of accounts. The accounts for GMMS for known years at five year intervals are summarised in detail below for the period 1877 to 1912 (Table 4.2).

Table 4.2: GMMS accounts showing sources of revenue, ordinary income and expenditure, selected years, 1877-1912.

source of revenue:	1877	1882	1887*	1892*	1897*	1903	1907	1912
Lady Collectors	48.3%	47.2%	24.2%	34.2%	33.6%	39.5%	34.7%	26.4%
Collector on (5%) Commission	39.2%	29.2%	14.9%	16.9%	15.7%	13.8%	12.8%	9.8%
via C.O.S (from 1885)	0%	0%	1.2%	3.0%	2.6%	3.7%	3.2%	3.5%
To Board (bequests, business etc)	9.1%	15.9%	21.6%	13.2%	14.0%	8.3%	13.2%	19.6%
for bible-women's salaries	0%	0%	2.3%	3.1%	3.1%	2.6%	4.5%	4.3%
Charges at the Dispensary	0%	0%	0%	0%	0%	14.3%	18.4%	28.6%
Other/ from reserves*	3.4%	7.7%	35.9%	29.5%	30.9%	17.8%	13.2%	7.8%
Total ordinary income	£1,157	£1,112	£1,952	£1,469	£1,446	£1,136	£1,011	£999
*actual amount by Lady Collectors	£559	£524	£472	£502	£486	£449	£349	£264
*actual charges on the poor	-	-	-	-	-	£162	£185	£286
Expenditure	£1,206	£1,148	£1,417	£1,514	£1,521	£1,192	£1,243	£1,205
Salaries	62.7%	60.7%	57.8%	62.1%	59.1%	64.4%	69.4%	66.8%
medicines/appliances/groceries	21.1%	21.0%	19.1%	18.1%	22.2%	13.4%	14.9%	15.4%
Other (upkeep/heating/printing/rents etc)	16.2%	18.3%	23.1%	19.8%	18.7%	21.2%	15.7%	17.8%
Profit/Deficit (for year)	-£49	-£36	£535	-£45	-£75	-£56	-£232	-£206
actual amount on medicines etc	£255	£241	£271	£274	£338	£160	£185	£186

Source: All calculations based on published annual reports.

Note: 'Other/from reserves*' sources of revenue include recorded patient donations, mission money boxes, and transfers from the reserve savings account etc. For the years 1887, 1892 and 1897 the amount of revenue from 'other' sources is inflated by either special appeal or transfer of funds from savings. In 1887 'other' included £581 raised on appeal to liquidate the accumulated debt in ordinary expenditure. This gave a manufactured profit of £535 for this year. In 1892 £286 was transferred from a Reserve Account to part-meet the newly accumulated deficit; and in 1897 a further £327 was transferred from the Reserve Account (thereby effectively wiping out all accumulated savings).

A number of interesting observations arise from the accounts (Table 4.2). The medical mission's reach constantly exceeded its grasp. The GMMS operated with a constant budgetary deficit. Expenditure outstripped ordinary revenue on a year by year basis. From time to time a bequest or legacy might successfully shore up the accumulated debts of the society, but such sources of income were by their nature unreliable. Special appeals were used to fund the purchase of different equipment, but by their

nature, such appeals could only be undertaken occasionally. The sale of premises early on in the history of the GMMS meant that a reserve account of funds was established. However, constant losses throughout the life of the society meant this reserve of money had dwindled within two decades. Substantial transfers of savings to cover yearly debts had to be made twice during the 1890s, to satisfy the bank, and to keep the GMMS solvent. By 1896, the deficit had reached £340 for just that year. Still the situation worsened. Directors reported that 1897 opened with a debit balance of £451, and that during the year the accounts showed a further loss of £400. In order to clear debts a second and final transfer from savings of £357 had to be authorised. A further £75 was borrowed from the GMMS treasurer, Robert Gourlay. It no doubt helped the society gain a sympathetic ear that Gourlay was at this time the manager of the Glasgow branch of the Bank of Scotland.¹³⁰ With reserve funds finally exhausted, expenditure (and therefore workload) had to be drastically cut. The implementation of a policy of penny-charging, the cut of opening times at the two dispensaries to alternate days, and with new public appeals for donations, retrenchment measures began to yield dividend: the outstanding deficit of the GMMS fell in 1898 to £163.¹³¹

The importance to voluntary charities of diverse streams of revenue is demonstrated. Recognising a new source of income, from 1885, Table 4.2 records that Charity Organisation Society appeals came to provide a steady if unspectacular source of new income, typically raising £35 to £45 per year. From about the same time, similar amounts were being raised by the GMMS each year on appeals made specifically in order to offset monies expended on the deployment of trained bible-woman nurses at the dispensaries (and whose salaries combined by the mid-1880s cost in excess of £250 per annum). These sums, although not great, were vital. Whilst bequests remained an unreliable if highly prized sources of income, monies collected by professional agent on commission fell steadily over the period (from £454 collected in 1877, to just £129 in 1907). The main new source of revenue at the GMMS was the ‘nominal’ charges for medicine that were levied on the patients from 1898. The penny fees quickly provided an essential fillip to ordinary funds. In 1903, £162 was raised by penny charging for prescriptions; and in 1907, £185 was raised. With charges

¹³⁰ Robert Gourlay was also at this time the treasurer of the COS in Glasgow (and was therefore another example of interlinking philanthropic supporters for different medical charities).

¹³¹ *The Scotsman* (15 Dec, 1899), p. 8: ‘this result had been attained principally through the kindness of several donors’.

doubled to two pence in 1912, £286 was raised that year. This was the equivalent, by this time, to 28.6% of all revenue (Table 4.2). The reported amount spent on medicines in 1912 was actually only £186, meaning that, in actuality, more than the cost of medicine was raised by these charges.

Charging the poor for medicines became a staple of charity services by the end of the nineteenth century right across Britain, although charging at medical mission stations had a chequered history. Monkwearmouth Medical Mission Dispensary in the mining north of England provided a first example of a medical mission in Britain charging patients. It had begun operations in 1873. Introduced of necessity, others were urged to follow the Monkwearmouth example.¹³²

The adoption of nominal charges for treatment reflects both changing economic circumstances plus the impact of charity organisation at this time across Britain. By the end of the nineteenth century, financial problems and changed attitudes towards the utility of charity meant that few voluntary medical dispensaries could any longer afford to offer a purely benevolent service. Traditionally, medical mission theorists had vehemently opposed the notion of charging patients for fear that such would distort the true purpose of their work. Gradually, however, provident systems became preferred. Although, unlike the GMMS, the EMMS never introduced charges, a shift in ethos and priorities can be measured in the changing of attitudes towards raising monies from patients found amongst key Edinburgh medical mission figures. In 1886, then EMMS Medical Superintendent, John Lowe, argued rather pragmatically in favour of the introduction of nominal charges. He defended his support for charging on the basis that ‘injudicious charity, of whatever kind, is hurtful, and tends to pauperize the recipients and undermine their self-respect.’ Three decades earlier, Lowe’s predecessor, Burns Thomson, had vehemently argued against any charge for treatment, saying this that whilst charges could be justified in some cases of medical charity - either in order to counter the appearance of opulence, or where medicines supplied involved much expense, or where a recipient might otherwise become overly

¹³² EMMS Quarterly Vol. 1, p.184: ‘We would very specially direct the attention of *our friends in Dundee*, and wherever, in large industrial centres, a Medical Mission may be contemplated, to [Monkwearmouth]’.

suspicious of the motives of the benefactor -, generally the poor should be treated gratuitously if the medical mission wished to achieve its main object:

... If the patient thinks he is paying for what he has received, the feelings which the medical missionary desires to awaken and cherish in him are either prevented or weakened, and the very object for which the missionary is sent out to that extent is counteracted.¹³³

The third main observation that can be made from the GMMS accounts (Table 4.2) is that through the period to 1912, the most consistently important source of ordinary revenue was the monies collected door to door by the voluntary lady collectors attached to the mission. Although the relative importance of it as a source of funding declined steadily after the 1880s, and despite the fact that overall amounts collected dropped quite substantially during the 1900s, from the 1870s and into the 1900s, the lady collectors together typical accounted for between one-third and one-half of ordinary revenue each year.

Annual reports leave sufficient trace of the work of the lady collectors to enable a profile of the women involved. In the census year, 1881, GMMS lady collectors numbered 67. They were organised by two *ladies' auxiliary treasurers*. The two organisers, both aged 50, were Mary Wilson, wife of an iron-merchant, and Grace A. Douglas, wife of a Professor at the Free Church Training College. These women are synecdoche of the main sources of support for medical missions from outside the medical profession. During 1881, the lady collectors raised £502, 15s, 1d: the highest single sum collected by any one collector was £35. Like the lady-collectors, the subscribers collected from are recorded in the reports to have been all-but universally female. The medical mission therefore operated on monies collected by women from women. For 1881, around 2,500 'doorstep' donations are detailed, with sums given typically being either one shilling, half a crown, or a guinea each. The lady-collectors were not simply a coterie of youthful campaigners. There was a spread of ages amongst the women, from sixteen year old, Miss Mary Howie, daughter of the minister of St Mary's Free Church in Govan, to 63 year old Miss Mary Lamont, unmarried sister of a retired shipbroker.¹³⁴ More important than age, and a factor significant in terms of available time and inclination to undertake the task, 75.6% of

¹³³ Thomson, *Medical Missions*, p. 42 and p. 44.

¹³⁴ It was possible to identify the age of 45 of the 69 collectors and organisers in the 1881 Census from details contained in the Annual Reports.

the lady-collectors that can be identified were unmarried, with another 4.4% widowed. The households of 80% of the lady collectors can be identified.¹³⁵ These ladies were from 'middle-class' homes based in and around the West-end of Glasgow or Pollokshields (a wealthy residential suburb on the south-side of the city). 61.8% of the women lived in households with two or more servants; and although 75.6% of all residents of the households in which the collectors lived were female, only three of the lady-collectors were listed in 1881 as head of their own households. The fathers, brothers and husbands of the collectors were typically professional men, industrialists, or merchants. Collection services of the medical mission were arranged such that married women organised and supervised the unmarried. This arrangement was extended by the 1900s. In 1907, for example, the GMMS assigned collection superintendent duties to 27 women: these oversaw 159 district lady collectors. 63% (17) of the superintendents were married, whilst 85.5% of the collectors (136) were unmarried. Only in four instances were unmarried women assigned supervisory roles over married lady collectors.

The overt concentration on middle class philanthropy can be misleading. Some monies sent to the board from businesses emanated from the shop floor. There is evidence too of masked working class benevolence in the sums collected by the lady collectors. Thus reviewing the work of the lady collectors, the 1876 GMMS Annual Report reflected:

It is interesting to remark that, during last spring, two [of the collectors] in different districts, on returning [for subscriptions], after having previously left the Report were told by the servants who opened the doors "There is nothing, ma'am' but I'll give you six pence myself".¹³⁶

¹³⁵ 55 of 69 households are identifiable from details in the 1881 Census and in the GMMS Annual Report (1881).

¹³⁶ GMMS Annual Report (1876), p. 9.

4.6 Medical Missions and opportunities for women

Philanthropy provided a range of opportunities for female involvement in public life in Victorian Britain.¹³⁷ At Scotland's medical charities, middle-class females formed the main phalanx of fund-raisers. Women from all classes found engagement as pamphlet, tract or flower distributors. Dozens of female volunteers went door to door to collect the annual rounds of subscriptions for medical missions. In addition, by virtue of the supposed advantages of their gender, women were deployed in a host of visitation tasks. The home was adjudged the natural female sphere of influence. Female health visiting that took off from the 1900s grew from such gender logic. Growing recognition of the importance of nursing provision meant that as outdoor nursing established, further opportunities opened to women interested in medicine. Medical missions were at the forefront of outdoor nursing. As is known, whilst access to full medical training and to registration to practice within Britain remained contentious, changes to regulations from the mid-1880s meant women in Scotland became able to graduate to practice medicine, and did so in numbers from the mid-1890s. A number found access smoothed by association with medical missions.¹³⁸

A noticeable feature of the year was an increasing number of patients on Sundays, most of them being women who were working through the week, and whose wages were so small that they could not afford to pay doctors' fees very often.¹³⁹

Medical missions were not only geared towards providing services especially suited to the needs of poor women (and children), the main medical mission societies in both Glasgow and Edinburgh were amongst the first in Scotland to promote and encourage

¹³⁷ For example, see F.K. Prochaska, *Women and Philanthropy in Nineteenth Century England* (Oxford: Clarendon Press, 1980); and Lorraine Walsh, *Patrons Poverty & Profit: Organised Charity in Nineteenth-Century Dundee* (Dundee: Abertay Historical Society, 2000). Prochaska makes several arguments. Philanthropic work fell neatly within the concept of a woman's 'natural' sphere. It provided an acceptable outlet for the unemployed energies of middle class women not in paid employment. Female traits and skills were seen as especially suited to philanthropic work. Women were attributed traits that were seen as most suited to home visiting, being 'naturally... moral, modest, attentive, intuitive, humble, gentle, patient, sensitive, perceptive, compassionate, self-sacrificing, tactful, deductive, practical, religious.' Also women were seen as 'traditionally skilled' in the care of the young, the sick, the elderly, the poor, a.k.a., those groups upon whom most philanthropic endeavours were focused.

¹³⁸ On the early history of female medical practice in Britain see Miss E. Moberly Bell, *Storming the Citadel* (London: Constable & co, 1953), and Wendy Alexander, *First Ladies of Medicine* (Glasgow: University of Glasgow Wellcome Unit, 1989).

¹³⁹ Dr George Muir Connor, GMMS medical superintendent, quoted in *The Scotsman* (11 Dec, 1896), p. 4.

opportunities for females to practice medicine. The role played by medical missions in the advancement of women in medicine proved particularly significant given that the cause of medical missions - in Edinburgh especially - enjoyed much support from amongst the elite ranks of the medical profession. As has been acknowledged by others, medical mission charities, as outdoor, dispensary and visitation based organisations, generally played an important facilitative role in the early careers of qualified women, who otherwise found restricted opportunities to practice indoors at established medical institutions.¹⁴⁰

Whilst not initially amongst the charity dispensaries in Edinburgh to offer support to Jex-Blake and the other female medical students who enrolled in 1869, within a decade a change of heart amongst the directors of the EMMS was clear.¹⁴¹ Impressed by the example of Methodist-sponsored American female medical missionaries and by the work of the Zenana mission in India, where female practitioners were deployed to gain access to women in purdah, the directors of the EMMS announced in 1878 that it had decided to seek opportunity to support British females also desirous to study medicine. Although drawbacks in terms of restricted accommodation, stretched funds and (at the time, most fundamentally of all) lack of opportunity to graduate were identified, one 'promising' female candidate was selected as a pioneer and underwent full, supervised medical training in the city. Unnamed, it was recorded in the *Quarterly Papers* of the EMMS that the first female candidate selected to undertake a full course of medical training was from 'Ireland, and will go out to India in connection with the Irish Presbyterian Church'.¹⁴² The EMMS directors enjoyed

¹⁴⁰ Alexander, *First Ladies of Medicine*, p. 60: 'In the 1870s and 1880s the humanitarian case for women physicians in India - to treat Indian women... significantly undermined professional and public opposition to women's medical training in Britain. A large proportion of the first women medical students... took up the course with a view to becoming medical missionaries.' Alexander quotes Margaret Balfour and Ruth Young, *The work of Medical Women in India* (London: Oxford University Press, 1923), p. 182. Alexander notes that, in Glasgow, female students were debarred from the GWI until 1920; and that the GWI, despite its association with Glasgow University, did not appoint a woman as a resident medical officer until after World War Two. The first woman resident at the GRI also did not happen until 1899; and the GVI only made a first indoor appointment in 1910.

¹⁴¹ *The Scotsman* (20th February 1872), p. 4, records that at this time the EMMS were refusing to allow female medical students then under tuition in the city to attend at the Cowgate dispensary, despite the avowed intention of several of the first batch of female medical students to go on to serve as medical missionaries. At this early juncture both the ERPD and the Edinburgh Royal Hospital for Sick Children were allowing the female students to attend.

¹⁴² See EMMS *Quarterly* Vol. 2, p.190 to 191: 'The [EMMS] Sub-Committee felt that without a certain amount of hospital training, the preparation of female missionary candidates for their work would not be complete. The accommodation in our new premises does not admit of our receiving in-door patients; nor, if it did, with such a splendid hospital as we have in Edinburgh, would we be justified in providing

leverage. The managers of ERI were persuaded to allow the female missionary candidate access to the wards. The infirmary provided her ‘the privilege of six month’s residence and hospital training’.¹⁴³ Although none could yet hope to sit for final examination, by the end of 1878, there were four ladies under medical training under the auspices of the EMMS. 1878 was a significant year for female medical practice in Edinburgh. It was the year that Jex-Blake acquired her M.D. in Dublin and returned to Edinburgh to open the Edinburgh Provident Dispensary for Women and Children. Speaking in November 1878, after the first placement, John Lowe, EMMS medical superintendent, sought to diffuse criticism of provision of medical training for women. He drew distinction between the medical training offered to each sex. Differences were highlighted in terms of utility, maintained (male) authority and (limited) prospective market opportunity:

We [the EMMS board] wish it to be distinctly understood, that what we aim at in this direction, is not to provide a course of Medical and Surgical education, that shall enable ladies to undertake general practice on their own responsibility, but to give them such instruction in the diagnosis and treatment of ordinary diseases, and such opportunities of gaining a practical knowledge of hospital nursing and dispensary work, as shall fit them for being of great service to their suffering sisters in India or elsewhere, under the superintendence of a Medical Missionary or other fully qualified practitioner. This is all we can do, under present circumstances... Ladies inspired with the true missionary spirit – and it is such only that we invite to come forward – trained to hospital nursing, and instructed in the use of ordinary medicines, the treatment of common diseases, and in minor surgery, - such ladies will be able to render great assistance to the Medical Missionary... gaining access, where he alone cannot enter.¹⁴⁴

The EMMS scheme that provided training without access to qualification persisted on an ad hoc basis until the opening up of examination opportunities for women in Scotland after 1886. The issue of how to formally train female students in medical mission work was once again returned to. At the annual meeting in 1888, EMMS managers announced plans to establish a new training institution dedicated to the training of females. Set upon an opening to coincide with its jubilee year of 1891, the

for such? For this part of the training, we had, therefore, to look elsewhere, and our best thanks are due to Miss Pringle, the Lady-Superintendent of the Edinburgh Royal Infirmary, and to the Managers of that Institution, for so kindly agreeing to supply our want. By an arrangement entered into with Miss Pringle, our lady candidates are to be allowed the privilege of six months’ residence and hospital training under her superintendence, after which they will begin their course of training with us, which will extend over two, or two and a half years.’

¹⁴³ This fact was confirmed in *the Scotsman* report of the annual meeting of the EMMS board in November 1878. See *the Scotsman* (23rd Nov., 1878), p. 6.

¹⁴⁴ EMMS Quarterly Vol. 3, p.78.

EMMS advertised the need to raise £10,000 for the purpose. What became a self-contained Institute and Training School for 'senior lady [medical] students [doing] woman's work for women' accepted its first intake into the EMMS in October 1891.¹⁴⁵ Unlike male students, who were housed above the dispensary in the Cowgate, the lady students were boarded out with families in the city. Rather than mixing students during training, the EMMS premises were extended to incorporate a separate, dedicated female clinic.

The 'first lady medical missionary' fully trained under the auspices of the EMMS and legally qualified to practice was Miss Eleanor Montgomery. Montgomery - like the pioneer of the scheme announced in 1878 - was the daughter of a Belfast minister. She graduated with the double diploma from Edinburgh's medical colleges in 1895. (Through connections) she received appointment under the Irish Presbyterian Church to work in Gujarat in India.¹⁴⁶ Montgomery was one of eight 'first female medical missionary students' in a photograph carried as the frontispiece to the November 1895 EMMS Quarterly Paper.¹⁴⁷ Miss Lillie Cousins graduated with Montgomery. Early in 1896, Cousins was appointed by the London Missionary Society to take charge of the Margaret Hospital in Hankow.

It is highly significant that the first women trained by the EMMS all went abroad. The training of female medical practitioners for medical careers in Britain was not freely welcomed by the general run of medical practitioners. Many feared the competition. At the 1895 Annual Meeting of the EMMS, Rev. Stalker, from Glasgow, reflected on professional medical opposition to growing numbers of female medical missionary practitioners, threatening the over-crowded home medical market.

He [Stalker] did not know whether medical men felt at all agreeable about the part medical women were likely to play in *this* country. He had always noticed that the *odium medicum* was a much stronger passion than the *odium theologicum*, but whatever might be felt about the competition that might take place in this country, he was sure there would be universal agreement that there was immense work before medical women in other parts of the world.¹⁴⁸

¹⁴⁵ EMMS Quarterly Vol. 5, p.313.

¹⁴⁶ See EMMS Quarterly Vol. 7, p.90.

¹⁴⁷ Photograph frontispiece of EMMS Quarterly Vol. 7 (November 1895).

¹⁴⁸ EMMS Quarterly Vol. 8/9, p.12-13.

As well providing an early avenue for medical training, the EMMS also supported the introduction of females into other new branches of medicine. From 1906 to 1908 a Miss Wade served as the dispenser for the EMMS at the Cowgate. Wade's role included teaching male students, and assisting in the training offered at the dispensary in practical materia medica. On her resignation, Wade was described as 'the only lady in Scotland who holds the qualification of "Pharmaceutical Chemist"''.¹⁴⁹

In Glasgow as in Edinburgh, the GMMS always had a high level of female staff and female involvement. Taking one year, at the beginning of 1878, the societies two dispensaries manned by two male medical missionary superintendents were supported by three full-time female bible nurses (Jane Stalker, Janet Tosh, and Helen Fleming), two female dispensers (including a Madame Haranchamps), and two female hall-keepers. As has been demonstrated, subscriptions were collected by dozens of lady collectors. Bible-classes, mothers meetings, flower distribution and sewing-classes - all staple auxiliary services - were organised by women for women. When the economy bit hardest, as it did in 1885 in Glasgow, it was the Ladies' Auxiliary Committee of the GMMS that organised a soup kitchen. A sign of the times, speaking in 1885 of the work of the ladies attached to the GMMS, Lord Balfour of Burleigh commented that 'they must all rejoice that they are getting rid of the feeling that the only proper employment for the ladies of the upper classes was to play the piano and do fancy work'.¹⁵⁰ Additionally, by its nature, medical missionary work was often a family commitment. Through its early history, different female relatives of the medical practitioners employed at the EMMS and the GMMS became involved as subscribers, organisers, directors, collectors, appeal managers, facilitators, and as ad hoc 'auxiliary' volunteers. The 1887 GMMS annual report recorded special thanks to 'the ladies who met in *the house of Mrs. Joseph Coats* and made articles of clothing for our poor patients.'¹⁵¹ Flexible female philanthropy carried with it valuable opportunity to network and to socialise.

¹⁴⁹ EMMS Quarterly Vol. 12, p.30.

¹⁵⁰ GMMS Annual Report (1885), p. 6.

¹⁵¹ GMMS Annual Report (1887), p.12.

Whilst it provided relatively early opportunity in the medical training of women, female medical practitioners came relatively late to Glasgow.¹⁵² The year before Jex-Blake returned to Edinburgh, in 1877 an Association for the Higher Education of Women was found in Glasgow and Queen Margaret College (QMC) instituted. The opening of QMC buildings followed in 1884, but it was only following the Universities (Scotland) Act, 1889, that QMC began offering medical training. In the academic year, 1892-93, the first 50 QMC female students were able to matriculate to study medicine at Glasgow University.¹⁵³ The first two women to graduate in medicine from Glasgow University, Marion Gilchrist and Alice Louisa Cumming, graduated in July 1894. Although she did not pursue a missionary career and resented implication that she should, speaking in retirement, Gilchrist reflected upon the close connection that was made between female medicine and missionary work at the time.

To show the state of mind that prevailed in some quarters one of the missionary students said to me one day: “I do not think, Miss Gilchrist, that you have any right to study medicine unless you are going to the mission field.” To do here justice, she came to me later, after she had done her midwifery work at the west-end branch of the Maternity Hospital, and said: “I now see I was wrong. There is a great need for medical women at home.”¹⁵⁴

There was competition as much as sisterly camaraderie amongst Scotland’s female medical pioneers. Much to Gilchrist’s chagrin, neither she nor Cumming became the first woman to set up practice in Glasgow. London medical graduates Elizabeth Pace and Alice McLaren preceded her.¹⁵⁵ Setting up together in practice in Glasgow in 1893, ten years later Pace and McLaren found the Glasgow Women’s Private Hospital (following Edinburgh and Dundee precedents). McLaren’s obituary records her as

¹⁵² Michael Moss, J. Forbes Munro, Richard H. Trainer, *University, city and state: the University of Glasgow since 1870* (Edinburgh: Edinburgh University Press for the University of Glasgow, 2000), p. 77.

¹⁵³ Alexander, *First Ladies of Medicine*, p. 6. On the early history of opportunity for females in Glasgow see also Rona Gaffrey, ‘Women as doctors and nurse’ in Olive Checkland and Margaret Lamb (ed.), *Health care as social history: the Glasgow case* (Aberdeen: Aberdeen University Press, 1982), chapter 9.

¹⁵⁴ Marion Gilchrist quoted in *Surgo: Glasgow University medical journal* (March 1948). Per Dr. Margaret W. Menzies Campbell research notes for Margaret W. Menzies Campbell ‘Glasgow Women’s Private Hospital, 1902-48’ in Glasgow City Archives, ref: HB 10/2/17.

¹⁵⁵ Henry Brougham Morton, *A Hillhead Album – Glasgow W2* (Glasgow: Robert Maclehose & Co Ltd, 1973), p. 91: ‘Dr Gilchrist, although the first woman to graduate in medicine from any Scottish University, was not the first woman general practitioner [in Glasgow]. Dr.’s Elizabeth Pace and Alice McLaren had... started general practice in 7 Elmbank Street in 1893’. Morton quotes Ellen B. Orr, MB, CM (1911) that: “Dr Gilchrist sorely resented the setting up in Glasgow as general practitioners of Dr Elizabeth Pace and Dr Alice McLaren, graduates from the Royal Free Hospital, trained in London... Dr Gilchrist elected to become a member of the Scottish Eastern Association [of the Medical Women’s Association] in order to make her disapproval of Dr Alice McLaren and Dr Pace.”

‘one of the first five women to obtain the London M.D. in 1893’. In 1895, ‘by her appointment as assistant surgeon at the Royal Samaritan Hospital,’ McLaren also ‘became the first woman elected to the visiting staff of a Glasgow hospital.’ Before moving to Glasgow, she had briefly returned to her birthplace Edinburgh. Here McLaren had served as the first female resident house physician at Leith General Hospital. As was shown in the previous part of this thesis, Leith General Hospital had an active home visitation service. Its situation and the nature of its work meant it was peculiarly disposed at an early juncture to the deployment of female practitioners. Pace, whose first appointment after graduating in 1891 was at the New Hospital for Women in London that had Elizabeth Blackwell and Elizabeth Garrett as consultant physicians, subsequently became the first female appointment of Glasgow Victoria Infirmary when made gynaecologist of its Bellahouston Dispensary.¹⁵⁶ Previously overlooked is the fact that the first opportunity for both in early days after establishing their partnership in Glasgow was provided by GMMS.

For part of 1894, during their first year in Glasgow, McLaren and Pace were jointly appointed to help the GMMS medical superintendent, Rev. Archibald Templeton, at the Oxford Street Dispensary in Govan. Specifically, they were appointed with a view to overtake what had become a prodigious home visitation case schedule. During the years 1893 to 1895, before financial difficulties forced retrenchment, medical staff of the two GMMS dispensaries was conducting between 4,000 and 6,000 home visits to patients a year (with a further 6,516 visits also conducted by nursing or bible-nursing staff over 1894). This was the busiest period of visitation in the history of the GMMS after 1874. The GMMS annual report for 1894 records: ‘[during the year] we had the valuable assistance of Dr Elizabeth Pace and Dr Alice McLaren for some months, 969 of the consultations having been given by them, as well as 165 additional visits paid.’¹⁵⁷

¹⁵⁶ See the respective obituaries for McLaren and Pace in *Glasgow Medical Journal*, v. 27 (1946), p. 89, and *British Medical Journal*, v. 1 (1957), p. 347. McLaren is also mentioned as having obtained an appointment in 1895 as clinical assistant to one of the honorary surgeons at the Dispensary of the Royal Hospital for Sick Children Glasgow in Derek A Dow, *The Dispensary of the Royal Hospital for Sick Children Glasgow: James Nicoll and the Dispensary* (brochure published in Dept. of Clinical Physics and Bio-Engineering, West of Scotland Health Boards, 8 November 1980).

¹⁵⁷ GMMS Annual Report (1894), p. 17.

At the Moncur Street Dispensary in Calton, medical superintendent George Muir Connor, M.D., similarly gained assistance with home visits. By quid pro quo, in return for providing an outlet for practical training of the female bible-nurses that were attending at the Lady Missionary Training Home then based in Dennistoun nearby the dispensary, the Home's main patron, Miss Forrester-Paton, agreed to fund the employment of qualified medical help. Using Forrester-Paton money, George Batchin Thompson was employed during the busiest months of January to March over two years during 1893 and 1894 purely to overtake the backlog of home visitation duties: these were times of year when work in the city hardest to come by, and travel into the dispensary most difficult. Thompson graduated in Glasgow in 1893.

Reflecting on the utilisation of Thompson in 1893, Connor lamented:

Our only regret is that we cannot have a young qualified physician permanently engaged to look after this special department. We cannot but think that if the charitable public really knew how many poor people cannot obtain the services of a doctor at their own homes, they would supply our Society with the needed funds... we sincerely hope that some effort may be made to enable us to attend patient unable to go to a public dispensary for advice. This is desirable, not only from a *medical*, but also from an *evangelistic* point of view. Families can be reached better in this way than by the short address given daily to the patients in the waiting-room.¹⁵⁸

In 1894 Connor lamented further that Thompson could not be used full-time, pointing out the lack of alternative non-parochial dispensary visitation services in Glasgow:

[Thanks to the assistance offered by the medical staff of the Lady Missionaries Training Home] the duties the Superintendent are not now so exacting, and more time has been left for him to see the poor patients in their own homes. *This is probably the best department of our Mission, though it is certainly the most laborious.*

...After more than nine years' experience, the Superintendent thinks that there are sufficient free Medical Dispensaries in our city, but there is still much room for providing *the genuine poor with gratuitous medical assistance in their own homes*'. [My emphasis]¹⁵⁹

In 1895 Miss Forrester-Paton's assistance was again vital. That year a Dr Ramsay was employed for a couple of months on the same condition as Thompson, once more to help overtake the home visitation workload. 1895 was a year of particular economic hardship in Glasgow and Edinburgh both, with severe economic distress magnified by

¹⁵⁸ GMMS Annual Report (1893), p. 12. Details of the work of the Lady Missionary Training Home (LMTH) survive in the form of Annie Watson's Lady Missionary Training Home Notebooks. These are held in GGHB archives, ref HB71/4/1 to HB71/4/3.

¹⁵⁹ GMMS Annual Report (1894), pp. 12-14.

an exceptionally cold and long winter. Connor noted that: 'Never during the last ten years [of my service] have so many visits been paid to patients in their own homes, though we are conscious they were not visited as often as desirable.'¹⁶⁰

With the relocation of the Forrester-Paton Lady Missionary Training Home after 1896, and the severing of arrangements between the two institutions, the GMMS not only lost an important source of nursing assistance but as well vital funding support for its visitation operations.

Whether he played a direct role in scouting female medical students and practitioners deployed at the dispensaries of the GMMS is unclear, but the board of directors of the medical mission at the time of the appointment of McLaren and Pace included David Yellowlees. Yellowlees became President of the GMMS from 1901. He was well known as a champion of the cause of female medical practice. Alexander has noted, for example, that before 1900 only his lectures at Glasgow University were mixed for both male and female students.¹⁶¹ Yellowlees also became the first president of the Glasgow Women's Private Hospital found by McLaren and Pace in 1902. The willingness of the GMMS to employ female medical staff was an exercise in pragmatism as much as philosophical commitment. As with the Leith General Hospital on the outskirts of Edinburgh, the two GMMS dispensaries were situated on the outer perimeters of the city, in poorer neighbourhoods (and therefore some distance from the relocated medical centre of Glasgow in the west-end). They found attracting students and staff a sometimes difficult task. In 1890, George Muir Connor noted as much, reporting:

The out-door department of our medical work is very arduous... and I regret that so few students lend a helping hand, owing no doubt to our being unattached to, and at a great distance from, any medical school.¹⁶²

¹⁶⁰ GMMS Annual Report (1895), p.14. It is unclear whether this was Andrew Maitland Ramsay, ophthalmologist and a lecturer at QMC, and who later married Dr Elizabeth Pace, or Robert Ramsey, MB, CM, 1892, who spent a period in Australia after graduating.

The impact of severe winter weather in Edinburgh in 1895 can be measured, for example, by the fact that the emergency *Northern Districts Public Soup Kitchen*, for example, was opened continuously for six weeks over February and March 1895, dispensing over eight thousand rations of soup and bread (double the previous winter).

¹⁶¹ Alexander, *First Ladies of Medicine*, p. 27.

¹⁶² GMMS Annual Report (1888), p. 11.

The directors of the GMMS feted the female medical students of QMC. At the annual meeting in December 1892, that year's chair, the newly elected Lord Provost, James Bell, made clear that 'the Society afforded an opportunity for the higher education of women'¹⁶³. Bell (later Sir James Bell), a partner in a Glasgow-based shipping firm, and a significant figure in late Victorian Glaswegian society, noted:

With the medical classes of Queen Margaret College established as a branch of the Glasgow University, many of the women students would doubtless make medicine a profession, and in following out that profession they had an opportunity, under the auspices of this Society, of very greatly increasing the value of their work by attending the poor, and thus obtaining a practical knowledge of medicine and surgery.¹⁶⁴

There was at least one direct link between the medical staff employed at the GMMS and the managing board at the newly found QMC. Dr Robert Jardine served as assistant surgeon at the GMMS Moncur Street Dispensary from 1891: Jardine's wife was at this time the honorary secretary for correspondence classes at QMC. During 1896, final year QMC medical student, Mabel Catherine Poulter, became the first female medical student employed by the GMMS. Poulter, who graduated in 1898, went to China in 1899, and stayed in active practice in Asia until retirement in 1934. Following McLaren and Pace, a succession of other female medical practitioners also spent periods early in their careers assisting the medical superintendents at one or other of the two GMMS dispensaries in Glasgow. This included Jessie Hawkesworth Smith, who was the first female Glasgow University medical graduate employed; Margaret Edith Bryson, who assisted at the Oxford Street Dispensary in 1903 before going as a medical missionary to China; Helen Stephen Baird, who went to New Zealand; Marion Jamieson Ross née MacDonald, who assisted between 1903 and 1907, and who before coming back to Glasgow had caused a stir when she had gained appointment as junior house surgeon at Macclesfield Infirmary in 1901;¹⁶⁵ and Kate Fraser, who was employed to assist and visit patients at the GMMS Oxford Street Dispensary during 1907. Fraser, daughter of Paisley practitioner Donald Fraser, gained her M.D. and D.P.H. in 1913, and was awarded an O.B.E. in 1945 for her services to General Board of Control of Scotland and her work with mental illness.

¹⁶³ GMMS Annual Report (1892), p.8.

¹⁶⁴ GMMS Annual Report (1892), p.8.

¹⁶⁵ Alexander, *First Ladies of Medicine*, p. 60.

4.7 Justifying Medical Missions

Medical missions were not without contemporary criticism, and debates regarding the justification for medical missions were, in fact, well established by the 1870s.¹⁶⁶

During August 1857, for example, just as home dispensary services were taking root in Edinburgh, a fierce dispute flared in the Scottish press over medical missionary objectives. The use of medical treatment as a means through which to secure converts was said by some to be an immoral use of the privilege and power of medical practice. Discussions at this time over the legitimacy of the work of medical missionaries at home and abroad occurred against the backdrop of events in India: the Indian Mutiny occasioned much questioning of all imperial endeavours. On the 11th August, 1857, Professor George Wilson, M.D., wrote to *The Scotsman* to defend the work of the EMMS after criticism had appeared in an article in the newspaper.¹⁶⁷ Wilson's reply pointed to the work of the EMMS amongst the Irish poor.¹⁶⁸

Wilson defended the right of all medical practitioners – 'as Christians' - to act as 'spiritual counsellors' to patients they attended, arguing: 'the religious duties required from them [as medical missionaries] do not differ in *kind*, however much they may in degree, from those which on legitimate occasion may be required from every physician or surgeon who claims the title of Christian.'¹⁶⁹ Logically, if controversially, Wilson also defended liberty of Catholic physicians to act as a Catholic when treating non-Catholic patients.¹⁷⁰

A seemingly intractable problem admitted by Wilson was the delineation of 'legitimate occasions' for a medical practitioner to offer spiritual advice, from occasions when a medical practitioner might simply be seeking to take advantage of his 'professional position' to gain unjust influence over the patient.¹⁷¹ He saw the matter to be one of delicacy and integrity, arguing that all representatives of the EMMS acted: 'peculiarly cautious, prudent, and circumspect in all its proceedings'. In

¹⁶⁶ On a local criticism in novel form see, for example, David Sime, *In Manbury City* (London: 1876)

¹⁶⁷ *The Scotsman* (15 Aug, 1857), p. 3.

¹⁶⁸ *The Scotsman* (15 Aug, 1857), p. 3.

¹⁶⁹ *The Scotsman* (15 Aug, 1857), p. 3.

¹⁷⁰ *The Scotsman* (15 Aug, 1857), p. 3.

¹⁷¹ *The Scotsman* (15 Aug, 1857), p. 3: 'I at once admit that it is impossible to lay down rules as to what are the legitimate occasions on which medical men may become the religious advisers of their patients. But the question really before us is, Are there any such legitimate occasions? And that there are no unprejudiced person can deny.'

what became to most the most aired defence, Wilson concluded that the EMMS and other organisations like it were found on the first principle of following Christ's example of preaching and healing.¹⁷²

A response to Wilson's letter defending the work of medical missionaries was carried in the same edition of the newspaper. This dismissed medical missionary work as politically inexpedient, pointing out that arguments that medical missionaries follow the work of Christ and the Apostles was based on 'a dangerous a presumptuous fallacy – [that] their teaching was infallible and their cures miraculous'. The response criticised the notion of any one man serving as both spiritual and physical healer, drawing comparisons between such a system and native religions condemned by missionaries elsewhere. The issue of the ethics of medical practice were directly addressed. It was argued that the doctor taking advantage of his position to attempt to convert a patient to his religious view was breaking the tacit terms of the agreement that had gained him initial access to the patient – i.e. that he was simply there to treat a physical condition. The proselytising physician thus was

guilty alike of impertinence as a physician, and an immorality as a Christian; for to so act would be to commit a breach of the tacit understanding on which he alone... would be called to the bedside [of a patient] – namely, that the relief of his patient's body from disease, not of his soul from error, was what was looked for at his hands.¹⁷³

The respondent to Wilson stated that they did not wish to criticise the EMMS 'as a society' rather they wished to criticise the objective of medical missions: 'based on an unsound and pernicious principle, and therefore likely to be both perilous and mischievous in practice.'¹⁷⁴

¹⁷² For example, Dr Palm, 'Paper on Medical missions' in EMMS Quarterly, vol. 4, p.40: 'We may well be content to urge, that healing the diseases of the body occupied a large portion of the time and strength of our Lord himself during His earthly life...'. In the same volume, p. 119, American Rev. George E. Horr is quoted from an American publication, 'The Christian at Work,' also grounding the work of the medical missionary in the example of the work of the early Christian church: 'Through the early ages, and especially during the Middle Ages, from the fall of the Western Empire in 476... the Church was the great eleemosynary institution. Provision for the poor, medical attention, all manner of physical relief, came from the Church.' T.F. Davey, Introduction to Stanley G. Browne (ed.), *Heralds of Health: the sage of Christian medical initiatives* (London: Christian Medical Fellowship, 1985), pp. 5-7: Davey claims the Bible established that medicine is 'a sacred vocation'; and that Jesus, as a missionary, had a particular attitude to poverty, suffering and dying.

¹⁷³ *The Scotsman* (15 Aug, 1857), p. 2

¹⁷⁴ *The Scotsman* (15 Aug, 1857), p. 2.

This was not the final word. Several days later another correspondent added a further objection by arguing that the ‘pinning together’ of religion and medicine was fraught with problems, for the success (or failure) of the one endeavour would automatically mean the success or failure of the other.¹⁷⁵ In the same edition, John Coldstream, M.D., joint-secretary of EMMS until his death in 1863, defended the society from the charge that its agents acted deceitfully.

As to Jesuitry [sic!] being involved in the scheme of employing medical agents as helpers in missions to the Heathen, neither the missionaries themselves nor their supporters at home are, in the least degree, conscious of any deceit being practised in any form. All the proceedings, both of the Society and of its agents, are perfectly patent to all observers and inquirers.¹⁷⁶

Coldstream here argued that the patients who used medical mission services had in effect ‘freely contracted’ into treatment: the missionary intent was undisguised.

In essence, whenever challenged, medical missionary activity was defended within the wider remit and tradition of the evangelical and welfare work of the church. Medical missionary work was conceptualised as the fundamental duty owed by Christian men to give *practical* expression to their belief. Medical mission work was defended as a practical rebuttal to ‘heathenism’. It was justified in terms of demand, and the efficaciousness of the enterprise. Writing in 1904, Dr Arthur Neve - a former medical student at the EMMS before 1881 - claimed no fracture of purpose in the duality of the medical and missionary ends of medical missionary practice. For him, medical missionaries ‘consecrated’ their scientific and medical understanding for higher purpose, and therefore whilst: ‘much might be debated about the relative perspective of these two points of view (the medical and the evangelical)... it has been found that in actual life they blend like the pictures of a stereoscope.’¹⁷⁷ For Dugald Christie – a contemporary to Neve – any duality was simply resolved: all medical advances were manifestations of God’s power and mercy.¹⁷⁸

Medical missionary work was presented as ground in the practical example of the work of Christ and the Apostles as portrayed in the Bible. With reference to the

¹⁷⁵ *The Scotsman* (19 Aug, 1857), p. 3: ‘If the doctor fail and the man die, he is not likely to have been made a Christian of, and his death will not increase the missionary’s influence as a Gospel messenger.’

¹⁷⁶ *The Scotsman* (19 Aug, 1857), p. 3.

¹⁷⁷ EMMS Quarterly, vol. 11 (1904), pp. 32-3.

¹⁷⁸ Dr Dugald Christie, ‘Medical Missions’ in EMMS Quarterly, vol. 11 (August 1907), p. 402.

‘historical’ writings in the New Testament, a clear link between a person’s bodily and spiritual welfare, between the ‘application of corporal physic and spiritual physic’, and between ‘the preaching of benevolence’ and ‘the display of beneficence’ was formed.¹⁷⁹ Exemplifying the mindset, David Livingstone, was said once to have written: ‘God had only one Son and He was a medical missionary’.¹⁸⁰

¹⁷⁹ “And into whatsoever city ye enter... heal the sick that are therein, and say unto them, The Kingdom of God is come nigh unto you” Luke x, 9.

¹⁸⁰ Clement C. Chesterman, *In the Service of Suffering* (London: The Carey Press, 1940), p. 25.

4.8 Differences between home medical missions in Edinburgh and Glasgow

Whilst the home medical missions of Edinburgh and Glasgow were bound by shared purpose and objectives, there were, in fact, major differences in emphasis, outlook and approach. Variations reflected differences in local medical cultures, and in the social and economic circumstances of the two Scottish cities.

Speaking as the presidency of the EMMS passed to him in 1893, Sir Thomas Grainger Stewart noted ‘the great work’ that the society had done ‘for the world, and for Edinburgh and Scotland...’.¹⁸¹ The order of these claims is important: despite its status as the home of home medical missions, the EMMS remained focused upon foreign concerns. The society reflected the cosmopolitan outlook of a city that had been a centre of European enlightenment. The EMMS saw itself as an international society first and foremost, a centre for the medical training of medical mission students, and a home service only by extension. This was understood. *The Scotsman*, in 1903, put it most simply: ‘Its method is to equip young men and women for medical mission work in foreign lands *by* training them in medical mission work among the poor in the slums of Edinburgh’.¹⁸² Appeals for financial support advertising the work of medical missions placed most emphasis on the foreign work being done by EMMS trained doctors. Speaking in 1874, launching an appeal for the proposed rebuilding of the Cowgate dispensary, Rev G.D. Cullen highlighted what he called ‘the cosmopolitan character’ of the training institute.¹⁸³

[It] was *not* a local agency, but an Institution which, while it had of necessity its habitation in Edinburgh, beside their Edinburgh School of Medicine, it was labouring for all the world.¹⁸⁴

In contrast to the EMMS, GMMS had and maintained a more myopic focus. It was primarily a local agency. The GMMS, whilst a missionary agency with grander

¹⁸¹ *The Scotsman* (1 Dec, 1893), p. 4.

¹⁸² *The Scotsman* (2 Dec, 1903), p. 9.

¹⁸³ Reported in *The Scotsman* (7 May, 1874), p. 4.

¹⁸⁴ EMMS Quarterly, vol. 4, pp. 82-83. See also EMMS Quarterly, vol. 7, pp. 61-62: ‘They [the EMMS directors] all knew that “The Edinburgh Medical Missionary Society” was in no true sense, a *local* society, that their work extended to all parts of the world, that, especially in the department of training Medical Missionaries for the work, they trained men gathered from all parts of the country, connected with all [Protestant] denominations, and trained them for all various Missionary Societies.’

intentions, first and foremost committed to filling a gap in the supply of outdoor medical relief for the poor in Glasgow: and whereas the EMMS became one of a series of charitable dispensaries offering home visits to the sick-poor in Edinburgh, GMMS operated more or less as a stand-alone in terms of charity medical visitation services in Glasgow. A difference in place, approach and emphasis is highlighted by the fact that managers of the GMMS ambition was the aborted plan of the mid-1870s to extend by stages the scope of its service so as to eventually lead to a citywide network of dispensaries.¹⁸⁵ The EMMS seemed not to harbour similar plans. Its directors remained content to operate out of its one established location. This was despite having far superior financial resources to its Glasgow counterpart, as reflected in its ability to raise by public appeal several substantial sums for rebuilding between 1875 and 1903. Instead of spreading its wings across the city, the EMMS intensified its operations by expanding its social welfare arm (through the opening of ‘the Rock’). Additionally, the EMMS reached out of Edinburgh by setting up auxiliary bodies across Scotland, opening branches of the society in towns like Dalkeith and Dundee.¹⁸⁶ The national and international focus of the Edinburgh society compared to the more local focus of the Glasgow society perhaps reflected essential differences the respective character and mental outlook of the two towns? If this is so there is certainly an historical paradox in these mindsets. The industrial economy of Glasgow was, of course, globally linked, whereas the Edinburgh economy was fundamentally more parochial, with the city geared to performing the function of professional and administrative centre of Scotland.

Other differences abound. The EMMS, with its dispensary located close-by other key medical institutions in Edinburgh and near to the university, was a fully established component of the medical training culture of the city. It enjoyed most of its support from the medical elite of the university. The GMMS, with its dispensaries other than for a short period in the early 1870s at a considerable distance from the university, placed far less emphasis on the training of medical students and the patronage of medical academia. Whilst it too had the sympathetic ear of elements of the medical

¹⁸⁵ GMMS Annual Report (1874), p. 4: ‘Your Directors venture to hope that they may soon see their way to extend the benefits of the Medical Mission by means of branches, so as to be more accessible to those who live in the large outlying districts around the city.’

¹⁸⁶ Per *The Scotsman* (5 May, 1864), p. 2, on the work of ‘the Dalkeith Auxiliary of the Edinburgh Medical Missionary Society,’ which at this time included sixty-three subscribers contributing around £14 to the work of the EMMS.

establishment, and whilst its list of presidents were important medical figures locally, as crucial to its survival and longevity was the support and patronage it engendered amongst the prominent local business elite, men like Lord Overtoun.

Economic necessities were obviously important in the different choices made. Routinely the GMMS operated on a much smaller level than the EMMS. Although both organisations eventually ran into financial difficulties, particularly as the Scottish industrial economy began to suffer in the 1890s and 1900s, the society in Glasgow was forced to rethink its services much earlier, and to implement a more drastic program of retrenchment in order to survive. Year by year, income into the EMMS was significantly greater than that into the GMMS, although its commitments were more diverse. Leaving aside for the moment legacies and other occasional donations, total ordinary income into the EMMS during the 1880s and 1890s reached a high point where it neared £5,000 per annum; and from the mid-1870s to mid-1890s EMMS ordinary income was typically around three or four times as much as GMMS ordinary income each year. Taking one year, for 1893, the EMMS reported total income of £4,888, with subscriptions and donations of £2,409 (49%, up £500 from previous year), legacies of £1,484 (30%), and the remainder from fee-paying students; rents; interest on investments; subscriptions to the *Quarterly Paper*; and from fees for compliance with notification of infectious diseases. Total recorded expenditure was £6,143, with £3,626 (59%) the recorded expense of the ‘mission house and training institution, the dispensary and home, evangelistic and social operations’. The recorded cost directly attributed to the working of the Cowgate dispensary was just £540 14s 9½d (8.8% of the total of all EMMS expenditure); with £244 13s 3d as the cost attributed to medicines, instruments and dispensary supplies.¹⁸⁷ Per Table 4.2, during 1892, GMMS total income was £1,469, including £286 transferred from a reserve account to offset shortfalls. £502 had been collected from doorsteps. Revenue streams were less; there was no income from students, rent, publications, or for notification. GMMS expenditure was £1,521. Although only 24.8% of total EMMS expenditure in 1893, expenditure on ‘medicines, appliances, groceries’ at the GMMS’s two dispensaries came to £338, 38.2%: more than the EMMS equivalent. During the year to October 1893, the EMMS reported 13,640 visits to patients (many by students) and

¹⁸⁷ EMMS Annual Report (1893), p.22.

altogether 32,164 consultations at home and at the dispensary; the GMMS for 1893 reported 4,555 visits (nearly all by qualified medical staff), 4,743 visits by nurses, and altogether 44,675 consultations. Less oriented towards domiciliary care, GMMS got through more cases for less.

EMMS income did tail away from the mid-1890s, and the particularly lean years of the mid-1900s meant that it became increasingly dependent upon new legacies from supporters and sympathisers in order to sustain the scope of its operations. Such income was not only unreliable but also sometimes came with conditions as to how the money was to be used. Changes to finances thus impacted on the direction of the society. In January 1908, after several years during which monies collected had stagnated, and during which expenditure had outstripped ordinary income by between £1,000 and £2,000 each year, the then-President of the EMMS, physician and midwifery specialist Dr John William Ballantyne, announced that the reserve fund of the society had ‘finally been exhausted’. This state of affairs had been reached a full decade earlier by the GMMS.¹⁸⁸

Substantial legacies totalling £2,125 and £1,151 in 1909 and 1910 helped the EMMS temporarily clear debts that had accrued. The future appeared brighter as the directors of the EMMS began to look forward to the new opportunities for appeals for funds that the centenary of the birth of David Livingstone in 1913 promised to bring.¹⁸⁹ However, despite windfalls and the suggestion of better times ahead, the exhaustion of funds had forced a rethink of operations in Edinburgh; much as a decade earlier in Glasgow. In Glasgow retrenchment exercises enacted in 1897 had forced the directors to half services and to introduce nominal charges for medicines. In Edinburgh, faced with widening financial commitments and with the rising of training and dispensary costs, EMMS directors were also forced into change. Firstly, economy drives were undertaken to curb any and all unnecessary expenditure at the dispensary. Secondly, in 1900, the employment of Organising Secretary, G. A. Barclay, was discontinued ‘from motives of economy’. Barclay, a professional assurance agent with missionary experience had become employed as a kind of medical mission ‘spin doctor’. He was appointed in 1893, and spent much time undertaking promotional tours on behalf of

¹⁸⁸ *The Scotsman* (24 Jan, 1908), p. 6; EMMS Quarterly, vol. 12 (1908), pp. 117-19..

¹⁸⁹ EMMS Quarterly, vol. 12 (1909), pp. 339-41, and vol. 13 (1910), pp. 4-7.

the society, to raise revenues. When let go he was voted an honorarium of £100 in recognition of seven years of 'earnest work'. Once a couple of months passed, a Miss Jane N. Macgregor was employed and became his replacement, at a suitably reduced salary.¹⁹⁰ Thirdly, a drive to appeal to greater numbers of Edinburgh's women to volunteer as lady collectors was undertaken with a view to increase home revenues. This included the novel idea, fully established by 1912, that all lady collectors be invited to collect their books and annual reports for distribution direct from the house of the President of the EMMS, Professor Crum Brown. This was a direct acknowledgement that for some, at least, volunteering was about social opportunity as much as evangelical commitment.¹⁹¹ Fourthly, the drive to establish auxiliary societies across Scotland was extended. In the years after 1907 particularly, medical students were sent out to hinterland districts across Scotland such as Stirling and Alloa on Missionary Exhibition Tours, to advertise the work. Fifthly, showing the breadth of thinking in the push to raise revenue, in February 1911, a stamp bureau was established at the Livingstone Institute. The *Quarterly Paper* appealed for volunteers who 'know something of philately' to come forward and to dedicate time at the Cowgate. Six, the directors pushed harder than ever the idea that they were a multi-denominational Protestant society; all the time with a view to maximise support.¹⁹² Lastly, and most significantly of all, after announcing that it had only £320 left in available funds, in March 1909, it was decided that all medical missionary applications from students that would require monetary help from the society would henceforward be rejected unless individual sponsors could be found to underwrite costs for each.¹⁹³ The harsh economic circumstances of the 1890s and 1900s that had reduced services in Glasgow and forced a rethink in Edinburgh led the 1910 Edinburgh hosted World Missionary Conference to declare that '*the Decisive Hour of*

¹⁹⁰ On the appointment of Barclay see Edinburgh Medical Missionary Society Annual Report for the year ending 31st October 1893 (Edinburgh: Edinburgh University Press, 1894), p.15. On Macgregor see EMMS Quarterly, vol. 10, p. 61.

¹⁹¹ EMMS Quarterly, vol. 13, p.55.

¹⁹² *The Scotsman* (29 Jan, 1909), p. 11: 'The [EMMS] Chairman said that at the present mission work was beginning to run too much along denominational lines, and there was perhaps a little tendency to give along denominational lines. He should like to say on behalf of the Society, which was on undenominational lines, that they were a standing proof and example to the world that men of all Protestant denominations could meet and discuss intricate and difficult questions of medical and missionary management without the slightest difference of opinion amongst them and in complete concord.'

¹⁹³ EMMS Quarterly, vol. 12, p. 118 and p. 141.

Christian Missions' was upon them with more than usual conviction.¹⁹⁴ The editorial of the EMMS *Quarterly Paper*, in February 1908, publicly weighed the impact of falling revenues. In considering where cuts might come, the editor drew again the connection between the home and foreign aspects of medical missionary work at the Cowgate, asking:

Is Damascus to be abandoned...? Is Nazareth to be forsaken...? Is Agra to be given up...?

Is the Home Mission work to be curtailed? It is useful not only for the direct good it produces in those whose benefit we seek, but it is one of the most effective agencies in the training of our students for the work which will meet them in the actual mission-field. Over 10,000 patients annually receive medical and surgical relief at the hands of the honorary physicians, the resident surgeon, and students; and at the same time they are daily pointed to Him who alone can minister to the soul's needs...

We are engaged in the struggle of light against darkness, of truth against error... [Therefore] the Directors earnestly appeal to all those who have the interests of the Society at heart to co-operate in the endeavour, by gaining new subscriptions and adding to the amount of existing subscriptions...¹⁹⁵

The extra monies that the EMMS routinely enjoyed over the GMMS had been used to fund its extensive training program. Medical student training was (as has been explained) on a whole other level in Edinburgh. Surplus monies were then directed to support foreign projects. This issue presents the starkest contrast between the EMMS and GMMS. Whereas by the mid-1880s, the EMMS had two dozen or more students formally under medical missionary training at any one time (plus several dozen regular students attending at the dispensary), the GMMS typically had but one or two students at its dispensaries most years. Indeed, the GMMS had trained no students at all at its dispensaries before 1881 (though its directors suggested that this was due more to a point of principle than to any lack of funds).

Contemporaries were not unaware of essential differences. Invited to address the annual meeting of the EMMS directors held in January 1896, Rev. Dr Stalker, from Glasgow, chose as the theme of his address a comparison of medical missionary work in the two cities. Complimentary of the work accomplished by his hosts, Stalker pointed out that, in his opinion, medical missions generally were less developed in

¹⁹⁴ The conference missionary prospective was written by John R. Mott, M.A. (Yale), LL.D. (Edinburgh), *The Decisive Hour of Christian Missions* (Edinburgh: World's Student Christian Federation, 1910).

¹⁹⁵ EMMS Quarterly, vol. 12, pp.2-3.

Glasgow than in Edinburgh. He noted that there was much less expenditure by the GMMS than by the EMMS. He pointed out that the training of medical missionary students was only sporadic in Glasgow, a fact he directly linked to insufficient income. Stalker also readily acknowledged that Edinburgh was the pioneer of home medical missionary work. He did however note that, as wants must, the lack of medical students had enabled missionary bible-nursing to become far more developed in Glasgow than in Edinburgh. The *Quarterly Paper* recorded:

Rev Dr. Stalker...said that when a visitor came from Glasgow to speak in Edinburgh about Medical Missions his words ought to be few and modest, because unfortunately that branch of Christian benevolence was much less fully developed in Glasgow than in Edinburgh. In spite of their great population, they only spent about £2000 upon local Medical Missionary work. Although they had the training of students for foreign work in their programme, yet they had never had a sufficient income to enable them to carry out that part of their work. In one respect they were perhaps a little ahead in Glasgow – the training of nurses in connection with Missions.¹⁹⁶

¹⁹⁶ EMMS Quarterly, vol. 8/9 (1896), pp. 11-13.

4.9 The SVDP and the Catholic-Irish response to challenge represented by Medical Missions

Of all the Churches in Victorian Scotland [the Roman Catholic]... was the only one that was reasonably successful in holding the loyalty of the poor and destitute.¹⁹⁷

The period from the 1870s to 1911 was an important one in terms of the development of Catholic institutions and representation in Scotland. The Catholic Church hierarchy was restored in Scotland in 1878. This was half a century after the Catholic Emancipation Act of 1829, passed despite vehement opposition at the time in Glasgow. For political reasons, Edinburgh was made the Chief Archdiocese of Scotland over Glasgow.¹⁹⁸ As Gallacher has argued: '[Catholic] church leaders, from about 1885 onwards, began to create a variety of organisations... [with] distinct religious, recreational, charitable, and social functions.'¹⁹⁹ The passing of the Scottish Education Act in 1872 was also significant, not least because it reinforced the fact that teaching rather than medicine or law became an early priority of the Catholic community.²⁰⁰

Per population estimates based on surveys by the *Catholic Directory for Scotland*, a significant minority of persons in both Glasgow and Edinburgh during the period 1875 to 1911 were of Irish Catholic descent. Whilst the Catholic diocese of St. Andrews and Edinburgh was calculated to have reached 63,000 persons by 1911, the diocese of Glasgow had reached 380,000. In 1878, within the city of Glasgow, there were 140,300 Catholics, and in 1901, approximately 186,100 (19.2% and 17.6% of the population of the city respectively). In 1822 there had been only 15,000 Catholics in Glasgow.²⁰¹ Whilst monolithic views of Scotland's Catholic community have

¹⁹⁷ Drummond and Bulloch, *The Church in Late Victorian Scotland*, p. 149.

¹⁹⁸ Tom Gallacher, *Glasgow: The Uneasy Peace: religious tension in modern Scotland, 1819-1914* (Manchester: Manchester University Press, 1987), p. 10 and p. 46.

¹⁹⁹ Gallacher, *Glasgow: The Uneasy Peace*, p. 53.

²⁰⁰ T.A. Fitzpatrick, *Catholic secondary education in south-west Scotland before 1972: its contribution to the change in status of the Catholic community of the area* (Aberdeen: Aberdeen University Press, 1986). My thanks here to Tom Fitzpatrick, who gave invaluable details to me on the development of the Catholic community in Glasgow.

²⁰¹ Per James Darragh, 'The Catholic Population of Scotland, 1878-1977' in *The Innes Review: Scottish Catholic Historical Studies* (The Innes Review), Volume 29, No. 2 (1978), pp. 211 to 247. *The Book of*

rightly been challenged - with the appointment of Yorkshireman Charles Eyre as the first post-reformation Archbishop of Glasgow symbolic of disputes between native Scots Catholics and Irish immigrants - through much of the period, Catholicism in Scotland meant a poor, tight-knit labouring class of Irish descent.²⁰² That said a nascent middle class of Irish-Catholics was in evidence in Scotland's main cities by the 1880s.²⁰³ In Edinburgh, the poor Irish were joined by a small community of equally poor Italian Catholics that settled in the city by the 1880s.²⁰⁴

Much focus within the Irish Catholic community was concentrated on Parnellism and Home Rule in Ireland, on unchecked proselytism, and on the development of a political voice and presence within Scotland. By the mid-1880s, the formation of a distinct Catholic local political hierarchy can be seen. Providing evidence that the population had grown sufficiently large, stable and confident, *The Glasgow Observer* (later renamed the *Catholic Observer*) was found and printed as a penny-weekly from April 1885.²⁰⁵ The period also saw a significant growth in Catholic charitable institutions. In Edinburgh, by 1875, there was a United Industrial School for boys and girls (established 1847); a Young Men's Society offering friendly society sickness and death benefits, and which was the springboard for the founding of Hibernian Football Club (and which by 1881, had 1,000 members); a Catholic-run Penny Saving's Bank, established in 1872; a Total Abstinence Society, the League of the Cross, found in 1873; and self-educational facilities in the form of a Catholic reading room and library. Thereafter a number of other Catholic institutions emerged in Edinburgh including a Children's Refuge on Minto Street (1904); an orphanage (1887); a House of Mercy for Servants (1880); and St Anne's Dispensary and Home for Respectable Girls, on St. John's Street (1899). In Glasgow, a range of different

the Church of Scotland (year-book) (Edinburgh: 1886 and 1894), p. 23, gave the Catholic population of Glasgow at slightly less, at between 10% and 11% of Glasgow's population.

²⁰² John F. McCaffrey, 'Politics and the Catholic Community since 1878' in *The Innes Review*, Volume 29, No. 2 (1978), pp. 140-1, 144; Mary McHugh, 'The Glasgow Archdiocesan Archive' in *Catholic Archives*, no. 5 (1985), p. 21; and Sheridan Gilley, 'Catholics and Socialists in Glasgow, 1906-1912' in Kenneth Lunn (ed.), *Hosts, Immigrants and Minorities* (Folkestone: Dawson, 1908), pp. 163-4.

²⁰³ Gallacher, *Glasgow: The Uneasy Peace*, pp. 61-2: 'already by the 1880s, a two-tier community was taking shape among the Glasgow Irish.'

²⁰⁴ *The Glasgow Observer* (May 30th, 1885), p. 5.

²⁰⁵ *The Glasgow Observer* (April 18th, 1885), p. 4: 'The Catholic residents of Scotland stand in want of a paper of their own, in which to ventilate their own views and advocate their claims to equal justice.' Before this, *the Glasgow Free Press* had run from 1851 to 1868 (when it was folded after condemnation by ecclesiastical authorities); and earlier still, a short lived Glasgow Catholic Association newspaper was published in the 1820s.

societies, confraternities and schools were attached to the Catholic churches of different districts. By 1875, also established, were temperance societies; penny savings banks; the St. Elizabeth's Clothing Society; branches of the Young Men's Society; and libraries and reading rooms. Lanark Hospital, outside Glasgow, was instituted as a Catholic hospital, under the care of the Sisters of Charity, and patients local to it were able to request home attendance. There was a Catholic orphanage at Smyllum nearby. By the mid-1890s, Glasgow also had two Catholic Industrial Schools on Abercromby Street; a Catholic Reformatory; a Deaf and Dumb Institute at Smyllum; an Asylum for the Aged Poor on Garngad Hill; a Day Feeding School (opened in 1883); a Children's Refuge on Whitevale Street (1887); a Home For Servants 'out of place'; a night shelter for working boys (1892); and, after 1893, the St Elizabeth's Home for District and Private Nursing, opened on Renfrew Street. Most significantly of all here, both Edinburgh and Glasgow had thriving St Vincent de Paul Society conferences.

The St Vincent de Paul Society (SVDP) was established in Glasgow - 'during the hungry forties' - in 1848. It provided, per Aspinwall, 'a microcosm of a social welfare state' for the Catholic poor.²⁰⁶ It provided a substantial *lay*, home-visitation, poverty relief organisation. Amongst a range of interventions it facilitated medical relief. Aspinwall claims the founder in Glasgow was Father Peter Forbes of St Mary's on Abercromby Street in Calton, although official credit is generally given to Rev. William Gordon, parish priest of St Andrew's Cathedral: dispute in this regards is symbolic of divisions within the community in Glasgow. St Andrew's was 'the mother church' of all the Catholics of the city, whilst St Mary's was the largest Catholic mission in Scotland.²⁰⁷ Forbes also established the St Elizabeth Society for the distribution of clothing to the poor, and had encouraged development of the Catholic Young Men's Society, a friendly society for Catholics.²⁰⁸

²⁰⁶ Bernard Aspinwall, 'The welfare state within the state: the Saint Vincent de Paul Society in Glasgow, 1848-1920,' in *Studies in Church History*, vol. 23 'Voluntary Religion' (For Ecclesiastical History Society, Basil Blackwood 1986), p. 449

²⁰⁷ Per the General Conference Report of the Catholic Young Men's Society of Great Britain (Glasgow: 1890), p. 5, Scottish Catholic Archives collection, Edinburgh: ref: GD67/1. St Andrew's parish Cathedral opened in Glasgow opened in 1816.

²⁰⁸ Bernard Aspinwall, 'A Glasgow Pastoral Plan 1855-1860: Social and Spiritual Renewal' in *The Innes Review*, Volume 35, No. 21 (1984), pp. 33 to 36.

The first Glasgow SVDP President was John Burns Bryson. Bryson was a solicitor recently moved from Edinburgh.²⁰⁹ This was significant, for despite its smaller Catholic population, the SVDP had actually established several years earlier in Edinburgh than in Glasgow, with a first meeting at St. Mary's, in the Cowgate, in 1842.²¹⁰ Becoming an international organisation, the origins of the SVDP lay with the Conference of Charity in Paris. Frederic Ozanam, a student at the Sorbonne, established this in 1833. Focus of early SVDP work in Edinburgh and Glasgow fell quickly on the sick and dying. For each member: 'Their main task was to visit the homes of the poor, and they had the privilege often of praying at the deathbed of the poor and sick and following their remains to the cemetery – and it was this more than anything else which impressed the non-Catholics in the city.'²¹¹

Survivalist strategies of different immigrant groups have much in common.²¹² Thus the response of both Catholic and Jewish immigrant communities in Scotland during the second half of the nineteenth century to welfare challenges faced were both home visitation centred. The establishment of the Glasgow Jewish Hospital Fund and Sick Visiting Association in 1899 typified. Home-based medical relief services had special utility. They required little or no fixed capital for communities to set up, just a willing practitioner to shoulder the work. Strategically, without a standing institutional building to signify their activity and draw resentment, home-based services also allowed organisations operating in hostile environs to go about their business largely undisturbed, 'below the radar' of broader public opinion, in what has been termed a 'legal half-light'.²¹³

²⁰⁹ Per *Manual of the Society of St Vincent de Paul Scotland* (SVDP Manual)(Council of Scotland: 1983).

²¹⁰ Anon., *printed correspondence relating to the St Vincent de Paul Society, Edinburgh, 1898-1910*, Scottish Catholic Archives collection, Edinburgh: ref: ED6/227. Per Aspinwall, *The welfare state within the state*, p. 446: 'Francophile Bishop Gillis built upon the existing Holy Gild of St Joseph in Edinburgh'.

²¹¹ SVDP Manual (1983), p. 208

²¹² Kenneth Collins, 'Jewish Medical Students and Graduates in Scotland, 1739-1945,' unpublished PhD Thesis (University of Glasgow, 1987), introduction p. 7: 'The initial concerns of the immigrant Jews were to secure an economic base, [and] develop the educational, welfare and social fabric of the Jewish community...'

²¹³ Speaking be-it of England and of the period to immediately before that of interest here, see Robert Kent Donovan, 'The denominational character of English Catholic charitable effort, 1800-1865' in *Catholic Historical Review*, vo., LXII (Catholic University of America Press, 1976), p. 222 & 204. Walker, *Irish Immigrants in Scotland*, p. 659, notes that tactfulness and discretion were the watchwords of SVDP work.

For a series of reasons, home visitation was understood as ‘especial’ work for the SVDP. Visits meant that the organisation was able to bring to the poor ‘not only alms, but comfort and [brotherly] Christian sympathy’.²¹⁴ Crucial here was the concept of ‘good works’. This can be opposed to the evangelical concept of bringing ‘good news’.²¹⁵ ‘Good works’ placed the emphasis on the provider of relief. The act of visitation brought a special spiritual benefit of sanctification to the visiting benefactor, and provided a ‘dignified’ form of relief to the poor beneficiary.²¹⁶ The rulebook of the SVDP, revised and annotated in Edinburgh in 1887, makes the point clearly. As adherents of the Catholic faith, SVDP members were granted plenary indulgences – ‘[which] may be for applied by way of suffrage to the souls in Purgatory’ – for different strands of their work. Indulgences work in the Catholic faith as a form of spiritual currency for the assuaging of suffering from sin. Plenary indulgences carry full remittance.²¹⁷ Thus Catholic medical men stood to gain through domiciliary care charity work, as a specific plenary indulgence was conceded to all benefactors (including medical practitioners) who supplied alms to support the work of the SVDP society, ‘provided they be truly penitent, confess their sins, and receive Holy Communion’.²¹⁸

The relationship between visitor and visited was a crucial one.²¹⁹

²¹⁴ *Rules of the Society of St Vincent de Paul* (Edinburgh: 1887), p. 11, National Library of Scotland Archives, shelf-mark ref: NF.1359.b.1

²¹⁵ Dr John R. Mott, ‘What is Evangelicalism? A symposium of views’ in *Evangelicalism: International Missionary Council Meeting at Tambaran, Madras*, vol. III (London: Oxford University Press, 1939), p. 52: ‘I would define evangelicalism as a proclamation of the Gospel, or the good news.’ Donovan, *English Catholic charitable effort*, pp. 200-223: Donovan begins his study by noting the centrality of ‘good works’ to traditional Catholic almsgiving.

²¹⁶ *Rules of the Society of St Vincent de Paul* (1887), p. 10. Per the *Manual of the Society of St Vincent de Paul* (translated from the French 20th Edition) (Dublin: 1946), p. 17, first amongst the five objects of the charity was ‘to maintain its members, by mutual example and advice in the practice of a Christian life’. Rev J. Ward, C.M., Lanark, ‘Spiritual Aspects of the Society of St Vincent de Paul’, in *Golden Jubilee of the Society of St Vincent de Paul in the Archdiocese of Glasgow* (Glasgow: P. Donegan & Co, 1898), pp. 39-45: the two-fold objective of the SVDP was (i) ‘the sanctification of its members’ and then (ii) ‘the relief of the poor and suffering’.

²¹⁷ See *The Catholic Directory for the Clergy and Laity in Scotland* (Aberdeen: 1895), pp. 81-2.

²¹⁸ *Rules of the Society of St Vincent de Paul* (1887), pp. 47-9.

²¹⁹ *Manual of the Society of St Vincent de Paul Scotland* (Council of Scotland: 1983), p. 106. Per *Report of the Superior Council of the Society of St Vincent de Paul in the Archdiocese of Glasgow* (Glasgow: 1895), p. 3: ‘The visiting of the poor in their own homes is the union of the hearts of the visited and the visitor.’

Per the President of the SVDP in Glasgow, in 1895, home visitation, whilst arduous and unpleasant, was also valued in that it served the additional purpose of ‘detection of imposition’ and facilitated ‘moral improvement’:

With regard to the visitation of the poor at their homes, the rule of the Society requires that under no circumstance should the relief be given otherwise than at the home of the poor person or family. The visitation of the abodes of the poor, on each and every occasion on which relief so sought for, or given, is not only required by the rule, but experience has shown that it is essential for the double purpose of detecting imposition, and of enabling the visitors to further the moral improvement of applicants.²²⁰

Reflecting available records, focus here is upon Glasgow. The first report on its work published by the SVDP in the city appeared in 1852.²²¹ It described an organisation that was structured around clusters of locally established, semi-autonomous conference cells, with each conference of brotherhood placed under the patronage of the local district Catholic ‘mission’ or church body, and each of these under the umbrella of the archdiocese. SVDP conferences in Scotland as elsewhere were named after local parish units, and then aggregated into regional councils under the name of the respective town, and in turn into Superior Council areas. Glasgow Superior Council, for example, included conferences in Paisley, Neilston, Renfrew, Port Glasgow, Uddingston, Wishaw, Motherwell, Johnstone, Greenock, Hamilton, Barrhead, Clydebank, Coatbridge, and Dumbarton: Edinburgh similarly included surrounding towns.

Conferences in major urban areas met daily. A board comprising of a lay elected president with presidentially nominated vice-president, secretary and treasurer, governed each conference. Glasgow Superior Council had four different presidents between 1875 and 1911.²²² Intercommunication between conferences was promoted through meetings, member visits, circulars and monthly bulletins. There were three types of member attached to each conference: active members (whom engaged in

²²⁰ Francis Henry, SVDP President, quoted in *Report of the Superior Council of the Society of St Vincent de Paul in the Archdiocese of Glasgow* (Glasgow: 1895), p. 3. On the arduous and unpleasant nature of the work see Father Cameron, quoted in same report (p. 6).

²²¹ First Report of the Proceedings of the Brotherhood of St Vincent de Paul in Glasgow, From its Establishment, 23rd August 1848, till 30th June 1852’ [SVDP First Report] appended to *Report of the Superior Council of the Society of St Vincent de Paul in the Archdiocese of Glasgow* [SVDP Annual Report] (Glasgow, 1909), GCA, ref: T.PAR 1.13.1071.

²²² Presidents in Glasgow were John Burns Bryson, solicitor (1848-52), James Walsh, publisher (1852-59), Charles O’Neil, architect (1860-63), Philip Reilly, merchant (1863-76), Patrick Rogan, clothier (1876-81), Daniel Graham, clerk (1881-90), and auctioneer and valuator Francis Henry (1890-1922).

visitation); honorary members (who used their influence and contacts in the local community to assist the former); and corresponding members. In addition, each conference kept its own subscriber records. Subscription provided an avenue of opportunity for female involvement. Medical practitioners and others who additionally contributed to the work of the SVDP were known as benefactors. Commitment meant both ‘time and means,’ and this confirmed the essentially middle-class nature of the society.²²³ Reflecting burgeoning economic opportunities within the community, identified occupations of the 119 leading members of the main SVDP conferences in Glasgow, circa 1906, included wine and spirit, or egg, butter and ham merchants; several auctioneers or pawnbrokers; cotton waster or machinery brokers; timber and metal merchants; tailors; teachers; a bookseller; a stevedore; a journalist for the leading Glasgow Catholic newspaper; a blacksmith; and a cooper.²²⁴

SVDP members were assigned cases to visit; after visiting, they made recommendation before the board as to the relief required in each case. Not all cases visited were assisted. Applications were filtered. As with most other welfare agencies, ‘worthiness’ was held as a determining factor. An accurate record or roll of cases visited was maintained; to aid filtration process, and keep ‘regular’ the operations of the society. Record keeping was the responsibility of conference secretaries. As with other nineteenth century private welfare agencies, the SVDP found it necessary to construct an elaborate bureaucratic procedure.²²⁵

By 1852 there were seven conferences of the society in Glasgow. This number had increased tenfold fifty year later. In contrast, in 1898, the diocese of St Andrews and Edinburgh had forty conferences. Addressing the first annual meeting held at the Trades’ Hall in the city in August 1852, Mr James Walsh reiterated that the SVDP, as

²²³ Francis Henry, Glasgow President, quoted in SVDP Annual Report (1898), p. 5: ‘There are many who, having both time and means at their disposal, yet from other circumstances do not wish to become Active Members of the Society; this class is strongly appealed to become Honorary Members. An Honorary Member of a Conference is one who does not attend the meetings, nor visit the Poor, but who gives in lieu of such services an extra sum yearly or quarterly... *The working classes* the Brotherhood will only ask to continue the generous support which they have always accorded to the Society.’

²²⁴ Persons identified from *Report of the Superior Council of the Society of St Vincent de Paul in the Archdiocese of Glasgow* (Glasgow: 1906), and trades then identified from that *Glasgow Post Office Directory* (1906). Trades or occupations for 43 of 119 conference members were listed.

²²⁵ *Rules of the Society of St Vincent de Paul* (1887), pp. 15-16.

a Catholic institution, served to defend the religious identity of the poor it assisted.

For Walsh, the rationale for the society was clear:

[The Society of St. Vincent de Paul] is founded on religion and supported by charity. It has for its Members active and zealous laymen, who are ever ready to assist the Clergy in every good work. Possessing a knowledge of the world, and much experience, the Members of the Brotherhood have already done much to stem the torrent of proselytism, pauperism and crime...²²⁶

As the first annual report pointed out, large numbers of poor Catholics eked a living as small independent traders or hawkers. These were thus especially vulnerable to the vagaries of personal health or of the economy.²²⁷

Like the Protestant medical missions, the SVDP addressed both the physical and spiritual needs of the poor. Whilst it mirrored Protestant charity organisations in many respects, the SVDP made boast that in being willing to assist any poor person - regardless of religious persuasion -, in offering assistance, it did not challenge a man's faith. Addressing the annual meeting of the SVDP in 1899, Bishop Maguire drew a distinction between right action, and action from right motive.²²⁸

The SVDP noted the willingness to play the welfare market of some of the poor:

I have intimate experience with regard to the efforts of our poor to keep body and soul together. I have seen in this crowded city of ours hundreds of families in which it was simply a question of take the open Bible or starve; and, worse still, I have seen children sold – absolutely sold – to proselytisers, with no hope of ever seeing them again, for the simple reason that the proselytising herd were able to offer better terms... Take a case that occurred the other day. I called into a house in the city – you don't want the name and if you do I won't give it to you -... in which was a poor widow who was once upon a time a fervent Catholic. She had five children, all of them of tender years, with no income to support them except a small pittance from the Parochial Board. The woman herself, more anxious for her personal relief than for her poor children, utilised whatever little means at her disposal in providing for her own wants. This case was under the cognisance of the St Vincent de Paul Conference of the district, which, on account of the degraded feeling of the mother, made provision that the children should be supplied from a

²²⁶ SVDP First Report in SVDP Annual Report (Glasgow, 1909), p.127. See also *Golden Jubilee of the Society of St Vincent de Paul in the Archdiocese of Glasgow* (Glasgow: P. Donegan & Co, 1898), pp. 15-17. A major turning-point in relations between the parochial boards of Scotland and the Catholic community occurred in 1864, when (Catholic) ratepayers were henceforward granted the privilege access to the names of children and adults receiving parochial assistance and who were in Glasgow's poorhouses.

²²⁷ SVDP First Report in SVDP Annual Report (1909), p.117.

²²⁸ SVDP Annual Report (1899), p. 5.

neighbouring grocery store with the wherewithal to abstain a miserable existence. The brotherhood had occasion to call and question the selfish and extravagant propensities of this mother in utilising the only means at hand to appease a desire for strong drink. For this she was called in check, and the reply, ready to the lips of the mother, was that '*if the Church did not see its way to support her children, she could find others that would.*'²²⁹

In Glasgow and its surrounds, in 1897, the SVDP claimed 42,564 home-visits with the poor in their homes; 34 sick were acquired infirmary admittance as a result. In 1900, it claimed almost 50,000 home-visits; 4,398 families relieved; and 130 admissions made to infirmaries. Altogether, from 1899-1910, Vincentian brothers claimed an average of over 52,000 visits across the conferences that made up the Superior Council of Glasgow per year, to an average of 23,793 persons or 6,219 families; with, on average, 154 persons each year found admittance to hospital. During 1909, 21,444 of those persons relieved lived in the city centre of Glasgow. Given population estimates, approximately one in eight of all Glasgow's Catholics were visited each year during the 1900s. This was achieved on a reported average annual expenditure across all greater Glasgow conferences between 1899 and 1912 of £6,149: £3,000-£4,000 was the reported expenditure within the city area in 1898.²³⁰ Across the conferences of Edinburgh, the SVDP also distributed £3,000-£4,000 annually.²³¹ Speaking in 1896, Father O'Reilly noted: 'It was a remarkable fact that the St. Vincent de Paul Society should claim to have relieved almost as many poor as the three parishes of Govan, Barony, and City, during the past year.'²³²

As a facilitation service staffed by lay-volunteers, no medical practitioners were directly employed by the SVDP. Medical practitioners were however deployed to undertake domiciliary treatment on a gratuitous basis by the different conferences. Numbers visited or total visits made are difficult to get at, but as Aspinwall points out, many, if not all, local Catholic medical practitioners did – and would have been expected to – give freely of their services to the society. The SVDP were major contributors to the main Catholic nursing organisation in Glasgow, the St. Elizabeth's Home (founded 1893), the nurses of which, before the introduction of the NHI Act, also visited an average of 2,500 medical cases per year.

²²⁹ *The Glasgow Observer* (June 6th, 1885), p. 4.

²³⁰ *The Scotsman* (17 Nov, 1898), p. 6.

²³¹ Edinburgh SVDP Annual Meeting reported upon in *The Scotsman* (19 Jan, 1897), p. 4.

²³² SVDP Annual Report (1896), p. 7.

Study of annual reports for the different conferences around Glasgow reveals that in total 22 different medical practitioners were thanked for having attended cases on behalf of the SVDP between 1895 and 1911 (21 of these have been positively identified and are listed in Appendix XI). It has been noted by Catholic historians from interviews held with medical practitioners at the time that: 'in a community corresponding to 250,000 people in 1880, there were only six Catholics studying at Glasgow University, five in medicine and one in law,' and that 'even as late as 1914 the number of Catholics had not grown appreciably.'²³³ Reflecting that there were a relative small number of Catholic doctors in the city at this time, not all the medical men that attended on the poor on behalf of the SVDP were Catholic. Support from the medical community was both professional and pecuniary: the annual reports also acknowledge a further 55 medical practitioners around Glasgow who were said to have also subscribed funds at one time or another.²³⁴

Medical practitioners like John Conway - not on the list in Appendix XI, for he died in 1894 - were not only important contributors to the work of the SVDP, but also to other Catholic institutions. Conway, who graduated M.B., C.M. from Glasgow University, was amongst the small cohort of Catholic students at the university in the early 1880s that included fellow first generation Scots-Irish Catholics, Patrick Aloysius Smith and Joseph Scanlan. Son of John Conway senior - 'one of the most spirited Catholics of his day,' and who 'had the honour of being the first Catholic representative of the Parochial Board in Glasgow'²³⁵ - in November 1887, Conway became one of the main founders of the greatest of all Scots-Irish institutions, Celtic football club. In 1888, Conway took over the medical practice of John McCarron. McCarron had been one of the first Catholics to establish a medical practice in Glasgow, and was too, when appointed in 1855, almost certainly the first Irish

²³³ Gallacher, *Glasgow: The Uneasy Peace*, p. 61. Gallacher picked this point up from John Durkan, David McRoberts, and James McGloin, 'The University of Glasgow and the Catholic Church, 1450-1950' in *St Peter's College Magazine* (Glasgow) and reprinted by the Scottish Catholic Historical Committee (Edinburgh: 1951), pp. 14-15.

²³⁴ A typical acknowledgement can be seen in SVDP Annual Report (1895), pp. 5-6: 'We gratefully acknowledge the services rendered by the Trained Nurses of St Elizabeth's Institution, by their constant attendance upon the Sick Poor, and by the supplying of medicines and distribution of clothing; also, to the several Medical Gentlemen who their gratuitous services to our Poor, and whose names appear in the Conference Reports of the district where such aid was given.'

²³⁵ *The Glasgow Observer* (27th January, 1894).

Catholic doctor employed under the poor law in Glasgow.²³⁶ This was one year prior to the first Glasgow-born Jew achieving an M.D. at the University of Glasgow.²³⁷ Conway's obituary notes his involvement with St Alphonsus' Catholic Benefit Society, the Irish National Foresters Friendly Society, and that he was a shareholder and director of the group that organised the initial publication of *The Glasgow Observer*.

Amongst other Catholic doctors identified (Appendix XI), Peter Macquire, M.B., C.M., was son of the SVDP Vice-President in Glasgow. Macquire not only undertook visits after qualifying in 1905, he also provided medical attendance at the Catholic Working Boy's Home established in Anderston. SVDP medical visitor, 'Chevalier' Thomas Colvin, received the Papal Knighthood for his charitable work. Other important SVDP-associated doctors, like James Alphonsus Joseph Conway, who graduated Glasgow University in 1911, fall outside this timeframe.

Although little in the way of direct evidence survives that indicates the kind of treatment administered by medical practitioners visiting the poor on behalf of the SVDP, an insight into method can be gained from the M.D. thesis submitted by John Conway in 1884. Of his thesis 'On Treatment,' Conway described how it was 'written at odd half-hours, which we [sic!] were able to snatch, between the performance of the duties of an existing practice.' Conway described his approach to medical diagnosis and therapy as being guided by interventionist rather than mere ameliorative concerns: waiting for symptoms to appear, Conway said, reduced the medical practitioner to 'helpless onlooker'.²³⁸

The 1894 annual report carries 'a few sample cases' from the work of the Vincentian brothers that highlight the role played by medical practitioners, and as well by the St Elizabeth's Nursing Home. Two cases are listed from the Holy Cross Conference of the SVDP, in the Govanhill district of Glasgow. Three medical practitioners were

²³⁶ McCarron, born in 1821 in Monaghan, Ireland, had qualified LFPSG in 1848, having studied at Anderson's Medical College - as a number of other Irish medical hopefuls would also do, and where academic entry credentials were less exacting, and the culture of anti-Irish prejudice less entrenched, than at the university.

²³⁷ Collins, *Be Well!*, p. 134.

²³⁸ John Conway, 'On Treatment,' unpublished M.D. Thesis (University of Glasgow, 1884), pp. 46-7.

thanked for medical attendance by this conference for this year: Patrick Aloysius Smith, Ebenezer Duncan, and J.W. White.

A woman, whose husband had lost his employment partly through drink, with two children, one an infant, was reported to the Conference as being in need, in the early part of the year. Her chief trouble was the rent, which was in arrear. This the Conference assisted to pay. In November, one of the Brothers calling by chance, to endeavour to encourage the husband in sobriety, found the woman ailing seriously. *A Doctor was consulted*, Miss White, Matron of St. Elizabeth's Nurses' Home, 171 Renfrew Street, was communicated with, and one of her nurses gave regular attendance to the case, until, arrangements having been completed with Sister Clare Redman, the woman was sent to Lanark Hospital, in hope of recovery.

A person who had suffered repeatedly from ulceration of the stomach, and been treated in the City Infirmaries, *was visited by a Doctor*, at the request of the Conference, as also by Miss White's District Nurse, and ultimately sent to Lanark Hospital, where she was quite restored. She was offered a situation in the town, and fulfilled it for six months, without any recurrence of health trouble. [My emphasis]²³⁹

During 1894, nurses of the St Elizabeth's home attended eleven cases dealt with by the SVDP in Govanhill. The Holy Cross Conference, during the year, had relieved 28 families (comprised of 106 persons); plus an additional 80 families due to hardships endured during a miner's strike. The conference had made subscription contributions to both the St Elizabeth's Home (ten shillings) and to the Lanark Hospital (five pounds). In subsequent years, regular donations were also made to the Victoria Infirmary and the Victoria Infirmary Dorcas Society; and to Glasgow Samaritan Hospital. Whilst it tended to rely on the freely given time of medical practitioners, at different times the Holy Cross was required to expend money directly to provide medicines and medical equipment: in 1903, to take one example, fourteen shillings went on 'the hire of waterbed for invalid'.

Taking one year, in 1905, all Glasgow SVDP income and expenditure was £6,150. Approximately half of this total had been raised from church door collections; and this amount was then given as 'relief in cash' across the conferences. £102 in total went as subscriptions to various hospitals and infirmaries; and £100 was given as the subscription to the St. Elizabeth's Home. Hunger was a significant issue, and thus

²³⁹ SVDP Annual Report (Glasgow: 1894), p. 63.

£1,195 (19.3%) was given as relief in groceries.²⁴⁰ Whilst medical assistance represented a small amount of budget, it was nonetheless significant.²⁴¹

²⁴⁰ SVDP Annual Report (Glasgow: 1906).

²⁴¹ SVDP Annual Report (Glasgow: 1905), p. 2.

4.10 Conclusion

Religion was vitally important in shaping Scottish society in the nineteenth and early twentieth century, and amongst the most important providers of domiciliary care for the poor in Scotland's main cities in the decades before 1911 were the medical missions. Indeed, Edinburgh was the home of home medical missions. Medical missions deliberately set down amongst poorer neighbourhoods, particularly those with a strong Irish component (Chapter 4.1). Medical missionary endeavour was the manifestation of the realisation that medical care could be used to invoke feelings of gratitude in treated patients (Chapter 4.2).

The main medical mission organisations in Edinburgh and Glasgow were the EMMS and GMMS, although these were not the lone organisations (Chapter 4.3 and 4.4). Thousands were visited at home each year by them, involving tens of thousands of visits (Figures 4.1 and 4.2).

Despite similarities, differences abound between the focus and approach in Edinburgh compared to Glasgow, due to differing social and economic contexts of respective organisations (Chapter 4.8). That said home visiting was a central feature of the medical work in both locations. Visits could be notoriously dangerous and were always time-consuming; and treatment administered was often as much about food as medical provision. Despite this, five clearly discernable reasons can be given to explain why medical personnel continued to include visits as an integral component of medical mission relief service (Chapter 4.5).

Medical missions were at the forefront in providing opportunities to women for involvement in public life or pursue medical careers (Chapter 4.6). Whilst strongly supported amongst the faithful in Scotland and amongst the elites of the medical profession, there was nonetheless no lack of criticism of medical missions (Chapter 4.7). The response to the challenge of medical missions and their proselytising agenda amongst the Irish community was a significant force in shaping Irish institutions in Scotland (Chapter 4.9).

Conclusion

The aim of this thesis was to initiate historical research into domiciliary medical care for the poor. Study of outdoor medical provision in Britain over the decades before 1911 has often been relegated to the margins, as historians have sort to account for the rise of the hospital, normally associated with the development of surgical skill, science and specialist strands of medical treatment. Home visits to the poor by medical practitioners as representatives of different agencies, therefore, is a topic that is under-valued and overlooked, yet one that has been shown to be fundamentally important if one is to understand both how medicine provision worked in the era before substantial state intervention into medical care for the masses, and what it was that was changed with the passing of the 1911 National Health Insurance Act.

The late-Victorian and Edwardian period has long been uniquely characterised by historians (Introduction). Here, the mid-1870s to 1911 is again identified as a particular epoch, in the terms of provision of medical home visitation of the poor in Scotland. An array of public and private medical agencies – poor law, charitable and missionary -was in operation in Glasgow and Edinburgh, constituting a locally determined ‘mixed economy’ of services, in both places, at this time. The maturation of the Scottish poor law system introduced in 1845 (Chapter 2); the expansion of a host charitable services from the mid-1870s in both Edinburgh and Glasgow (Chapter 3.2 and 3.3, Tables 3.2, 3.3 and 3.4); the massive growth in the numbers of medical students under study around this time - to a peak in the 1890s -, and the subsequent expansion in the number of qualified medical practitioners plying trade in the medical marketplace (Figure 3.1); the established system of using medical charity dispensary services - in Edinburgh particularly - for education purposes (Chapter 3); plus the development of home medical mission services as a dedicated outgrowth of the broader world missionary movement, and which proliferated from the end of the 1860s (Chapter 4): all these factors meant that a unique set of circumstances coalesced to create the network of home visitation amongst the poor in Edinburgh and Glasgow described in this thesis.

This thesis has shown that there were a range of reasons why domiciliary medical care was supported, and its utility as a medical service defended, by medical charity (Chapters 3.1 to 3.3), and by medical mission in Edinburgh and Glasgow (Chapters 4.3 to 4.5). Some of the advantages of medical home visitation of the poor have been outlined in this thesis, by Scottish trained men or Scottish practitioners: men like Glasgow MOH, Archibald Kerr Chalmers; the maverick, Robert Reid Rentoul; Glasgow PMO and COS activist, James Erskine (Chapter 3.1); and the first chief medical officer at the Ministry of Health, Sir George Newman (Chapter 3.4). What has been identified is that there were a host of issues affecting whether a particular patient applying to a particular charity or service was more likely to be seen ‘outdoors’ as opposed to ‘indoors’ in a hospital setting, and whether that patient was then more likely to be attended to at the dispensary, at the doctor’s surgery, or at home, on any given occasion. At different moments, emphasis could be placed on an array of different factors: economic, social, structural, technological, professional, practical, and religious. Medical condition was not the sole consideration in determining the site of a particular medical encounter. The prologue to this thesis points to historical continuity in many of these considerations.

Firstly - as this thesis has shown - ‘personal contact with the poor’ was a fundamental of Victorian philanthropy, and home visitation a leitmotif of nineteenth century charitable giving. Visits were two-way processes, conducted amongst the poor during treatment at one end, and by different agency representatives to the homes of potential subscribers at the other. In this sense, charity served as a vector between the homes of the rich and the poor, and visitation a conduit of exchange. Via distributed charity literature, accounts of the home conditions of the poor were brought into the homes of the wealthy. Collection rounds to the doorsteps of donors served as an opportunity to gauge support and reaction, whilst visits to a poor patient enabled the determination of deserts and needs.¹

Systematic home visitation was also an intrinsic component of Calvinism and of the Scots-Presbyterian welfare tradition of a ‘true’ Christian community. It was a tradition with rigid parochial focus, of territorially defined activity, and of home-centred

¹ Kidd, *State, Society and the Poor*, pp. 77-84.

pastoral care: it was ‘work from within’ and it became radicalised in Scottish cities in the early decades of the nineteenth century.² As Chapter 4 outlines, the rise of home visitation correlated to the rise of the ideology of evangelicalism. Developments within the church movement in Scotland were part of a broader trend.³

The notion that home visits are a crucial component of general practice and central to the traditional role of the family doctor is explored in Chapter 1 of this thesis. Home visits enabled medical practitioners to see a patient’s complaints in wider social context and, when patients were too ill to speak for themselves, interviews conducted with family members during home visits enabled practitioners to fill in vital missing elements of case studies.⁴ So it was that D. J. Pereira Gray, in 1977, reflected on the deeper territorial instincts of all people at all times, arguing that ‘since humans, like animals, behave much more naturally at home, visitors such as doctors and health visitors who are privileged to go there have a unique opportunity to observe their patients “at home” and so are able to understand them better.’⁵

For ‘the weak and bed-ridden, as well as the terminally ill,’ some medical visits were necessary, pragmatic responses to particular situations. For those too sick or frail to negotiate stairwells of tight tenement closes, or who were near to death, home visits proved an essential adjunct to routine services. It was not uncommon, for example, for charity medical practitioners to be called to attend the dying.

Visits could also be essential for those not regularly free to attend a dispensary or outpatients at given opening times. Amongst some factory workers, servants and others - for whom taking time off work to attend a dispensary was both costly and requiring of a consensual employer -, out-of-hours services always proved popular.

² K.A. Campbell, ‘The Free Church of Scotland and the territorial ideal, 1843 – 1900,’ unpublished PhD thesis (University of Edinburgh, 1998).

³ Eileen Yeo (ed.), *Radical Femininity. Women's Self-Representation in the Public Sphere* (Manchester, 1998), pp. 15-16.

⁴ See, for example, claimed by Professor William Tennant Gairdner in GMJ, v. 10 (April 1878), p. 152: Gairdner noted that a case of tubercular meningitis was difficult to diagnose *until* key data was provided by ‘the statement’s of the patient’s wife’.

⁵ Gray, *Training for General Practice*, p. 42, and D.J. Pereira Gray, ‘Feeling at Home. James Mackenzie Lecture 1977,’ in *Journal of the Royal College of General Practitioners*, 28 (1978), pp. 6-16. On a patient’s natural territorialism, Gray refers to M. Lalonde, *A New Perspective on the Health of Canadians* (Ottawa: 1975); T. McKeown, *The Role of Medicine – Dream, Mirage or Nemesis?* (London: 1976).

As has been argued in this thesis, and as Fissell has pointed out for Bristol's poor in an earlier period, the overwhelming interest of general hospitals in 'curable' cases meant the tie between home treatment and chronic illness was particularly strong.⁶ Indeed, the establishment of specialist 'homes' for care of incurables and consumptives in Edinburgh - in 1875 and 1906 - and in Glasgow - in 1876 and 1904 - was premised upon the very fact that the infirmaries in each city did not cater for long-term chronic patients, and also the understanding that the homes of certain sufferers could not cater for the medical supervision required by such cases: the conditions found in the homes of the poor was always a factor in the success or continuation of medical home visits.⁷

Fear or dislike of incarceration remained another factor in determining the location of certain medical encounters. A charity patient could refuse to enter a hospital, as was their whim. Distaste for institutionalisation was mixed up with a tradition of fear of the possibility of death in an institution, and foreboding for what might then happen to their bodies (with attitudes towards post mortem and other forms of medical dissection well-engrained in Scotland).⁸

Fear or trepidation also characterised the attitude of city authorities and elites to periodic outbreaks of infectious disease. A preoccupation in Victorian cities with medical policing of the poor was kick-started by different epidemic crises, especially the cholera outbreaks. This link is clearly shown in the development of standing Medical sub-Committees to manage medical treatment of outdoor poor law cases in Scotland's large parishes (Chapter 2.3). James Burn Russell in Glasgow stated clearly that given that habits and habitats of the poor, 'in their daily contact with the public

⁶ Mary E Fissell, *Patients, power, and the poor in eighteenth-century Bristol* (Cambridge: Cambridge University Press, 1991), p. 96.

⁷ Hospitals for incurables were found by the Association for the Relief of Incurables in Edinburgh, and their sister organisation, the Association for the Relief of Incurables in Glasgow and the West of Scotland.

⁸ Down to the Human Tissues Act (1961) and beyond, doctors had only to demonstrate that they had made 'reasonable enquiry' of families to use the bodies of patients for autopsy: permission was always likely to be harder to come by from family and relatives of patients that died at home than in hospitals. On the use of the body parts of the poor in the period see, for example, Elizabeth T. Hurren, 'A Pauper Dead-House: The Expansion of the Cambridge Anatomical Teaching School under the late-Victorian Poor Law, 1870-1914', in *Medical History*, 48:1 (2004), pp. 69-94. On popular attitudes of working classes of Glasgow to post-mortem of children see J. B. Russell arguments in *GMJ* (December 1878), p. 559.

they are magazines of infectious disease'. Therefore towns were 'compelled to respect the sickness of the poorest member of a community on the narrow ground of self-interest'.⁹ The attempt to curtail the spread of infection meant that in Edinburgh the main charity dispensaries were also expected to provide key public vaccination services.¹⁰ During the summer of 1892, when fear of a new cholera outbreak was rife after a fatal case had been diagnosed in seaman docked in Grangemouth en route from Hamburg, it was suggested in the Edinburgh press that:

In cases where danger is great, house-to-house visitation by discreet and competent persons may be of the utmost service, both in quieting unreasonable alarm and in leading or assisting the less educated and the destitute parts of the population to do what is needful for safety.¹¹

As well as providing a check on the potential spread of disease, it was recognised that earliest intervention through home visitation enabled too the nipping in the bud of complaints that, if unattended, had potential to develop into chronic illness. If complaints went unchecked in early stages, the future independence of entire families could be undermined. Thus some home visitation services were sold to potential subscribers by the medical charity that undertook them as a shrewd investment and as a form of first line security. Thus in 1852, the ENT D played on public fears in a time of cholera to stress 'it is only by giving personal attendance to the diseased poor at their own houses, and in cases of contagious fever and other diseases, providing for their instant removal to public hospital, that the higher classes can expect, by human means, to avert such a calamity from their own family circles.'¹² The annual meeting of the directors and subscribers of the ERPD in 1879, similarly heard John Walker, secretary, make claim that through home visitation and the 'early treatment of cases of infectious diseases... the dispensary discharges important duties to the public at large... maintaining the general healthiness of Edinburgh.'¹³ In 1904, the medical officers and students of the Cowgate Dispensary of the EMMS were acclaimed to have thwarted a potential outbreak of smallpox after discovering three cases 'in the

⁹ GMJ, v. 6 (1874), p. 476.

¹⁰ A key figure and pioneer in the ERPD vaccination services was Dr William Husband, to his death in 1901 the Superintendent of the Central Vaccination Institution of Scotland under the LGBS. ERPD played crucial role public health role as a vaccination station: during the 1901 smallpox epidemic, for example, it vaccinated large numbers of adults.

¹¹ *The Scotsman* (29 Aug, 1892), p. 7. See also GMJ, v. 38 (1892), p. 277.

¹² ENT D Annual Report (1852).

¹³ *The Scotsman* (27 Jan, 1879), p. 4.

same stair of a tenement' during daily rounds of visitation.¹⁴ The Edinburgh Provident Dispensary found that fees claimed back from the city for reporting cases of infectious disease uncovered during home visits to patients provided an important source of revenue; the dispensary actually brought in more revenue some years via bounties for reporting infectious disease cases than via charges levied on patients.¹⁵ And in 1858 ENT D annual report noted:

[The managers of the dispensary] cannot refrain from stating their firm and decided conviction that were it not for the well-conducted and constant system of visiting the sick poor in their dwellings, many diseases which at the outset were slight and easily cured, would, but for the timely visits of skilful medical men, have become obstinate, dangerous, or even fatal. The sufferings of thousands have been alleviated, and many restored to sound health who must otherwise have become a burden upon the community.¹⁶

The directors of ENT D repeatedly emphasised that visitation of the poor represented a future cost-saving to the community, by keeping patients from becoming a burden on the poor rates:

'It is impossible to over-estimate the benefits conferred on the sick-poor by domiciliary visiting. Not only are the sick themselves attended to, but in numerous instances the poverty and distress consequent upon sickness are relieved...'¹⁷

Home visitation services provided by different agencies operated not only as policing and sanitary services but also, in places, as frontline medical emergency services. That said, recounting a not untypical experience, Dr Ernest F. Neve, EMMS dispensary resident physician, noted the ever-present dangers of dispensary and visitation work in all its guises.

On Tuesday last [in November 1884], he [Neve] was called in the middle of the day to see a man who was said to be insensible to from a blow. He found him lying on the floor intoxicated, and learned that he had been quarrelling with a woman, who had hit him with a poker. The room was in a wretched state. It was a drunkard's home, empty of furniture, having an old bedstead with a filthy covering upon it. The windows were broken, and rags, pots, pans, and tattered articles of clothing strewn over the floor. A half-dressed child was in the bed, a baby crying in the cradle, and there was a young girl of thirteen, the sole inmate who could give him information. While dressing the wound, in came three women, all more or less under the influence of drink. The man pointed to one of them, his wife, and not the woman who had injured him,

¹⁴ *The Scotsman* (15 Apr, 1904), p. 3.

¹⁵ *The Scotsman* (18 Dec, 1880), p. 6.

¹⁶ ENT D Annual Report (1858), p. 2.

¹⁷ ENT D Annual Report (1859), p. 2.

said, “That is the woman,” and, throwing himself over the cradle, hurting the baby badly, suddenly seized hold of the poker, and would have hit her, had not he (Dr Neve) prevented him. The man then seized a large kettle from off the fire – fortunately the water was not boiling – and after upsetting part of it over the poor baby, he was going to throw the kettle at the woman, when he (Dr Neve) again stopped him, and compelled the women by main force to leave the room. Scenes of this kind they [medical practitioners on visits amidst the poor] were constantly witnessing.’¹⁸

Some domiciliary visitation was undertaken as a form of proactive outreach activity. Some medical charities deliberately widened their net in order to maximise optimum clinical material for their staff, and secure the strategic positional importance of an institution. In this vein, from 1907, the directors of the Edinburgh Royal Maternity Hospital ERMH took the decision to expand its catchment area by opening an additional outpatient service in Leith in order that new clinical material could be secured. More cases were needed sufficient to enable the hospital to meet expanding training obligations under ‘the more stringent practical training required by the Central Midwives Board’.¹⁹

Home visits too played a significant role too in what today is commonly referred to as ‘step-down’ care. Re-visiting was often crucial to the management of recovery during post-operative periods of convalescence. The convalescent home movement of this period was built on this principle, and on the realisation that homes of the poor were often unsuitable sites within which to manage recovery.²⁰ However well intentioned and welcomed as respite by some, convalescent homes were still not home. Thus it has been noted of one convalescent home that

...many of the patients did not remain for their full fortnight of convalescence. The explanation, graphically described in the LAA minutes, was touchingly simple – ‘Ye ken, lady, it’s the bairns at hame’.²¹

Debates in the medical literature in the period often emphasised the general dissolution of the poor. Doctors, in particular, chastised the undisciplined approach of the poor to treatment regimes prescribed. Such complaints formed part of the

¹⁸ EMMS Quarterly, Vol. 4 (1885), p. 174.

¹⁹ Edinburgh Royal Maternity Hospital (ERMH) Annual Report (1907) (Edinburgh: Lothian Health Board Archives) ref: LHB 3/18/3.

²⁰ On the convalescent home movement in Scotland see Jenny Cronin, ‘The origins and development of Scottish Convalescent Homes, 1860-1939,’ unpublished PhD thesis (University of Glasgow, 2003).

²¹ Derek Dow, *The Royal Samaritan Hospital for Women, Glasgow: Centenary 1886-1986* (Glasgow, 1986), p. 29.

backdrop to broader debates over the efficacy of introducing compulsory hospitalisation. The home setting was understood as a largely unregulated space, and as such domiciliary medicine was a major motif of the independence of private practice. Private practitioners, in their general rounds, worked without direct supervision, outside the immediate gaze and scrutiny of peers. The hospital - as a 'public arena' - meant procedure and protocol. This equated to restrictions on the power of an individual doctor, as well as on individual patients.²² Taking public or honorary appointment, either at a charity dispensary or under the poor law, therefore brought erstwhile independent operatives out into the open and under the agency of one or other institution. When operating in the home, medical practitioners were called upon to apply their own understanding and exercise their own judgement in identification and management of diseases. For this reason, optimising the supervision of untrained medical students sent into homes was always a prescient issue. Writing about the introduction of health insurance in 1912, three London-based medical practitioners were explicit about the symbolic relationship of domiciliary treatment to individual private practice. They noted that the main 'bone of contention' for B.M.A. members regarding the findings of the Minority Report proposals of 1909 was that they 'in general was opposed to any system that gave the Medical Officer of Health anything like a controlling influence in a service which would be largely concerned with domiciliary medical attendance.'²³

The range of occasion and purpose in which a medical practitioner was asked to examine and certify as to the fitness of a patient, or pronounce on cause of injury or death, expanded over the period under study. Various forms of medical refereeing involved home visits, including those carried out by an array of welfare charities like the Edinburgh Destitute Sick Society, or the Association for the Relief of Incurables in Glasgow or in Edinburgh. The EDSS, found in 1785, with home visitation of the temporarily sick, industrious poor and their family was its central feature.²⁴ Visitation

²² Ivan Waddington, 'The role of the hospital in the development of modern medicine: a sociological analysis', *Sociology*, 7 (1973): pp. 211-25.

²³ A. S. Comyns Carr, W. H. Stuart Garnett and J. H. Taylor, *National Insurance* (London: 3rd ed., 1912), pp. 57-8.

²⁴ *Centenary of the Society for Relief of the Destitute Sick, Edinburgh: The Society's origin, constitution, and operations* (Edinburgh: Scott & Ferguson, 1885), p.3 'The constitution and operations of the Destitute Sick Society are accurately described by the one word "visit," the one important feature in our operations. We never give blindly or lavishly.'

and certification demanded tact and care, and was not unfamiliar work for medical practitioners with experience working for the poor law, or for friendly society or insurance society.

In summary, domiciliary medical services were a valued and defended component of outdoor medical charity: visits enabled early detection of medical problems, enabled better awareness of the context of illness, enabled knowledge gathering on disease and facilitated disease-mapping, and helped prevent the spread of infections. Visits could be used to enable and facilitate training; and to prevent the abuse of charity. They enabled access to the family of patients, and this in turn could enable compilation of fuller case studies. Home visits were necessary for some bed-ridden patients, and simply just preferred by many others (who might express a preference by simply refusing to enter hospitals); they were necessary too as convalescent services. Home visits were part of the traditional Scots-Presbyterian approach to charity and were used to promote contact and communication between social groups; they brought medical practitioners into their patient's world. Chronic cases were necessarily treated outdoors for often not catered for by the infirmaries. Other contingencies affecting the likelihood or possibility of a home visit included the issue of access; the private womanly realm of the home, and questions of morality; medical refereeing; and the wider social and political importance of making contact with the poor.

Whilst they had clear medical and social value, medical home visits were not uniformly supported. Visitation services were not seen to be without drawbacks, affecting the volume of services carried out. This is clearly shown, for example, in the decision taken by the managers of the Glasgow Western Infirmary to abandon plans for a visitation service, on legal advice, in January 1888 (Chapter 3.4). Home visits could be dangerous for the doctors involved. They were tiresome, time-consuming, and hard work. Thus they were not necessarily conducive to maximisation of throughput of patient numbers (where this was the ultimate aim). A lack of portability in many types of medical equipment limited the range of treatment options available. Homes of most Scottish workingmen lacked even basic amenities, and were increasingly identified as ill-equipped arenas for some types of specialist treatment and deemed not to be conducive to protracted courses of convalescence. Homes of the

poor were environments that could in themselves cause illness, and were full of distraction.²⁵

Where volunteers (or students) could not be found, domiciliary staff could also be difficult or expensive to appoint. Arduous work meant turnover of staff was typically swift. Additionally, visiting medical staff and patients alike could prove difficult to supervise (a real problem in the case of the use of students). Lack of supervision meant patients could be difficult to monitor, and difficult to encourage to follow a given course of treatment. Instructions were prone to be misunderstood or ignored once the practitioner had departed. Without the facilities and outside of a regimen of quality control, treatments suggested could prove inappropriate or difficult to co-ordinate, or oversee.²⁶ From the point of view of the visited, visitation was associated with judgement, and was an imposition; and could be welcomed or resented as such.²⁷ There were family, nursing and neighbour problems that always attach to medical visits: and the visiting doctor, if a stranger to a neighbourhood, could find – as he still might – that he was viewed as a suspicious, intrusive, interfering and ultimately unwelcome presence. Left at home, and to their own devices, patients and families of patients could prove extremely fickle:

Those who know something of the life of the poor can realise the difficulty of this apparently simple task. Few poor persons have any hesitation in changing their doctor, their dispensary, or their medicine at a chance suggestion from a neighbour, or because “one bottle” has not worked an instantaneous cure. The writer has known a woman take her delicate baby regularly to three dispensaries, and give it simultaneously the three different medicines recommended... Another woman, whose child had, with much difficulty, been placed under the care of an eminent surgeon... was discovered to be also taking it each evening to a “wise woman,” whose very different advice practically nullified the surgeon’s efforts, and in fact rendered the child an invalid for life.²⁸

²⁵ See Sidney and Beatrice Webb, *The State and the Doctor* (London: Longmans, Green & Co, 1910), p. 81.

²⁶ M. Frantz Glénard, ‘The treatment of enteric fever by cold baths’, translated by Glasgow’s William Macewen, GMJ, v.6 (Glasgow: 1874), pp. 370-396, provides an example of the limitations of home treatment in the particular case of fever requiring a regimen of cold baths and compresses.

²⁷ Stephen Reynolds and Bob and Tom Woolley, *Seems so! A working-class view of politics* (London: Macmillan & Co., 1912), p. 27, referred to by Pat Thane, ‘The Working Class and State ‘Welfare’ in Britain, 1880-1914,’ in *Historical Journal*, no. 27 (Cambridge: Cambridge University Press, 1984), p. 894.

²⁸ *Organised Help*, Vol. 14 (Glasgow: Charity Organisation Society, 16/1/1899).

Finally, it should be noted that the system of domiciliary care of the poor in Glasgow and Edinburgh described in this thesis, declined after 1911, as the forces and features that had come together to create it fell into abeyance, or were countermanded or usurped by changing priorities and events. One can point to an array of factors that ushered this decline.

First, and most fundamental, was changing legislation. The NHI Act, 1911, once implemented, had an immediate and dramatic impact on demand for charitable services right across the board. Many more of the population who previously had no other recourse than the public charity of the poor law, or the private charity of outpatients, dispensary or mission society when sick, found themselves able to secure access to doctors under the new scheme. Several examples can be offered of reports from different medical institutions in Edinburgh and Glasgow of the impact of national insurance.²⁹ Demonstrating, however, the on-going ability of medical missions to re-invent themselves and adapt to new market conditions, the directors of the GMMS were determined to make a virtue of changed circumstances:

this decrease (in attendance) is not a cause of regret, from either a medical or a missionary point of view, as it enables the staff to give more time and attention to each individual patient... [Though] there are now many more religious and philanthropic institutions in Glasgow than in 1867... there is [still] no other Society whose objects are exactly the same, and the Directors are convinced that the need for a medical mission is as great as ever.³⁰

The 1911 NHI Act was not the only piece of government legislation to have impact on visitation medical services for the sick-poor of Scotland. With the introduction of pensions after 1908 – which took large numbers of elderly persons off the rolls – the demands on Scottish poor law medicine had already begun to change. The whole organisational structure of poor law medical relief provision was altered at an early opportunity after 1911; with legislation after the war in 1919; and the Local Government (Scotland) Act, 1929 (which transferred poor law functions).

Second, the Edwardian period saw changing national interest in issues of public health, particularly as the un-healthiness of the industrial poor – and by extension the

²⁹ See, for example, ENTD Annual Report (1913): Patients fell from 5,137 seen at the dispensary and 1,634 at home in 1911, to 3,263 dispensary and 921 domiciliary in 1913, to 1,304 dispensary and 72 domiciliary in 1920. See also GMMS Annual Report 1912, p.8

³⁰ GMMS Annual Report 1914, p.6/8

economic and military inefficiency of the nation - came under spotlight after the Boer War. Changing national priorities placed new focus on the single main issue undermining the fitness of many of working population, tuberculosis; and on the key issue affecting the prospect of raising healthier future generations, mother and infant welfare (Chapter 3.5). The new emphasis of social medicine was pro-action, and the goal of new approaches became prevention rather than the simple provision of palliative or ameliorative care. Change renewed the importance of domiciliary care. Emphasis on ancillary medical systems of nursing and of health visitation - focused upon convalescent and health surveillance work, and on the dispensation of advice (rather than treatment) - led to the farming out of a number of once standard 'medical' visitation duties. By the First World War, the emphasis in visitation had shifted from that that could only be conducted by doctors to that that could be entrusted to paramedical agencies.

Third- signalled by the publication of the Royal Commission on the Housing of the Industrial Population of Scotland Report in 1917- there was public cognizance and political acceptance of what many medical practitioners working for the poor law, charity and missions, had been reporting for decades, that the homes of the poor were fundamentally unfit (Chapter 1.2). The RCHS Report concluded with the realisation that 'a healthy family [required] a healthy home'. The *raison d'être* of whole swathe of domiciliary medical care services was undermined at a stroke, as it was argued that attempting to treat diseases like tuberculosis in the overcrowded, insanitary and badly facilitated homes of the poor was an entirely unproductive and futile exercise all the while that Scotland's housing stock was allowed to remain in such a shocking state. Government focus on housing and house-building programs during the interwar period of the 1920s and 1930s can be seen a direct by-product of this. Re-housing the poor in places like Edinburgh and Glasgow most often meant moving them out of the slums in the city centre and into suburban estates. This process of relocation, at a stoke, put a distance between the downtown charity dispensaries and medical schools – which in Edinburgh, particularly, had been so important in providing home visitation services – and the poor. This made provision domiciliary care less viable. The impact of depopulation was already underway by the end of the nineteenth century. In 1899, the medical superintendent of the Edinburgh Medical Missionary dispensary, located in the heart of the main slum district of the old town, noted a new

trend for decreasing numbers of patients, suggesting that: ‘the decrease [in new patients] might be partly due to the gradual demolition of some of the slum property in the neighbourhood...’³¹

Fourth, the (continuing) rise in prominence of hospitals was obviously also an important factor in the decline of domiciliary medicine. Municipal or poor law hospital services, particularly, continued to gain a better general reputation amongst the poor, who had formerly had such fear of the poorhouse, and particularly as new facilities like at Stobhill in Glasgow bedding down. Additionally, the advent of new technologies and diagnostic and treatment approaches, and new funding priorities, also continued to put growing emphasis on the ward. The lack of availability of hospital treatment for those partaking in the new national insurance system also put more emphasis when raising charitable funds on the hospital system.

Fifthly, an important aspect in the decline of domiciliary care provision by students, in Edinburgh, was changing educational priorities. Bodies, like the Rockefeller Foundation, providing funds for new academic chairs, ushered a shift in focus towards time spent in the clinic and in medical research during undergraduate educational training, and away from a focus upon the training of rounded generalist practitioners of the kind that Edinburgh had traditionally been famous for: indeed, one Rockefeller representative to Edinburgh in the 1920s, had declared himself much shocked by the previous emphasis that had been put on domiciliary visitation during educational training in the city.

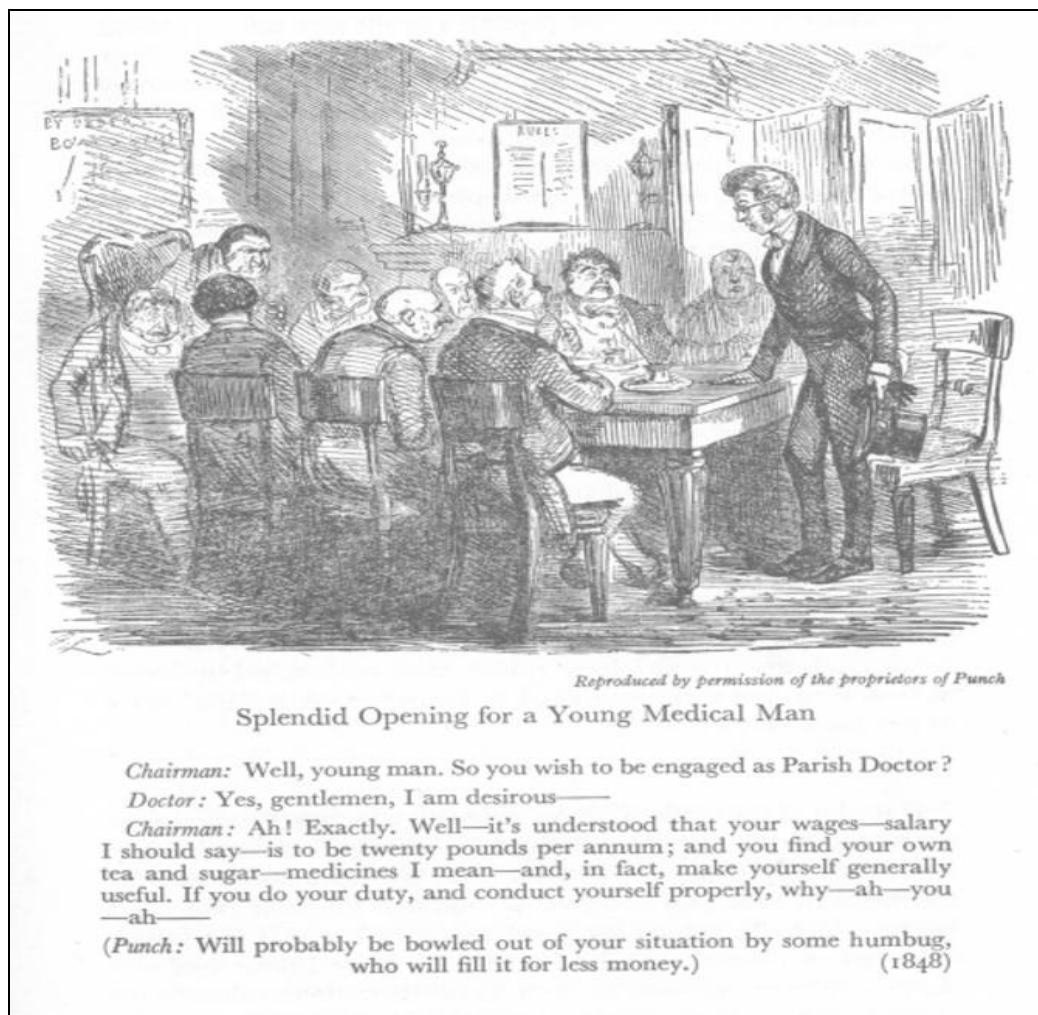
A Sixth aspect in the decline of domiciliary medical visitation in Scotland was the growing secularisation of Scottish society during the twentieth century. A plethora of home medical missions have been shown as extremely active in visiting the poor of Scotland over the period from the 1870s to the 1900s. Much research activity has been spent on trying to determine exactly when it was religion ultimately declined as a force in Scottish society. Research presented in this thesis on medical missions shows that whilst periodic revivalist movements buoyed interest and involvement in medical mission work, the process of raising funds for that work was becoming far

³¹ *The Scotsman* (27 Jan, 1899), p. 7.

more a challenge for the managers of medical missions in the straightened economic circumstances of the 1890s (although new fields of opportunity in the east – after wars with China - seemed to be opening up new possibilities for a new front in the medical mission movement at the end of the 1900s).

After World War One - a time of profound religious and spiritual crisis for many - the interests of the masses became more secular. The role the state played in ordinary people's lives became more prominent; and ordinary people also became more prominent in the affairs of the state, through representation. The shift in concern for, and categorisation of, the masses - in public discourse -, from a label that routinely described them as 'the poor,' to the growing adoption of the language of class, is another sign of the secularisation of society: 'the poor' can be thought of as an essentially religious or moral label, with its moral and charitable connotations, whilst working class and underclass essentially social or economic concepts. Although Scotland (and particularly Glasgow) still looked to the empire for its economic strength in the interwar period, changing imperial priorities impacted on the work of missionary societies abroad, and by extension, upon the support for, and the requirement of, its home medical missions.

Appendix I: The appointment of a Parochial Medical Officer, from Punch (1848)



This is a depiction from Punch magazine, 1848. This was the year the Scottish Poor Law (Amendment) Act helped codify the appointment of parochial medical officers as a statutory requirement in Scotland, coming three years after the New Poor Law (Scotland) Act of 1845. Whilst it is a satirical representation it seeks to portray contemporary popular and medical opinion of the thankless task of being appointed a parish medical officer, and the thankless future awaiting. The cartoon has been reproduced or referred to often by historians ever since and widely used as supporting evidence for the general inadequacies of poor law medical service in Britain as a whole.¹

¹ See, for example, E.S. Turner, *Call The Doctor: A social history of medical men* (London: Michael Joseph 1958), p. 195; John Cule, *A Doctor for the People: 2000 years of general practice in Britain* (London, 1980); Anne Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), p. 253; and more recently Joan Lane, *A social history of medicine: health, healing and disease in England, 1750-1950* (New York: Routledge, 2001), p. 63. That it has been so widely reproduced and for so long, by historians, shows the longevity of the impression created.

Appendix II: PMOs in Glasgow and Govan in 1875.

Glasgow PMOs circa 1875		birth town	Educated:	Year appointed	Age qualified	Age appointed	Age in 1875
GLASGOW CITY PARISH:							
Mather	George Ritchie	Glasgow	Glasgow Uni (M.D.)	1870	24	31	36
Buchanan	Simson	-	Glasgow Uni (M.D.)	1866	-	-	-
Macewen	William	Bute	Glasgow Uni (M.D.)	1871	21	23	27
Lothian	John Alexander	Edinburgh	Edinburgh & Aberdeen (MD)	1865	21	37	47
Smellie	James	Glasgow	Glasgow Uni (M.D.)	1864	27	30	41
Mackay	Alexander Fraser	Inverness	Glasgow	1873	30	33	35
Orr	Robert	Renfrew	Edinburgh (M.D.)	1868	25	37	44
Leitch	John Gibson	Glasgow	Glasgow Uni (M.D.)	1870	21	25	30
Walker	David	Glasgow	Glasgow	1842	22	34	67
Known Averages					23.9	31.3	40.9
BARONY PARISH:							
Smith	James Allan	Calder	Glasgow & St Andrews (MD)	1869	27	33	39
Young	William	Shettleston	Glasgow	*1828	19	-	64
Young	William Graham	Glasgow	Glasgow Uni (M.D.)	*1867	23	-	38
Patrick	William	Glasgow	Glasgow Uni (M.D.)	*1867	25	-	38
Reid	William Loudon	Motherwell	Glasgow Uni (M.D.)	*1870	21	-	30
Cowan	Robert	Bothwell	Glasgow & St Andrews (MD)	1858	31	32	49
Cameron	Murdoch	Glasgow	Glasgow Uni (M.D.)	*1873	23	-	38
Mathie	John	Ayrshire	Glasgow	*1868	33	-	45
Speirs	John	-	Glasgow	*1867	-	-	-
Maclean	Daniel	Greenock	Glasgow Uni (M.D.)	1867	24	32	40
McInnes	James	Glasgow	Glasgow	*1872	24	-	59
Hay	Alex	Kirkintilloch	Glasgow Uni (M.D.)	1865	20	21	31
Known Averages					24.5	29.5	42.8
GOVAN PARISH:							
Barras	James	Perth	Glasgow & St Andrews (MD)	1863	24	27	39
Taylor	Robert Davie	Stirling	Glasgow Uni (M.D.)	1873	23	30	32
Menzies	Joseph Home	Berwick	Glasgow Uni (M.D.)	1872	32	39	42
Henderson	Alexander	Ayr	Glasgow & Edinburgh (MD)	1871	23	26	30
Barrie	John	Haddington	Glasgow Uni (M.D.)	*1873	26	-	43
Known Averages					25.6	30.5	37.2
Total averages for Glasgow & Govan:							
* in these cases appointed year given is <i>the earliest recognised year in service as a PMO</i> : actual appointment year might have been much earlier.					24.5	30.6	41.0

Appendix III: PMOs in Edinburgh and Leith in 1875.

Edinburgh PMOs circa 1875		birth town	Educated:	Year appointed	Age qualified	Age appointed	Age in 1875
EDINBURGH CITY PARISH:							
Sinclair	Alex James	Edinburgh	Edinburgh Uni (M.D.)	*1873/4	22	26-27	28
Cuthbert	Clarkson	-	Ednbrgh & St Andrews (MD)	1875	32	49	49
Carmichael	Walter Scott	Edinburgh	Edinburgh Uni (M.D.)	1875	25	65	65
Cappie	James	Lanark	Edinburgh Uni (M.D.)	*1861	21	-	46
Moir	Alexander	-	Ednbrgh & St Andrews (MD)	1875	-	-	-
Known Averages					25.0	46.8	47.0
ST CUTHBERTS - CANONGATE							
Middleton	John	-	Edinburgh Uni (M.D.)	*1853	-	-	-
Turnbull	J. Rutherford	Roxburgh	Edinburgh	*1863/4	23	25	37
Lowne	Thompson	England	Edinburgh Uni (M.D.)	*1864	29	-	58
Smart	Andrew	St Ninnians	Edinburgh Uni (M.D.)	*1865/6	39	-	50
Husband	William	Dunfermline	Edinburgh Uni (M.D.)	*1860	30	-	59
Alexander**	William Black	Edinburgh	Glasgow	1874	25	30	31
Known Averages					29.2	27.5	47.0
SOUTH LEITH PARISH:							
Williamson	Thomas	Greenock	Edinburgh Uni (M.D.)	*1853	21	-	60
Alexander**	William Black	Edinburgh	Glasgow	*1874	25	30	31
Known Averages					23.0	30.0	45.5
NORTH LEITH PARISH:							
Macnair	Robert	Paisley	Edinburgh Uni (M.D.)	*1868	34	-	47
Total averages for Edinburgh & Leith:							
* in these cases appointed year given is <i>the earliest recognised year in service as a PMO</i> : actual appointment year might have been much earlier..					27.2	37.6	46.8

Appendix IV: The 110 PMOs that served in Glasgow and Govan and Edinburgh and Leith between 1875 and 1911.

Parish Medical Officer	Parish	Year appointed	Served until	Years of service
Aitchison, Robert Swan	Edinburgh	c. 1894/5	after 1909	14+
Alexander, William Black	St Cuthberts/Edinburgh	c. 1874	c. 1919/21	45+
Alexander, William Black	South Leith	c. 1874	1894	20
Balfour, Andrew	Edinburgh	1901	1907	6
Barras, James	Govan	1863	1913	50
Barrie, John	Govan	c. 1868-74	1897	24-29
Black, Malcolm	City, Glasgow	1883	1918	35
Bowie, John Macaulay	Edinburgh	c. 1903/4	after 1909	5+
Brown, William Herbert	Glasgow	1908	1919	11
Bryce, William	Glasgow	1911	1926	15
Buchanan, Simson	Glasgow City	1866	1876	10
Buchanan, Thomas	Barony	1876	1885	9
Cairns, Thomas	Edinburgh City	c. 1873/4	1875	1+
Cameron, Murdoch	Barony	c. 1872-74	1878	4-6
Campbell, Finlay Stewart	Glasgow	1910	1918	8
Campbell, Gilbert	Govan	1884	1915	31
Campbell, Malcolm	Glasgow	1904	(at least) 1929	25+
Cappie, James	Edinburgh City	before 1861	1880	19+
Carmichael, James	Edinburgh City	1880	1884	4
Carmichael, Walter Scott	Edinburgh City	1875	1884	9
Carruthers, James Bell	St Cuthberts/Edinburgh	c. 1881	after 1911	30+
Carswell, John	Barony, Glasgow	1880	1914	34
Chisholm, John Oliver	Barony, Glasgow	1889	1924	35
Clark, Simon Prince	Govan	1897	1926	29
Couper, David	Barony, Glasgow	1884	1911	27
Cowan, Robert	Barony	1856	1884	28
Cowie, David	Barony, Glasgow	1878	1910	32
Craig, James	Govan	1878	1883	5
Cullen, William B.	City, Glasgow	1893	1919	26
Cuthbert, Clarkson	Edinburgh City	1875	1877	2
Dewar, Daniel McKellar	City, Glasgow	1886	1907	21
Dewar, Peter McKellar	Glasgow	1907	c. 1921/3	14+
Dittmar, Fred	Glasgow City	1898	1898	less than 1
Donald, George	North Leith, Leith	c. 1883	after 1911	28+
Dudgeon, John Matthew	St Cuthberts	c. 1883/4	1886	2+
Duncanson, John Janet Kirk	Edinburgh City	1874	1875	1
Duffus, John Charles G.	Barony	1894	1897	3
Erskine, James	Glasgow	1910	1922	12
Fairlie, John Edmond	Glasgow City	1883	1886	3
Findlay, William	City, Glasgow	1880	1907	27
Fortune, George Roy	Glasgow City	1894	1897	3
Furley, Robert Charles	Edinburgh City	unk.	1875	unk.
Gordon, David	Edinburgh City	c. 1878/9	c. 1880/1	2
Graham, James	St Cuthberts	c. 1882/3	c. 1883/4	1
Halket, George William	Barony	1877	1892	15
Hammond, William	Edinburgh City	1875	1875	less than 1

Hay, Alex	Barony, Glasgow	1865	1905	40
Hay, Henry	City, Edinburgh	1884	after 1909	25+
Henderson, Alexander	Govan	1871	1877	6
Hodge, Peter	Glasgow City	1890	1892	2
Husband, William	St Cuthberts/Edinburgh	before 1861	1901	40+
Inglis, Thomas	Edinburgh	1907	after 1910	3+
Johnston, George Minto	South Leith, Leith	1886	after 1911	25+
Langmuir, Robert	Glasgow	1911	c. 1921/3	10+
Leitch, John Gibson	Glasgow City	1870	1890	20
Longwill, David	Glasgow	1906	1926	20
Lothian, John Alexander	Glasgow City	1865	1877	12
Lowne, Thompson	St Cuthberts/Edinburgh	before 1865	c. 1902/3	38+
Macewen, William	Glasgow City	1871	1883	12
McInnes, James	Barony	before 1872	1877	5+
Mackay, Alexander Fraser	Glasgow City	1873	1880	7
McKie, John	Barony, Glasgow	1897	1927	30
McLaren, John	Edinburgh	c. 1898/1900	after 1910	10+
Maclean, Daniel	Barony	c. 1866/7	1889	22-23
Macnair, Robert	North Leith	before 1868	c. 1883/4	15+
Martin, Matthew	Barony, Glasgow	1890	1913	23
Martin, William Lewis	Edinburgh	1897	after 1910	13+
Mather, George Ritchie	Glasgow City	1870	1883	13
Mathie, John	Barony	1867	1877	10
Mathie, John Wilson	Glasgow	1904	after 1925	21+
Menzies, Joseph Home	Govan	1872	c. 1884/5	12+
Middleton, John	St Cuthberts	before 1853	c. 1881/2	28+
Mitchell, Andrew Ronald	City, Glasgow	1893	1904	11
Moffat, David	Barony, Glasgow	1892	1918	26
Moffat, James	Glasgow	1910	1920	10
Moir, Alexander	City, Edinburgh	1875	after 1894	19+
Muir, James Steel	Glasgow	1899	1926	27
Muir, William Limont	City, Glasgow	1889	1923	34
Murdoch, Alex Macdonald	Barony, Glasgow	1883	1910	27
Murison, John Falconer	City, Glasgow	1897	1910	13
Orr, Robert	Glasgow City	1868	1898	30
Park, Robert	Glasgow City	1877	1894	17
Patrick, William	Barony	before 1868	1876	9+
Rankin, John Semple	Govan	1897	1917	20
Reid, William Loudon	Barony	c. 1870	1877	7+
Robertson, Alexander	City, Glasgow	c. 1903	1908	5+
Robertson, John	St Cuthberts/Edinburgh	1883	1897	14
Ross, William	Govan	1897	1912	15
Russell, Thomas	Glasgow	1899	1906	7
Sinclair, Alexander James	Edinburgh City	c. 1873/4	1884	10+
Sloan, Allen Thomson	City, Edinburgh	c. 1885	after 1909	24+
Smart, Andrew	St Cuthberts	c. 1865/6	c. 1881/2	15+
Smellie, James	Glasgow City	1864	1889	25
Smith, James Allan	Barony	1869	1894	25
Smith, John Davidson	Glasgow	1906	1928	22
Speirs, John	Barony	before 1867	1875	8+
Stewart, Robert	St Cuthberts/Edinburgh	1887	after 1909	22+

Stirling, Stewart	St Cuthberts	c. 1882	c. 1883	1
Taylor, Robert Davie	Govan	1873	1916	43
Thyne, Thomas Jackson	Edinburgh	c. 1902/3	after 1909	6+
Todd, George Bell	City, Glasgow	1898	1911	13
Turnbull, John Rutherford	St Cuthberts	c. 1863/4	1882	18+
Walker, David	Glasgow City	1842	1885	43
Wallace, John Veitch	Govan	1885	1912	27
Watson, William Riddell	Barony	1877	1883	6
Webster, Arthur Douglas	Edinburgh City	c. 1880/1	1885	5
Williamson, Thomas	South Leith	before 1853	1885	32+
Wilson, William McKnight	Glasgow City	1885	1893	8
Young, William	Barony	1828	1890	62
Young, William Graham	Barony	before 1867	1877	10+

Appendix V: 'Ways of knowing': the awarding bodies of medical qualifications to all Glasgow and Govan PMOs, 1875-1911; all Edinburgh and Leith PMOs, 1874-1909; and of all Dundee medical practitioners listed in the Dundee Post Office Directory, 1875-1911.

Glasgow & Govan PMOs 1875-1911		
Glasgow Uni	98	57.6%
Glasgow medical colleges	33	19.4%
Glasgow sub-total	131	77.1%
Edinburgh Uni	1	0.6%
Edinburgh medical colleges	20	11.8%
Edinburgh sub-total	21	12.4%
Aberdeen Uni	6	3.5%
St Andrews	4	2.4%
England	6	3.5%
Ireland	0	0.0%
other/unknown	2	1.2%
Scottish sub-total	163	95.9%
total qualifications [of 72 PMOs]	170	

Edinburgh & Leith PMOs, 1874-1909		
Glasgow Uni	6	5.9%
Glasgow medical colleges	1	1.0%
Glasgow sub-total	7	6.9%
Edinburgh Uni	49	48.5%
Edinburgh medical colleges	36	35.6%
Edinburgh sub-total	85	84.2%
Aberdeen Uni	0	0.0%
St Andrews Uni	4	4.0%
England	1	1.0%
Ireland	0	0.0%
other/unknown	4	4.0%
Scottish sub-total	98	97.0%
total qualifications [37* PMOs]	101	

*One man served two posts.

All Dundee doctors 1875-1911		
Glasgow Uni	64	13.3%
Glasgow medical colleges	19	4.0%
Glasgow sub-total	83	17.3%
Edinburgh Uni	187	39.0%
Edinburgh medical colleges	88	18.3%
Edinburgh sub-total	275	57.3%
Aberdeen Uni	52	10.8%
St Andrews Uni	38	7.9%
England	24	5.0%
Ireland	2	0.4%
other/unknown	6	1.3%
Scottish sub-total	448	93.3%
total qualifications [206 practitioners]	480	

Appendix VI: Central rules governing provision of outdoor medical relief of the poor in Scotland, circa 1890-1902, compliance with which was necessary for participation on the Medical Relief Grant.

1. All poor persons who stand in need of medical relief shall be duly and punctually attended by a *competent* medical practitioner, and supplied with medicines and medical and surgical appliances of such quality and to such an extent as may be necessary for the proper medical or surgical treatment of such poor persons.
2. A medical practitioner is not *duly qualified* unless he is registered under the Medical Act of 1858.
3. In addition to medical relief, Parochial Boards shall furnish the sick and convalescent poor with nutritious diet, cordials, clothing, suitable lodging, and sick-bed attendance, to such an extent as may be necessary, according to the circumstances of each case.
4. A medical practitioner appointed by the Parochial Board to attend any poor person shall intimate in writing to the inspector the description and extent of relief, under rule 3, which he may consider necessary for the proper treatment of such poor person; and on receipt of such intimation, the inspector, on his own responsibility, shall forthwith furnish or refuse the relief so intimated to be necessary, until he shall have brought the case before the Parochial Board, and receive their instructions regarding it. But if the inspector refuses or fails to furnish that relief or any part of it, he will be held accountable for such refusal or failure.
5. Medical attendance, including the cost of trained nursing in poorhouses as approved by the Board of Supervision, and medical and surgical appliances which are furnished by the medical officer or procured from a laboratory on his prescription, are chargeable under the head of medical relief; but nutritious diet, cordials, clothing, suitable lodging, sick-bed attendance (other than the cost of trained nursing in poorhouses), and such appliances and means as are not furnished by the medical attendants...are not chargeable...
6. A medical practitioner who has undertaken to attend the whole or any part of the poor in any parish, or district of a parish, shall attend personally, and at their homes if necessary, the poor persons entrusted to his care, and is responsible that such visits and attendance are duly and punctually made and given. If he employs an assistant to aid him in the performance of his duties, no subdivision of the duty of personal attendance, or diminution of personal responsibility, will on that account be recognised.
7. A medical officer appointed by the Parochial Board to attend the poor of a parish, or of a part of the parish, is bound to afford every reasonable facility for sending or conveying the medicines and appliance furnished from his own laboratory to paupers who are unable to go or to send for them; but when it is necessary to send a messenger expressly for that purpose, he may call upon the inspector, in writing, to provide such messenger, and the inspector, when so called upon, will be held responsible that the medicines and appliances are duly and punctually delivered.
8. A medical officer appointed to attend the poor, within twenty-one days of his appointment, or as soon thereafter as he shall be required by the Parochial Board to do so, shall, if practicable, name to the Parochial Board a duly qualified medical practitioner, whose nomination is not objected to by the Parochial Board, who will perform the duties of the medical officer in case of his absence from home or other unavoidable hindrance to his personal attendance, and for whose diligence he will be held responsible.
9. Every Parochial Board, as a condition of receiving a share of the Grant... shall name a duly qualified medical officer (or medical officers) at a fixed salary to attend the persons in receipt of parochial relief within the parish [The fixed salary of the medical officer should not include the cost of medicines and medical appliances.]

10. ... if any medical officer shall fail or neglect or refuse to perform the duties of his office, or shall be found unfit or incompetent to discharge them, the board of Supervision shall have power to dismiss him.

11. No alteration of the fixed salary of a medical officer shall be made without the consent of the Board of Supervision to such alteration being first obtained.

12. In the case of a Parochial Board which has not hitherto participated in the medical relief grant... a copy of the resolution specifying the amount of the salary to be given to the medical officer must be submitted to the Board of Supervision for approval.

13. No appointment shall be made to the office of medical officer until the vacancy has been advertised for three weeks, once in each week, in a newspaper circulating within the county. The medical officer shall not be dismissed or his services dispensed with, at any meeting which has not been duly called on ten days' notice, in terms of the Board's rules.

14. In every parish that participates in the Grant, lists of all aged and infirmed persons in the receipt of outdoor parochial relief, and residing within the parish or district of each medical officer, shall be prepared every six months, and a copy furnished by the inspector to the medical officer, who is bound to attend all such poor persons on their producing a ticket furnished to them by the Parochial Board.

15. Every medical officer appointed by the Parochial Board... shall duly and punctually attend upon and prescribe for all poor persons requiring medical or surgical assistance within the parish or district to which he is appointed, whenever he shall be thereunto required, by a written or printed order from the Parochial Board or the inspector of the poor; or in cases of sudden and urgent necessity, from a member of the Parochial Board; or by the production, on the part of any poor person, of the ticket referred to in the preceding rule.

16. Such medical officer shall keep a register of the sick poor... which shall be submitted to the Parochial Board at each of their statutory meetings, and at such other meetings as the said Board shall direct, and shall at all times be open to the inspector of poor and the officers of the Board of Supervision; make to the Board of Supervision such returns of the sick poor as that Board may from time to time require; give to Parochial Board and to the inspector of the poor, when required, any reasonable information respecting the case of any poor person under his care; make any such written report relative to any sickness prevalent among the poor as the Parochial Board or the Board of Supervision may require of him; attend the Parochial Board when summoned by them; give a certificate under his hand in every case to the Board of Supervision, and to the Parochial Board or the inspector of the parish of settlement or residence, or the poor person on whom he is attending, of the sickness of such poor person, or other cause of his attendance, when required.

17. The offices of the inspector of poor and medical officer shall not be held by the same person.

18. The medical officer of a parish, or a district of a parish, shall not vote at the meeting of any Parochial Board whose officer he is.

Approved by one of Her Majesty's Principal Secretaries of State, October 21, 1848, April 10, 1856, September 11, 1863, and February 26, 1885; and by the Secretary for Scotland, March 24, 1887, and 10th June 1890.

Source: Copy of 'Rules framed by the Board of Supervision, under the Statute 8 and 9 Vict. Cap. 83, as to Medical Relief of the Poor' from *Report of the Departmental Committee appointed by the Local Government Board for Scotland to enquire in the system of Poor Law medical relief and in the rules and regulations for the management of poorhouses*, vol. II (PP Cd. 2022, Edinburgh: 1904), appendix LXVI, pp. 283-4.

Appendix VII: Scottish Poor Law Medical Certificate Pro-Forma

Medical Officers, Parish of Govan, Glasgow.

MEDICAL CERTIFICATE.

PARISH OF GOVAN COMBINATION.

Date, 31st Dec 1886

To, Campbell, James Sloan

Name of Applicant, James Sloan

Name of Dependents, Flora M. Sloan

Residence, St Andrew St 2 up R

Age, 59 Occupation, Carpenter, Settlement...

I have this day examined the above-named Applicant, and hereby certify on oath and conscience, the particulars and details as far as they are in the full of my knowledge and belief.

Signed, J. Campbell Medical Officer

(Dated) 31st Dec 1886

Is the applicant in good health? No

Is the applicant able to do any work? No

Nature of applicant's sickness or infirmity? Neuralgia

If applicant has dependents, state whether they, or any of them, suffer from sickness or infirmity? No

Does the condition of applicant or dependents require immediate attention and medical advice? Yes

Is applicant or any dependent lunatic, insane, idiot, or of unsound mind? No

Are applicant and dependents able to be removed to the Poorhouse of Govan Combination without injury to their health? Yes - Can walk

Are applicant and dependents able to be removed to the Poorhouse of Govan Combination without injury to their health?

MEDICAL CERTIFICATE:

'Medical Officers' Hours of Attendance'

'[Whether] Applicant can [or cannot] call [on the surgeon]'

Doctor's details...

Questions...

- | *'Is the applicant in good health?*
- | *Is the applicant able to do any work?*
- | *Nature of applicant's sickness or infirmity?*
- | *If applicant has dependents, state whether they, or any of them, suffer from sickness or infirmity?*
- | *Nature of sickness or infirmity of dependents*
- | *Does the condition of applicant or dependents require immediate attention and medical advice*
- | *Is applicant or any dependent lunatic, insane, idiot, or of unsound mind?*
- | *Are applicant and dependents able to be removed to the Poorhouse of Govan Combination without injury to their health?'*

Source: Applications For Relief, Govan Parish (Glasgow: Glasgow City Archives, 1886) ref: GCA D-HEW 17/301.

Appendix VIII: A representation of the overall structure of the Glasgow and Edinburgh PMO

prosopographical database showing the ‘normalised’ tables, fields and keys.

PARISH MEDICAL OFFICERS (PMOs) - 18 fields.

M.O. ID#	Surname	first name	birth year	year of death	year appointed	year contract terminated	confirmed years service	est. minimum years as M.O.
birthplace	parish of employment	post	year of registration	est. minimum time as M.O.	where trained	obituary text file	value of estate	MEMO NOTES

ADDRESSES/PRACTICE LOCATIONS OF PMOs - 6 fields.

M.O. ID#	Address#	Address	use & source of location	used to see paupers?	years at
----------	----------	---------	--------------------------	----------------------	----------

EDUCATIONAL QUALIFICATIONS of PMOs - 6 fields

M.O. ID#	Qualification#	Qualification	issuing body	year of issue	SOURCE NOTES
----------	----------------	---------------	--------------	---------------	--------------

POSTS/ASSOCIATIONAL MEMBERSHIPS HELD BY PMOs- 9 fields.

M.O. ID#	Post#	post held	type of post or membership	held in 1877?	held in 1887?	held in 1897?	held in 1907?	SOURCE NOTES
----------	-------	-----------	----------------------------	---------------	---------------	---------------	---------------	--------------

PMO PUBLICATIONS - 6 fields.

M.O. ID#	Entry#	place of publication	year of publication	publication title	SOURCE NOTES
----------	--------	----------------------	---------------------	-------------------	--------------

CENSUS 1881 HOUSEHOLD COMPOSITION OF PMOs - 9 Fields.

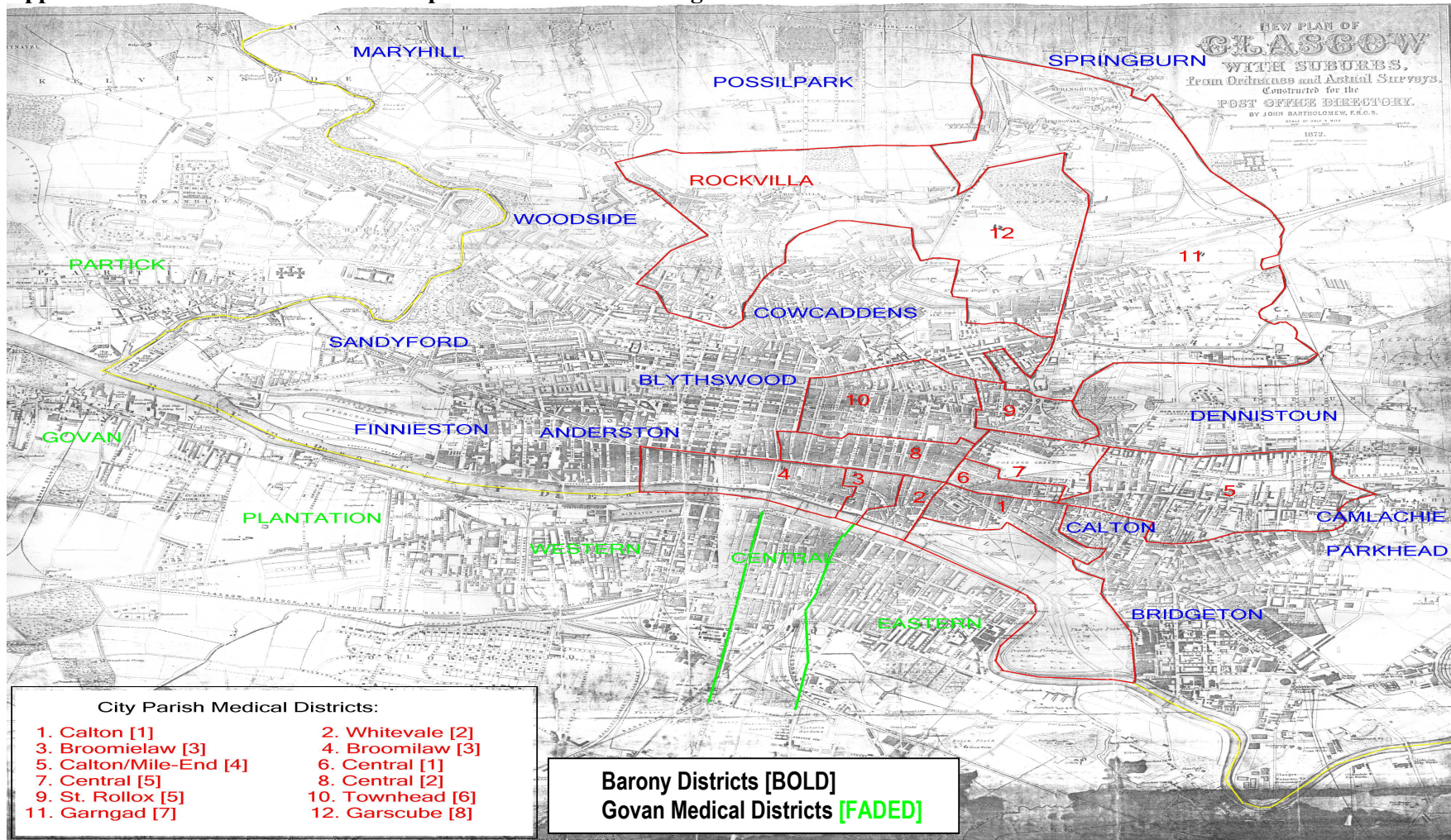
M.O. ID#	Relation#	surname	first name	Relationship to M.O.	age per 1881 census	marital status	gender	occupation
----------	-----------	---------	------------	----------------------	---------------------	----------------	--------	------------

APPLICANTS FOR VACANT POSTS - 9 fields

App. ID#	parish	district	date	successful (y/n)?	surname	first name	local applicant?	notes on applicant
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Appendix IX: Poor Law districts of the parochial boards of Glasgow



Appendix X: 'Private and Unofficial' Scheme for Managing the Medical and Surgical Dispensary of the Western Infirmary, drawn up by Professors Charteris and Cleland

SCHEME FOR MANAGING THE MEDICAL AND SURGICAL
DISPENSARY OF THE WESTERN INFIRMARY.

Drawn up by Professors CHARTERIS and CLELAND.

- I.—There shall be four Dispensary Surgeons. Three Surgeons shall be on duty at one time, each attending two days a week. Every month one Surgeon shall retire, and the Surgeon previously off duty shall take his place.
- II.—There shall be six Dispensary Physicians, who shall each attend two days a week in the eight months from November to June inclusive; and the Superintendent shall arrange for one Physician acting daily in the four other months, or for two if need be.
- III.—Students who have passed a professional examination in Materia Medica and Therapeutics shall be allowed to enter their names as Pupils for Out-Door and Dispensary practice. Each Student shall arrange to attend twice a week with one Physician, and shall assist his Physician or the Surgeon in attendance in prescribing, &c.
- IV.—The Physicians shall, in the case of Patients who are not considered suitable for admission into the Infirmary, but are too ill to attend again at the Dispensary, appoint a Student to visit them at their homes. The Surgeon in attendance shall divide the Surgical Patients to be seen at their homes among the Students of the day.
- V.—Prescriptions in Out-Door Practice shall be written on paper headed "Western Infirmary Dispensary," and bearing a printed notice of an hour during the day, and another in the evening, when Prescriptions may be brought to be made up.
- VI.—It shall be the duty of the Student in Out-Door Practice to report weekly the progress of cases in his charge, and to consult his Superior in event of any difficulty.
- VII.—A Printed Notice shall be put up in the Waiting-Room to the effect that Patients may be attended at their homes by Senior Students, under regulations made by the Managers of the Infirmary.

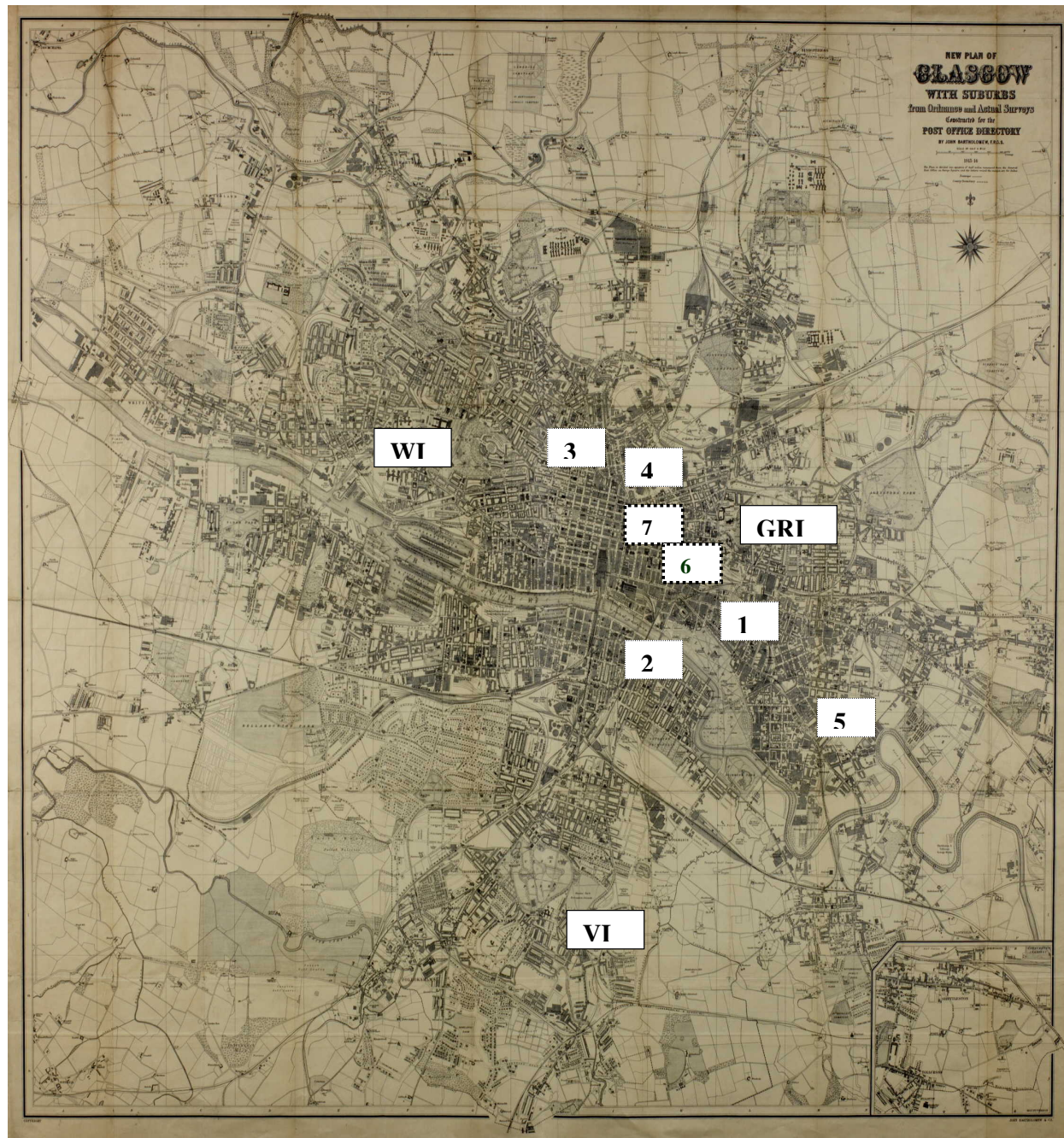
Source: Medical sub-committee report in Glasgow Western Infirmary Minutes (Glasgow: Greater Glasgow Health Board Archives (12th Nov., 1887) ref: GGHB HB 6/1/1

Appendix XI: List of medical practitioners recorded as *having attended cases gratis* on behalf of one or more conferences of SVDP in Glasgow, between 1895/96 and 1911/12

Visiting practitioner		Biographic details	birth	death	visited	qualifications
Colvin	Thomas	'Chevalier Colvin', Glasgow-born son of Catholic immigrants	c.1863	1940	1895-1911	MB, CM (Gla) 1893, MD (Gla) 1901
Connor	George Muir	Non-Catholic Free Church; GMMS med. super. 1885-1898	1854	1916	1907	MB, CM (Gla) 1885
Cosgrove	Henry Joseph	Also M.O. of Irish National Foresters & A.O. Hibernians			1895-1912	Triple 1892
Docherty	Peter Alpine	In England by 1910s	1864/5		1897	Triple 1890
Doherty	Daniel	In Londonderry after graduating; back to Ireland in 1910s			1895-99	Triple 1891
Duncan	Alexander	Son of the secretary of the FPSG	1866	1933	1897	MB, CM (Gla) 1887, DPH (Camb) 1898
Dunning	Matthew	1 st generation Scots-Irish son of Irish Stevedore	1865/6		1897-1911	MB, CM (Gla) 1895
Henry	Stephen John	From prominent Glaswegian Catholic family: father on Glasgow Parish Council, uncle was SVDP president.	1885/6	1948	1910	MB, ChB (Gla) 1908
Longwill	David	PMO 1906-1926; MO Irish National Foresters	1876		1907-12	MB, ChB (Gla) 1900
Maguire	Peter	Son of SVP vice president. Irish-born mother	1882		1906-11	MB, ChB (Gla) 1905
Mason	Alex. Whyte	In Durham by 1905; in Renfrewshire in 1911	c.1865		1899-1901	Triple 1893
McArdle	Daniel Conway	Catholic active in Crosshill (a hotbed of Irish-Catholicism)	1884		1910-12	MB, ChB (Gla) 1908
McKaigney	Thomas Joseph	Irish born and practising in Derry circa 1904		1935	1905-10	Triple 1902
McKail	David	M.O. for Catholic Friendly Societies	1874	1958	1904-06	MB, ChB (Gla) 1897, MD (Gla) 1908, DPH (Camb) 1907
McLaughlin	Michael	Prominent Catholic citizen in Glasgow; served as medical convener of Glasgow Parish Council in early 1900s: two sons became doctors, the other a priest.	1862	1942	1895-1912	Triple 1888
O'Hare	Patrick Joseph	Glasgow-born son of Irish immigrants	1882		1909-12	MB, ChB (Gla) 1906
Patterson	William				1909	L.D.S., DENTIST
Quigley	Edward	Glasgow born son of Glasgow-born pawnbroker who was a member of Glasgow Parish Council	1880	1914	1910	MB, ChB (Gla) 1908
Scanlan	Joseph	One of first Glasgow-Irish Catholics educated at G.U.	1862		1897-1912	MB, CM (Gla) 1885
Smith	Patrick Aloysius	Son of Irish immigrants; became a J.P.	1850	1910	1895-1909	MB, CM (Gla) 1885, LFPSG (1882), FFPSPG (1884), MD (Gla) 1896
Thomas	David	Son of a Presbyterian Minister; described in obituary as 'deeply religious' churchman	1867	1957	1901-07	MB, CM (Edin) 1893, MD (Edin) 1898

Note: Confirmed non-Catholics in **bold**.

Appendix XII: The location of the medical missions of Glasgow mapped in relation to main charitable dispensaries and infirmaries, c. mid-1890s



Key:

- | | |
|---|--|
| 1. GMMS Moncur Street Dispensary (1879-1954). | 2. GMMS Oxford Street Dispensary (1884-1960s) |
| 3. Grove St Institute (medical mission from c.1886) | 4. Cowcaddens Free Church Medical Mission (1884) |
| 5. Bridgeton Medical Mission (c. 1891) | |
| 6. Glasgow Central Dispensary (formerly Anderson's College Dispensary) (1878) | |
| 7. Glasgow Public Dispensary (1876) | |
| GRI: Glasgow Royal Infirmary (1794) | |
| WI: Glasgow Western Infirmary (1874) | |
| VI: Victoria Infirmary (1890) | |

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